INQUEST INTO THE DEATH OF JEFFREY JAMES: JURY RECOMMENDATIONS

We the jury recommend the following:

Accreditation Canada (formerly Canadian Council on Health Services Accreditation CCHSA)

1. That Accreditation Canada should set as a standard for accreditation, a required organizational practice that health care facilities providing psychiatric care should develop reporting mechanisms and practices that track all incidents of physical restraint involving psychiatric patients. This could fall under the auspices of "Required Organizational Practices, Patient Safety, Risk Assessment".

Centre for Addiction and Mental Health (CAMH)

2. That CAMH continue to aspire to provide care to clients/consumers/survivors in a restraint free environment.

3. That consistent with its leadership role, CAMH should share with all psychiatric and schedule 1 facilities in Ontario, its:
   - 3.1 Restraint Minimization Task Force May 30th, 2008 Final Report.
   - 3.2 Client Bill of Rights.
   - 3.3 Least Restraint Policy.

4. That CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to:
   - 4.1 Establish best practices guidelines for restraint.
   - 4.2 Discuss restraint minimization techniques and practices.
   - 4.3 Develop a data collection system regarding incidents of restraint use.

This data should be reviewed and compiled annually and presented in a report accessible to the public on line and be compliant with the Personal Health Information and Protection of Privacy Act, 2004. That CAMH should develop a business plan to be presented to the Ministry of Health and Long Term Care who should provide sufficient funding for CAMH to conduct this important work.

5. That CAMH should redesign all forms related to the charting of patients in restraint to reduce complexity and ensure compliance with written policy, in order to ensure that all aspects of written policy are carried out.

6. That CAMH should ensure that counseling and emotional supports are made available to patients on a unit following the death of a client/consumer/survivor.

7. That CAMH should ensure that all health service providers are provided mandatory in-service education on the minimization of restraints, the use of restraints, and the medical risks associated with restraints including pulmonary embolism.

8. That CAMH should ensure that all health service providers are provided with in-service education with respect to the Jury's Verdict and Recommendations.

Psychiatric and Schedule 1 Facilities

Guiding Principles

9. That all psychiatric and schedule 1 facilities in Ontario should aspire to provide care to clients/consumers/survivors in restraint free environments.

10. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's Client Bill of Rights. In facilities where a client Bill of Rights does not exist, one should be created and modeled after CAMH's Client Bill of Rights.

11. That all psychiatric and schedule 1 facilities in Ontario should review the CAMH's, "Restraint Minimization Task Force May 30th, 2008 Final Report" and incorporate the findings in developing and evolving their own approaches to restraint of psychiatric patients.

12. That all psychiatric and schedule 1 facilities in Ontario should review CAMH's "Least Restraint Policy" and review their own policies on seclusion and restraint.

13. That although individuals with psychiatric illness may manifest behaviour that puts themselves or others at risk and requires urgent physical intervention, seclusion and restraint should be considered extraordinary interventions.

14. That consideration should be given at all times to alternatives to physical restraint. These alternatives could include low stimulation seclusion rooms and chemical restraint. The chemical restraint will often provide a degree of treatment of the underlying core condition which has given rise to the concerning behaviour. The utilization of these alternative forms would be at the clinical discretion of the treating team.

15. That if a patient's behaviour requiring restraint is a function of an underlying psychiatric condition, that condition should be treated assertively in order to reduce the symptoms of the illness driving the behaviour requiring restraints.

16. That where restraint is applied, it should only be in place for as short a period of time as possible.

17. That all psychiatric and schedule 1 facilities in Ontario should, in the development of their own least restraint policies, seek the views of clients/consumers/survivors representing the client perspective from their own communities.

Quality

18. That all psychiatric and schedule 1 facilities in Ontario should track all episodes of physical restraint of psychiatric patients, and this should be reported and monitored by the organization's Quality Committees, as an important indicator of patient safety. These statistics should be presented to each Hospital's Board on a quarterly basis.

Policy

19. All psychiatric and schedule 1 facilities in Ontario should ensure that policies on restraint contain at a minimum, requirements that:

