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June 25, 2018

The Honourable Margaret Wiebe
Chief Judge
Provincial Court of Manitoba
5th Floor – 408 York Avenue
Winnipeg, MB R3C 0P9

Inquest into the death of James Livingston
Public Body: Winnipeg Regional Health Authority
Our File No: 2015-0188

Dear Chief Judge Wiebe:

As you are aware, it is the practice of my office to follow up on inquest recommendations when they relate to a provincial department, agency or municipality.

I am writing to advise you of the results of the inquiries made by my office concerning the inquest report recommendations into the death of Mr. James Livingston. The June 23, 2015 inquest report of the Honourable Judge Robin Finlayson was issued on June 26, 2015.

Mr. Livingston, 68, died on April 19, 2012 by hanging himself while being held at the Health Sciences Centre under the Mental Health Act.

The Honourable Judge Finlayson made two recommendations in the inquest report, both directed to the Winnipeg Regional Health Authority (WRHA). The recommendations are as follows:

Recommendation #1

That the Winnipeg Regional Health Authority implement a policy in writing that the observation level of each patient on the PX2 ward of Health Sciences Centre's Psych Health Unit is to be recorded in a manner easily and continuously accessible to all staff. Prior to the conclusion of each shift, the designated "charge nurse" is tasked with the responsibility of ensuring the observation level of each patient is accurately recorded in whatever method is utilized that is easily and continuously accessible to all staff.

We followed up with the WRHA regarding their implementation of the recommendation and on October 5, 2016, we received the following response:

…

With respect to the first recommendation, the WRHA is in full compliance. The following steps have been taken to fulfill this recommendation:

- *The WRHA established a regional working group to develop a Regional Guideline related to the observation of in-patients. The Guideline is currently being finalized for use across the region.*
- *At every shift change, the observation level is verbally reported by the nurse to the oncoming shift staff.*
- *In order for the observation level to be easily and continuously accessible to all staff, the observation level of each patient on PX2 is captured on the rounds sheet and highlighted in yellow on the sheet so they are immediately visible for the Unit Assistant (or nurse) to see when doing patient rounds on the unit. The observation level of each patient is also posted on a card at the front desk on PX and on a highly visible white board (i.e. the staff communication board).*

We requested a copy of the Regional Guideline referred to by the WRHA. In February 2018, we were provided a copy of the Guideline, which is titled *Mental Health Program (2016) Ensuring Informational Continuity Clinical Practice Guideline*. We reviewed the Guideline and noted that it addressed the substance of the recommendation.

However, as the WRHA had implemented a guideline and not a policy as specified in the wording of the recommendation, we requested WRHA's comments in this regard. The WRHA provided the following response:

> *The Mental Health Program's practice has been to create Clinical Practice Guidelines to assist the staff in making decisions about appropriate health care for specific clinical conditions and circumstances. The Clinical Practice Guidelines (CPG's) offer concise instructions on how best to manage health conditions and practice of care. The WRHA Mental Health Program has an active mechanism to create CPG's with policies created at the site and WRHA level. The CPG offers a more direct mechanism to ensure practice change occurs whereas policy once created would require a CPG to guide that practice. Much discussion occurred on this topic, looking at how to best integrate a policy vs our usual CPG process and decision was made by the program to create a CPG for this recommendation as it was seen to better serve the needs of our staff and patients.*

<u>Recommendation #2</u>

At each "Kardex[1] meeting" attendees are to be informed of the names of all patients who have had their observation level changed by any nurse or doctor since the last Kardex meeting was held, regardless of how long the change was in effect for or whether it is still in effect at the time of the meeting.

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[1] Information we obtained from the Health Sciences Centre indicates that Kardex meetings are "weekly meetings held on the inpatient units to discuss details of an inpatient stay on the unit. The usual attendees are the inpatient nurses, psychiatrists, social workers and occupational therapists".

The WRHA's response on October 5, 2016 regarding this recommendation is as follows:

With respect to the second recommendation, the following steps have been taken to fulfill this recommendation:

> *Each Kardex meeting on PX2 includes a reporting process as to the last Kardex observation level, including any changes that have occurred in the observation level since the last Kardex and the reason for the change regardless of how long the change was in effect or whether the change is still in effect.*

On May 15, 2018 the WRHA provided additional clarification upon our request that they indicate whether this recommendation was addressed in the Guideline. The WRHA responded as follows:

> *This recommendation was understood to be a stand-alone recommendation, not part of the Guideline. As such, it was dealt with in an independent manner with a process put in place on the unit.*

As the WRHA has provided a full response to the inquest recommendations, we will conclude our monitoring of the implementation of the recommendations.

Please note that an electronic copy of this report will be posted on the Manitoba Ombudsman website: www.ombudsman.mb.ca.

Yours truly,

Charlene Paquin
Manitoba Ombudsman

cc: Mr. Real Cloutier, Chief Executive Officer of the WRHA
Dr. John K. Younes, Chief Medical Examiner