Intervention report (excerpts)

Intervention concerning Institut universitaire en santé mentale de Montréal of Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal

Québec City, November 21, 2016

INTERVENTION

The Québec Ombudsman received a report condemning situations of violation of users' rights and deficient care and service quality at Institut universitaire en santé mentale de Montréal. The reporters were especially critical of isolation practices potentially harmful to users, primarily on the psychiatric intensive care unit.

More specifically, the report indicated that a user who had been placed in isolation on this unit was able to escape from a window on the 5th storey of the building. The user was escorted back inside by security guards. After this incident, the user was placed in isolation for an extended period.

The Québec Ombudsman decided to intervene to ensure that the institution promotes practices respectful of users' rights, sees to the proper application of these practices and delivers care in a safe manner.

CONCLUSION

The investigation by the Québec Ombudsman showed that even though the event that occurred on March 20, 2016, on unit 506 was isolated, it revealed deficiencies in the design of the facility's isolation rooms. Infrastructure should be such as to ensure that means of control are applied in a safe manner, which was not the case in the situation at hand. This incident also highlighted the importance of attentive and effective monitoring, but also of ongoing and prompt clinical assessment when such measures are applied.

Furthermore, the various testimonies gathered shed light on the importance of the security guards' work. These employees interact daily with users at times of acute crisis. This is why the institution must provide them with training that enables them to ensure delivery of quality services that are safe.

Lastly, the institution must ensure that users' rights are fully respected when means of control such as isolation are applied. These means may be necessary in exceptional circumstances in order to ensure users' safety, but also that of the members of the personnel. Be that as it may, their application must be limited only to situations provided for by law and in compliance with the protocols in place within the institution. The investigation we conducted led us to conclude that certain practices that breach this application framework persist. The institution must ensure that these practices cease. To do so, it must, in particular, have reliable tools that make internal monitoring of practices possible.

RECOMMENDATIONS

Given the preceding, the Québec Ombudsman recommends that Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal:

R-1 **Remind** the nursing staff at IUSMM in order to ensure that, starting now, they conduct ongoing suicide risk assessment, in accordance with mental health nursing practice standards (OIIQ, 2016) and the program to prevent and manage suicidal behaviour in psychiatric hospitals (IUSMM) when thus prescribed and provided for by the therapeutic nursing plan;

R-2 **Proceed** without delay to replace beds and modify the windows in all isolation rooms by taking particular account of the recommendations in the 2014 UETMISM report on physical design for better safety in psychiatric and emergency units;

R-3 **Take** all necessary measures so that, starting now, members of the personnel who monitor a user in isolation are able to see the entire room, for example, the installation of videosurveillance cameras, as recommended in the 2014 UETMISM report on physical design for better safety in psychiatric and emergency units;

R-4 **Offer,** by March 31, 2017, all IUSMM security guards training that enables them to intervene safely when they must physically control users;

R-5 **Take** measures, by December 31, 2016, to ensure that the nursing staff rigorously apply the protocol for the use of means of control in effect and cease all practices that violate this protocol or the law. This includes:

- protocol-compliant reporting of all forms of withdrawal that constitute isolation;
- obtaining the user's consent when a planned means of control is applied, unless there is an emergency situation;
- attentive monitoring of the user, ongoing assessment of his or her clininal condition and reassessment every 60 minutes of the need for the means of control, in compliance with the protocol;
- prior use of alternatives to means of control.

R-6 **Form,** without delay, a clinical committee to evaluate the application of the protocol on means of control in mental health;

R-7 **Procure**, by March 31, 2017, a reliable tool for collecting data and keeping an updated log on the use of means of control enabling an evaluation of practices and accountability, as provided for in the protocol for applying means of control.

In accordance with the *Act respecting the Health and Social Services Ombudsman* (CQLR, c. P-31.1), within 30 days of receipt of this report, the institution concerned must inform the Québec Ombudsman of the actions to be taken as a result of the recommendations or, if the institution has decided not to act upon them, of the reasons for such a decision.