- 19.1 Alternative methods and least restrictive care be a priority.
- 19.2 The client/patient be informed immediately and regularly what is necessary to be released from restraint.
- 19.3 The person in restraints be reminded of their right to contact with the Patient Advocate (pending revision of the Mental Health Act legislation).
- 19.4 Staff should provide ongoing support and comfort to the person restrained.
- 19.5 All staff (including agency staff) should be familiar with policies regarding restraint.
- 19.6 All clients in restraint ambulate (walk around) for at least 15 minutes every 8 hours where the treating team feels it can be safely accomplished.
- 19.7 Toileting needs are met.
- 19.8 Assessments of physical health by clients in physical restraint be performed by an MD in person at least every 24 hours.
- 19.9 Assessments for release from restraint must be performed by an MD in person at least every 24 hours.
- 19.10 No order for continuation of restraint can be signed by a person who has not seen the client within two hours.
- 19.11 External consultation/peer review by an MD not from the unit take place following every 72 hour interval, or sooner.
- 19.12 Policies and best practices regarding least restrictive care and restraints be followed (e.g. vital signs taken, limbs released).
- 19.13 One person each shift be assigned the responsibility of ensuring all requirements for the care of the client in restraints are met.
- 19.14 Has a system to notify the Officer or Person in Charge and/or their designate and the Clinical/Program Director or Unit Manager when a person is restrained.
- 19.15 Charting reflects what is required of caregivers in relevant policies.

19.16 In event of a death, charting be closed at a time proximate to an individual's death.

20. That all psychiatric and schedule 1 facilities in Ontario should develop a plan for restraint that minimizes the risk for the development of deep vein thrombosis. This plan should consider:

20.1 Early discontinuation of restraint

20.2 Planned intermittent mobilization with ambulatory limb restraints (hand/waist restraints) where feasible, and possible, based on the decision of health care providers. This may require the presence of security.

20.3 A clear description of desired target behaviors, which will allow the client to be released. These should be duly recorded in the client's health record, and provided to the client as soon as physical restraint is initiated.

21. That all psychiatric and schedule 1 facilities in Ontario should ensure that the Person in Charge or the Officer in Charge, and the Unit Manager are notified when a client is placed in restraints.

22. That all psychiatric and schedule 1 facilities in Ontario should ensure that all persons admitted as inpatients for the purpose of receiving psychiatric care, whether voluntary or involuntary, should be requested to provide their choices of management in the event that they decompensate and require physical, chemical or seclusion restraint. This preference should be duly noted in the patient's medical file. This would be consistent with Client-Centred Care.

23. That all psychiatric and schedule 1 facilities in Ontario should ensure that an individual plan of care and treatment be established as soon as is practicable. Every effort should be made to ensure that inpatients have access to meaningful day time activities and therapeutic programming from the time of admission.

24. That all psychiatric and schedule 1 facilities in Ontario should develop a plan with the client based on her/his self identified needs. Unless contraindicated, this plan will include a crisis plan describing:

24.1 Potential emotional triggers and how to address them.

24.2 What works best to help calm the individual if in crisis.

24.3 Options that the client identifies as least restrictive if the person is to be physically contained.

24.4 Whether the individual wants the Patient Advocate contacted if unable to contact them him/herself.

All of the above should be reflected in the client's chart.

25. That all psychiatric and schedule 1 facilities in Ontario should require that where a client/consumer/survivor has been placed in physical restraints, a policy should be created that an external review be undertaken by a psychiatrist who is not part of the treating team. This policy should clearly set out:

  25.1 Who is responsible for ensuring that the external review has been completed.

  25.2 The mandatory dates and times for when the review must be completed.

  25.3 Consideration that this review should occur within 72 hours, or less.

And that the review should be completed by a psychiatrist not associated with the treatment team or the initiating or continuing restraint order.

26. That all psychiatric and schedule 1 facilities in Ontario should create a document which specifies when a client has requested to see a Patient Advocate. This document should specify the time and date that the request was made, and allow for the recording of when the Patient Advocate saw the client.

Education

27. That all psychiatric and schedule 1 facilities in Ontario should consider the client perspective when training health care providers on the implementation of physical restraint. A role should be considered for clients/consumers/survivors and the Psychiatric Patient Advocate Office (PPAO) in assisting in the education of health care staff.

28. That all psychiatric and schedule 1 facilities in Ontario should ensure that members of the treatment team are aware of hospital policies, laws, and provincial guidelines governing restraint and ensure that staff acknowledge this awareness by affixing their signatures to documents prepared for the purposes of education.

29. That all psychiatric and schedule 1 facilities in Ontario should conduct an interdisciplinary review process (“a debrief”) following each and every episode where physical restraint has been utilized in the care of a client. This review should consider whether alternative treatment options were available, whether the length of time in restraint was minimized, and whether the restraint was provided in a manner consistent with written policy.

30. That all psychiatric and schedule 1 facilities in Ontario should invite the PPAO to the debrief where appropriate, and with the consent of the client/consumer/survivor.

31. That all psychiatric and schedule 1 facilities in Ontario should ensure that admitted patients have access to policies regarding restraint and that it is available in a readily understandable form from the time of admission. A member of the health care team should be available to explain the policy and its application when requested.

Nursing

32. That all psychiatric and schedule 1 facilities in Ontario should ensure that where continuous observation is being provided, wherever practicable, it should be done by a small cadre of nurses who would then become familiar with the client and be aware of, and sensitive to, changes in the client's status.

