Verdict of Coroner's Jury

Office of the Chief Coroner

The Coroners Act - Province of Ontario

Surname: Mpelos
Given name(s): Nokolaos
Age: 65

Held at: 25 Morton Shulman Ave, Toronto, ON
From: Oct. 16
To: Nov. 7, 2017
By: Dr. Roger Skinner, Coroner for Ontario
having been duly sworn/affirmed, have inquired into and determined the following:

Name of deceased: Nokolaos Mpelos
Date and time of death: May 26, 2013 at 6:27 a.m.
Place of death: St Joseph's Health Centre, Toronto
Cause of death: Dilated cardiomyopathy
By what means: Natural

(Original signed by: Foreperson)

The verdict was received on the 7 of Nov., 2017
Coroner's name: Dr. Roger Skinner
(Original signed by coroner)

We, the jury, wish to make the following recommendations:

Inquest into the death of:

Nokolaos Mpelos

Jury Recommendations

Use of Restraints

To all Hospitals in Ontario:

1. Ontario hospitals should aspire to provide care without the use of restraints.
2. Ontario hospitals should be reminded that restraint use must comply with Ontario legislation, including the *Patient Restraints Minimization Act* and the provisions of the *Mental Health Act* and *Health Care Consent Act*, where applicable.

To All Schedule 1 Facilities in Ontario:

3. All Schedule 1 facilities in Ontario should have a formalized Least Restraint policy that documents at a minimum the following aspects:
    a. All key activities involved in the emergency and non-emergency application of restraints including:
        i. Assessment, Alternative Solutions, Consent, Restraint Ordering and Application, Re-ordering of Restraints, Ongoing Monitoring, Removal, Debrief, and Evaluation.
    b. All roles and responsibilities associated to the activities above.
    c. Defined measures and metrics associated with the activities above.
4. Hospital policies are to be based on applicable law and principles of least restraint. Consideration should be given to recommendations from the Jeffery James inquest as well as from this inquest. In addition, least restraint policies should consider the following:
    a. Any order for restraint **cannot** be made on a "prn" or "as needed" basis.
    b. Mechanical or chemical restraint or seclusion should be ordered by a physician **only** after an assessment of the patient, except in circumstances in which immediate action is necessary to prevent serious bodily harm to the patient or to another person.
    c. When mechanical or chemical restraint or seclusion are initiated without a physician order, one should be obtained as soon as possible thereafter, and the patient should be assessed by a physician within one hour.
    d. The patient should be re-assessed by a physician every two hours thereafter during the period of mechanical restraint. The re-assessment should include consideration of whether continued mechanical restraint is required.
    e. If the patient is secluded, they should be re-assessed by a physician at appropriate intervals.
    f. The unit manager should be notified when mechanical restraint or seclusion is initiated for a patient.
    g. Restraint use should be documented, and this documentation should include:
        i. who ordered the restraint
        ii. a description of the means of restraint
        iii. a description of the behaviour of the patient that required the use and / or continuation of restraint
        iv. a description of environmental and/or relationship issues that may have been a stressor for the patient
        v. the time that the restraint was initiated and then discontinued

vi. the frequency of observation during the period of restraint
vii. a description of the effect of the restraint on the patient
viii. results of a complete physical assessment of the patient for physical injury, if any, associated with the use of restraints
ix. the manner in which the patient was observed during the period of restraint and
x. cumulative totals of the number and duration of periods involving restraint over any given 24-hour period

h. Restraints should be considered extraordinary interventions and used only when less restrictive alternatives, including engagement and de-escalation, have been unsuccessful.
i. It is important for all members of the interdisciplinary care team to have a clear understanding of their roles and responsibilities with respect to the use and application of restraints.
j. Addressing and documenting non-emergency situations where the patient/Substitute Decision Maker opposes the use of restraint as part of their treatment plan. Inform the Most Responsible Physician of the opposition.