33. That all psychiatric and schedule 1 facilities in Ontario should endeavor to assign a primary nurse and an associate nurse whose duties should be to provide as much of the constant observation of a client in restraint as possible.

34. That all psychiatric and schedule 1 facilities in Ontario should ensure that nursing forms utilized to monitor patients correlate well with written policy.

Physicians

35. That all psychiatric and schedule 1 facilities in Ontario should ensure through policy implementation that all admitted psychiatric patients are provided a full psychiatric assessment by the attending psychiatrist or designate within 24 hours of admission or transfer. Subject to weekends and holidays, this should occur as soon as possible thereafter. To be clear, this should never extend beyond 72 hours.

36. That all psychiatric and schedule 1 facilities in Ontario should ensure that when assigning psychiatrists to new patients on admission and transfer, that the patients should be seen on a weekly basis for the first month and on at least a monthly basis thereafter.

37. All psychiatric and schedule 1 facilities in Ontario should ensure, through policy that upon transfer of a patient, the attending psychiatrist contact the transferring facility, and speak to the sending psychiatrist, for the purpose of identifying any potential de-stabilizers and successful intervention techniques.

38. That all psychiatric and schedule 1 facilities in Ontario should ensure that orders continuing patient restraint are provided every 24 hours, and should only be provided by physicians who have personally examined the client/consumer/survivor.

39. That all psychiatric and schedule 1 facilities in Ontario should ensure that where a client is in physical restraint, the client must be seen by a physician who provides medical care, (as opposed to psychiatric care) to ensure that medical issues that may arise are appropriately attended to every 24 hours.

40. That all psychiatric and schedule 1 facilities in Ontario should require on call physicians to return telephone inquiries from the patient advocate, in respect of patients in restraint, where the issues can not be adequately addressed by the treating team, within 4 hours.

Centre for Forensic Sciences Toxicology Section

41. That the Centre of Forensic Sciences Toxicology Section should, where possible, set detection levels in the therapeutic range for the testing of psychotropic medications. This informs the Coroners Inquest process and does not lead to the erroneous belief that patients were actually not receiving drugs when evidence was provided that they were.

City of Toronto Fire Department (TFD)

42. That the City of Toronto Fire Department should conduct a critical incident review of the management of their involvement with Mr. James around delays in attending, with the assistance of CAMH. This review should consider what policies, if any, were in effect and acted upon. Following this review, the TFD should notify their members of any concerns relating to delays in providing service to Mr. James.

Local Health Integration Networks (LHIN)

43. That all LHINs should require health service providers that deliver psychiatric inpatient services to track episodes of physical restraint as a component of their service accountability agreement. The purpose of this would be to allow the service providers to compile the requisite data to follow an important indicator of psychiatric patient safety.

44. That all LHINs should meet with the PPAO and health service providers within their geographical area to determine the appropriate number (benchmark) of Patient Advocates that would be necessary within the LHIN to provide adequate rights advice and advocacy for clients/consumers/survivors. These numbers should be collectively tabulated and provided to the MINISTRY OF HEALTH AND LONG TERM CARE to allow for planning with respect to fiscal resources allotted annually to the PPAO.

The Ministry of Health and Long Term Care

45. That the Ministry of Health and Long Term Care should mandate that the PPAO have a physical presence (an office) in each of the former provincial psychiatric facilities.

46. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require the PPAO to provide ***rights advice and advocacy*** for all psychiatric facilities under the Mental Health Act. This should include not just the former provincial psychiatric hospitals, but in addition, all schedule 1 facilities in community and general hospitals where psychiatric care is provided.

47. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to require psychiatric facilities, community and general hospitals operating schedule 1 facilities to notify the PPAO when an inpatient (client/consumer/survivor) receiving care is placed in physical restraints.

48. That the Ministry of Health and Long Term Care should consider amendments to the Mental Health Act to incorporate language that indicates that physical restraint is to be used on a “last resort” basis.[1]

49. That the Ministry of Health and Long Term Care should provide funding to the PPAO to allow it operate with the extended mandate of rights advice and advocacy in all psychiatric facilities including schedule 1 facilities in community and general hospitals where psychiatric care is provided. This funding should contemplate that the PPAO provide service on a 24/7 basis. This funding should be based on a benchmarking exercise conducted by the LHINs, health service providers and the PPAO. (See recommendation # 45)

50. That the Ministry of Health and Long Term Care should provide funding to CAMH for the following:

> “ CAMH should take a leadership role with all psychiatric and schedule 1 facilities in Ontario to establish best practices guidelines for restraint, discuss restraint minimization techniques and practices, and collect data regarding incidents of restraint use. This data should be reviewed and compiled annually and presented in a report accessible on line to the public and compliant with the Personal Health Information and Protection of Privacy Act, 2004. CAMH should develop a business plan to be presented to the MINISTRY OF HEALTH AND LONG TERM CARE who should provide sufficient resources for CAMH to conduct this important work, initially, and on a continuing annual basis”.

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[1] MHA ="restrain" means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient;

51. That the Ministry of Health and Long Term Care should provide financial support to the Registered Nurses' Association of Ontario (RNAO) towards RNAO's development of a nursing Best Practice Guideline (BPG) for the use of restraints in psychiatric patients, and the development of an educational toolkit for nurses.

PPAO

52. That the PPAO should meet with the Ministry of Health and Long Term Care for the purposes of discussing models of governance which allow for sufficient institutional independence and do not contemplate interference by the Ministry with respect to the important duties of rights advice and advocacy provided by the PPAO.

53. That the PPAO should consider governance by a Board of Directors for the purpose of providing oversight and ensuring accountability of the PPAO to clients/consumers/survivors, and ultimately the public, which funds its activities.

54. That the Board of Directors could provide the PPAO with;

 54.1 Advice respecting strategic directions, performance expectations, and compelling ethical issues, and

 54.2 Direction on operational issues, budgetary planning and approval, making senior personnel decisions, and establishing a complaints process.

55. That the Board should have a membership consisting of competent members from institutions and organizations who are familiar with, and have expertise, acting in the public domain. The majority of these members should be drawn from the consumer/survivor community and further include advocate groups such as the Empowerment Council.

56. That following establishment of a Board of Directors for governance, the PPAO should undergo a strategic planning process which re-evaluates its mandate. This process should seek to evolve from its current mandate, established in the early 1980s, to a contemporary one. As a component of its strategic planning process, the PPAO should invite stakeholders such as the Empowerment Council, CAMH, representatives from LHINs, representatives from schedule 1 facilities, and others to advise and inform their process.

57. That as a component of its strategic planning process, the PPAO should seek to review and revise its model of service delivery.

58. That the model of service delivery, should consider, as a minimum:
    58.1 That the needs of clients/consumers/survivors are required 24/7. The current availability is Monday to Friday from 9 am to 5 pm.
    58.2 How long a Patient Advocate (PA) should take to respond to the requests of clients/consumers/survivors for a meeting, effectively creating a triaging system based on the situation and intensity of need. For example, physical restraint should be considered a critical incident requiring immediate attention.
    58.3 With the consent of the client/consumer/survivor, a review of the medical file to inform the PA should occur. This would ensure that the PA would advocate most effectively on behalf of the client and address the clinical team with a more fully informed assessment of the issues.
    58.4 The method and timeliness of recording client/consumer/survivor encounters. These should be entered into the logging system immediately following any interviews, and always contemporaneously, as is done by health care providers.
    58.5 Where notes are taken by PAs, they should be kept until resolution of the situation, and where death occurs, they should be kept indefinitely.
    58.6 A document should be created which allows the PA to record clients' wishes, and this should be presented to the health care team following verbal communication.

59. That the PPAO should develop a training program to educate its advocates regarding the reasons why persons are placed in restraints, including indication for restraint, risks and benefits.

Ontario Review Board (ORB)

60. That the Ontario Review Board should convene a Restriction of Liberties Hearing within 4 days upon notice by facilities whenever a person under ORB jurisdiction has been mechanically restrained for 7 days.

Registered Nurses' Association of Ontario(RNAO)

61. That the RNAO should develop a nursing best practice guideline for the use of restraints in psychiatric patients, in consultation with relevant stakeholders such as the Ontario Nurses' Association.

62. That the best practice guideline should be provided to nurses with the use of a toolkit.

63. That this education should be supported by all psychiatric and schedule 1 facilities and should include the nursing clinical educator of the unit providing a lecture on the risks and benefits of restraint with the following characteristics:
   - 63.1 Education should begin immediately upon completion of the BPG.
   - 63.2 The education should be provided in each facility.
   - 63.3 It should be targeted to the nursing staff and discuss the risks of pulmonary embolism.
   - 63.4 It should be repeated biannually.

The Office of the Chief Coroner (OCC)

64. That the Office of the Chief Coroner should conduct inquests into the deaths of psychiatric patients being cared for in psychiatric and schedule 1 facilities who die while being subjected to physical (mechanical) restraints. For clarity, this does not necessarily include those who die while under seclusion or chemical restraint, or while involuntarily admitted to these facilities unless they are in physical restraints. This policy is not intended to be retrospective, and should include deaths in which physical restraint was involved beginning October 10, 2008.

65. That the OCC should provide all psychiatric and schedule 1 facilities with a copy of the Jury's Verdict and Recommendations and the Coroner's Verdict Explanation.

66. That the OCC will provide a report to any interested parties with respect to the recommendations within one year of the Inquest being completed, upon request.