5. During periods of mechanical restraint or seclusion there should be direct, uninterrupted, and visual observation of a single patient. The patient under observation should be consulted about what type of interaction would be of comfort to them. Unless refused by the patient, observation should include meaningful interaction with the patient. Meaningful interaction includes:
   a. providing comfort and human contact
   b. considerations of the safety and well-being of the patient, including personal care needs
   c. the expectation for meaningful interaction is applicable to patients with mental health issues on locked units
6. A patient in restraint or seclusion should be advised of the reason for the restraint or seclusion, including the behaviour that led to the use of restraint or seclusion as well as what would result in removal from restraint or seclusion.
7. Where available, patient advocate or peer advocate / support should be offered to a patient on initiation of a period of restraint or seclusion.
8. Following periods of mechanical restraint or seclusion, there should be "debriefs" with both the patient and staff. Consider following a structured model similar to the OPEN Model as defined by St Joseph's Health Centre.
   a. With respect to the patient debrief:
      i. Where possible, clinical staff involved in the patient debrief should not be the staff involved in placing the patient in restraints.
      ii. Where available, debrief with peer advocate / support should be offered to the patient.
      iii. Comments from the patient about their experience should be documented, in their own words.
      iv. The patient debrief should be done as soon as appropriate following the end of the period of restraints, and within 24 hours.
   b. With respect to the staff debrief:

i. Staff directly involved in the act of restraining the patient should be rapidly surveyed for physical injury and psychological distress, and provided with appropriate support.
ii. The team should quickly list possible antecedents to the need for restraints.
iii. Lessons learned and opportunities for improvement should be documented and shared with staff.

9. Patients should receive on-going support specific to the psychological effects of having been in mechanical restraints or seclusion. This support should be considered as part of the patient's plan of treatment. Consideration should be given to whether the plan of treatment needs to be updated following a period of restraint.
10. Only personnel who have been trained in the facility's policies and procedures pertaining to restraint use can apply restraints.

Treatment and Care for Patients with Mental Health Issues

To All Schedule 1 Facilities in Ontario:

11. There should be a clearly documented plan of treatment for each mental health patient, which addresses medical and psychiatric diagnoses, and takes into account the patient's self-identified needs.
12. Medication reconciliation should be completed as soon as possible for patients presenting with mental health issues, and in particular for elderly psychiatric patients. This may be in the form of a Best Possible Medication History. This should include consideration of smoking and the possible need for nicotine replacement, newly introduced medications, as well as the impact this may have on current medications.
13. Ensure that the "5 rights" of medication administration is followed:
    i. right patient
    ii. right drug
    iii. right time and frequency
    iv. right dose
    v. right route
14. A "crisis plan" should be discussed and documented with the patient based on self-identified needs, with consideration of the following:
    a. potential emotional triggers and how to address them
    b. best options to help calm the patient in times of crisis
    c. options that the patient identifies as the least restrictive if physical restraint becomes necessary and
    d. whether the patient would like a patient advocate and/or some other individual of their choice contacted if they are unable to make contact on their own
15. All patients presenting with mental health issues should be assessed medically following in patient admission to hospital.
16. All patient assessments should be performed in a manner to protect patient privacy and confidentiality.
17. Elderly in-patients with mental health issues and multiple medical chronic conditions should, whenever possible, be assessed by a geriatrician or internal medicine specialist.
18. All fall risk assessments should include an assessment of the risk that may arise as a result of psychiatric medication prescribed in a patient's plan of treatment.

19. It is essential that sufficient nursing staff be assigned to care for patients in mental health units.

Education and Training

To the Ontario Hospital Association, Ontario Medical Association, College of Physicians and Surgeons of Ontario, College of Nurses of Ontario and All Hospitals in Ontario:

20. All clinical staff providing care in mental health units should have specific education and training in providing care to mental health patients
21. Continuing education for clinicians should include:
    a. Emergency department assessment of patients presenting with mental health issues should include a formal mental status exam which includes assessment and documentation of patient appearance, behaviour, speech, mood, affect, thought form, thought content, insight, judgment, and cognition.
    b. Emergency department physicians considering a Form 1: Application for Psychiatric Assessment should take into account information from direct assessment of the patient and corroborating information. Pre-populated forms should not be used.
    c. Psychiatric assessment should include a full assessment with a mental status exam, diagnosis, and treatment plan. This assessment should be documented in the clinical notes and records.
    d. Medical assessment during and following periods of mechanical and / or chemical restraint should consider the risks of deep vein thrombosis and cardiac effects of restraints.
    e. Psychiatric assessment requires regular psychiatric follow-up evaluation and should include full documentation of a mental status exam with each visit.
    f. Physicians should consider delirium as part of the differential diagnosis for any patient, especially in those 65 years and older, with altered cognition or altered level of consciousness.
    g. Nurses in all clinical settings should consider clinical changes in a patient's condition, and be alert to the need for further medical assessment.
    h. Clinicians should be aware that smoking cessation increases the impact of certain psychiatric medications. This should be considered in prescribing medications.
    i. Clinicians should consider the efficacy of nicotine replacement and should support patients to adequately use the available nicotine replacement treatment.
22. Documentation should comply with applicable College standards and guidelines, as well as hospital policies. Documentation should indicate which observations are subjective versus objective. Documentation should not include unfounded conclusions, value judgments, or labeling. Health care providers should be aware of the risk of their subjective assessments being informed by stigma or bias. Documentation should be subjected to periodic audits by the hospitals' quality control.
23. Training for clinicians and security guards should be provided in-house, and where applicable, should be provided to health care providers and security guards as a team, in particular, training regarding restraints.
24. Education should be provided to clinicians with respect to the recognition and management of delirium in the emergency department setting.

25. Clinicians should consider possible associations between psychiatric medications and cardiac issues.

To All Hospitals in Ontario:

26. All front line staff working in the emergency department should have annual training geared towards the prevention and management of aggressive behaviours, and non-violent crisis intervention, including training on:
    a. restraints, including avoidance/minimization of the use of restraints
    b. falls
    c. patient and staff safety
    d. effective communications

To All Schedule 1 Facilities in Ontario:

27. Clinicians dealing with patients with mental health issues should have annual training about the care and assessment of patients with mental health issues, based on a curriculum that should be informed by:
    a. a representative patient voice
    b. a meaningful portion delivered by a representative patient voice and
    c. principles of trauma informed care
28. Security guards who have responsibility to work in mental health units should be provided with annual training that includes the following:
    a. Crisis management training:
       Crisis management training is designed to help security professionals recognize when a subject is in crisis, and respond appropriately.
    b. Effective communication:
       The use of effective or appropriate communication is vital to lowering a person's crisis level. This training should include the skills required to respond to a crisis situation using verbal strategies intended to calm someone down, so training should include:
        i. professionalism
        ii. first contact with a personal greeting and the reason for the interaction
        iii. the importance of verbal and nonverbal messages
        iv. the need to use active listening skills
        v. the relevance of para-verbal communication
        vi. the relevance of displaying appropriate body language and
        vii. the need for verbal strategies that include feedback
    c. Subject restraint / Pinel restraint systems
       Security guards require training with respect to subject control and the principles associated with safe restraint.

29. Training should be provided to the inter-professional (clinical) teams and security guards working with patients with mental health issues that includes trauma informed care and addresses issues of safety for patients, staff, and others.
30. All new clinical staff and security guards working with patients with mental health issues should complete training as per curriculum within 60 days.

31. Hospitals should provide cultural awareness and sensitivity training that includes specific training in interacting with patients experiencing mental health issues.

Accountability

To All Hospitals in Ontario:

32. All hospitals should have process and procedures in place to support employee feedback, complaints and suggestions. Incorporate 'whistle-blowing' protection into the process and procedures.

To All Schedule 1 Facilities in Ontario and the Ministry of Health and Long Term Care:

33. Hospitals should monitor training and implementation / application of policies to patient care, including:
    a. track training and implementation of policies
    b. follow-up to monitor understanding and application of policies
    c. periodic reminders with respect to policies and best practices, including examples / case studies
    d. conduct periodic audits with respect to the application of key policies, including least restraint policies
    e. conduct periodic case reviews of periods of restraint, including chart and video review (where available) looking at pre-restraint, during restraint and post-restraint care and
    f. review the effectiveness of the policy and updating the policy, or training / implementation as may be appropriate
    g. effective transfer of information pertaining to patients by clinical staff during shift changes and after breaks
34. Patient satisfaction surveys should be conducted with people who receive mental health and addiction services.
35. Hospitals should track and review the number and duration of periods of mechanical restraints, seclusion, and chemical restraints. This should include information with respect to the event precipitating restraint use, if possible.
36. Data with respect to restraint use should be reported to the Ministry of Health and Long Term Care (MOHLTC).
37. The MOHLTC should make data with respect to the use of mechanical restraints, seclusion and chemical restraints publicly available, broken down by institution.

Communication with Support Person

To All Hospitals in Ontario:

38. Patients should be asked on admission, and at appropriate intervals thereafter, if there is a support person (including family members) that they would like to contact or have contacted. This should be documented as part of the patient record.

Community Based Resources

To the Ministry of Health and Long Term Care and the Local Health Integration Networks:

39. The MOHLTC and the Local Health Integration Networks (LHINs) should consider the development of intensive case management support and / or assertive community

treatment teams for seniors with serious mental health issues to manage their needs in community settings whenever possible.

40. Patients should be connected with individual supports that are flexible according to need, and are available in times of crisis.

Patient Advocacy and Support

To the Ministry of Health and Long Term Care and the Local Health Integration Networks:

41. Allocate resources for independent mental health peer advocates and related infrastructure to be available to Schedule 1 facilities.
42. In its requirements for patient engagement in Ontario Hospitals, MOHLTC/LHINs should set standards for engagement of mental health patients that includes the following:
    a. patient representatives should be accountable to other patients with association to the same facility
    b. patient representatives should be elected by patients of that same facility
    c. patient representatives should make decisions and take action in accordance with consultation with a broad base of patients
    d. patient meetings should be organized by peer advocates, where available

To All Schedule 1 Facilities in Ontario:

43. Patient advocacy and input should be considered in the development and review of hospital policies, safety and environmental factors at facilities that treat patients with mental health issues. It is recognized that, where available, an independent patient voice may offer additional insight to the patient experience beyond that of a volunteer patient / family advisor.
44. Where available, peer advocate / support should be offered to patients with mental health issues in the emergency department setting, as well as on in-patient units. Patients should have a say in the type of advocacy support provided.
45. Patients should be made aware of options and have opportunities to express concerns, complaints, suggestions and compliments, including hospital patients relations, patient advocacy groups and other resources as may be available. Patients should also be aware of the option to contact the Office of the Patient Ombudsman.
46. Schedule 1 facilities should consider working with representative patient advocacy groups to develop their own patient Bill of Rights specific to patients with mental health issues. The Centre for Addiction and Mental Health Client Bill of Rights may be used as a model. Information pertaining to patients rights should be readily accessible to all stakeholders.

Meaningful Patient Voice

To St. Joseph's Health Care:

47. Within six months St. Joseph's Health Care will have a comprehensive plan for robust patient and family engagement to support patient identified needs and service quality improvements in the mental health program. This plan will support a process of meaningful engagement of patients with mental health issues at St. Josephs' Health Centre. St. Joseph's Health Centre will engage with subject matter experts including a client/patient peer run advocacy organization in the realm of patient and family

engagement in the development of this plan. Focus of this work will include, but not limited to, policy, training, and implementation, all of which would include a patient and trauma informed perspective.

Staff Care

48. All clinical staff in mental health units should have a personal alarm similar to that used by the staff at the Centre for Addiction and Mental Health.
49. Information pertaining to employee assistance programs should be posted in accessible locations (i.e. break rooms, staff rooms, online, etc.).

Recommendation to St. Joseph's Health Centre

To St. Joseph's Health Centre:

50. St. Joseph's Health Centre should share lessons and changes resulting from this death with all Schedule 1 facilities.