Frank Alexander Inquest: Recommendation Implementation Plan

Manitoba

Introduction

On March 24, 2011, Mr. Frank Alexander was severely injured at Parkview Place Personal Care Home in Winnipeg after being shoved to the floor by a fellow resident and striking his head.

He was taken to Health Sciences Centre Winnipeg and diagnosed with a traumatic brain injury, then transferred to Riverview Health Center for palliative care. Mr. Alexander passed away on March 28, 2011.

On March 29, 2011, the Medical Examiner determined that Mr. Alexander's cause of death was the result of blunt head trauma. On October 16, 2012, the Chief Medical Examiner for the Province of Manitoba called for an inquest be held into the death of Mr. Alexander to determine:

- the circumstances of his death.
- if there are enough resources, facilities, and appropriately-trained staff to manage long-term care residents with Alzheimer's disease and other forms of dementia that might predispose them to violent or aggressive behavior resulting in harm to others.
- what, if anything, can be done to prevent similar deaths from occurring in the future.

On May 26, 2015, after hearing evidence from 14 witnesses over the course of 14 hearing days between January 20, 2014 and November 6, 2014, Provincial Court Judge Michel Chartier released a 39-page report. The report includes 23 recommendations to help prevent future harm from occurring while making system improvements for personal care home residents and staff.

Following its release, Health Minister Sharon Blady accepted Judge Chartier's report and recommendations, providing the following public statement:

> *Manitoba families have every right to expect their loved ones in a personal care home are safe and provided with professional care. Today, Judge Michel Chartier released his report into the tragic death of Mr. Frank Alexander. This was an important, independent judicial process to help get answers as to what happened and how we can work together to prevent such tragedies from happening again.*
>
> *No family should have to go through what these families did. I apologize to Mr. Alexander's family and to the family of Mr. Joe McLeod. I am committed to implementing the recommendations that are in Judge Chartier's report.*
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> *I have asked Karen Herd, deputy minister of health, healthy living and seniors, and Donna Miller, deputy minister of justice, to work together to develop an implementation plan for these recommendations and deliver that plan by Sept. 30. This implementation plan will be made public and updated as progress toward each recommendation is made.*
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> *Our government has worked very hard to make our home care program among the best in the country and to improve our long-term care facilities. Since we came into office, we have hired hundreds more personal care home staff to ensure each resident gets more direct time with staff, and we have added more than 1,000 personal care home and supportive housing beds. There are more than 300 personal care home beds in development right now to help our parents and grandparents receive the long-term care support they need, when they need it, closer to home. This includes new personal care homes in Winnipeg, Morden and Lac du Bonnet.*

As a part of new personal care home construction projects, we are adding more specialized spaces for individuals with complex behavioural needs and we are investigating whether more existing personal care home beds could be enhanced to help residents with complex needs.

I thank Judge Chartier for the work that has been done in preparing this report, as well as all of those who testified throughout the inquest.

Background

The challenges of providing long-term care for people with dementia who have a tendency to violence are extremely complex. When personal care home residents with dementia have aggressive or violent tendencies, they may need specialized care so their needs can be met without risk to other residents or staff.

Regional health authorities across the province are facing many challenges in providing the specialized care needed for residents/clients with dementia who may become violent. These specialized environments require significant investments in infrastructure and higher levels of staff to operate. In addition, more in-house education is needed to support staff as they provide care and help to implement specialized units.

In August 2015, the Office of the Auditor General released a report that reviewed the provision of home care services in the Winnipeg Regional Health Authority and Southern Health – Santé Sud health region. Part of this report included 28 recommendations to strengthen home care service provision in Manitoba.

The Minister of Health has created a leadership team, lead by Mr. Reg Toews, to review home care services across the province and look at the most appropriate and efficient structure for the delivery of home care services in Manitoba. The team will also develop an implementation plan to:

- make sure short and long-term human resource plans are in place to meet the needs of Manitobans while also recognizing the vital role of those who work in the system.
- harmonize home care services offered by regional health authorities throughout Manitoba.
- develop a reliable service for clients, families and informal caregivers, regardless of one's ability to pay.

Work on the review began in Fall 2015.

In addition, work is underway to implement the recommendations of the Brian Sinclair Inquest Report of which several address the needs within home care and long-term care.

As the Frank Alexander Inquest Report makes recommendations in both home care and long-term care as well as for the justice system, it also bridges the work underway in response to the auditor's home care audit and the Brian Sinclair Inquest Report recommendations. Implementing the recommendations will work towards a system that meets the needs of those accessing these services and their caregivers in a more comprehensive, person-oriented way.

The Frank Alexander Inquest Report Provincial Implementation Team

The Provincial Implementation Team (to be referred to as "the team") has been established by the direction of the Minister of Health in response to the publication of Judge Chartier's report (henceforth referred to as "the report").

The team includes representatives from Manitoba Health, Healthy Living and Seniors, Selkirk Mental Health Centre, Manitoba Justice, regional health authorities, personal care homes, the Alzheimer's Society of Manitoba, law enforcement agencies and legal experts.

Since the release of the report, the department, regional health authorities (the regions) and Manitoba Justice representatives have begun to address the recommendations by taking immediate action where possible, as well as outlining a detailed plan to respond to the recommendations by developing action statements for each of the recommendations.

The team will advise the deputy ministers of Manitoba Health, Healthy Living and Seniors and Manitoba Justice on the appropriate follow-up to implement the action statements and the status of implementation and provide regular updates, who will in turn advise the Minister of Health.

While some recommendations have already been met, others will require significant investments in planning, infrastructure and human resources. Before work can move forward on some projects, further feasibility studies and analysis will be done to determine the best approach.

The team will provide leadership on the implementation of these action statements in all regions to the fullest extent possible. Strengthened communications will be incorporated into the implementation of all action statements.

Action Statements to Guide the Implementation Plan

The action statements developed to guide the implementation process are divided into three main themes:

- specialized environments and aggressive/violent residents with dementia
- health care system and home care services
- justice

The action statements are organized by completed actions as well as short- (zero to nine months), medium- (nine to 24 months), and long-term (24+ months) for assessment and implementation.

Short-term action statements are the least complex and have a wide scope, but tend to focus on policy/protocol/process development at the provincial government department level as well as the regional level.

Medium-term action statements tend to have greater scope and complexities. The focus on policy/protocol/process development remains, but further analysis and feasibility studies of current resources and future needs are also included. These statements tend to require significant financial investment.

Long-term action statements have the greatest scope and complexity for implementation.

Specialized Environments and Aggressive/Violent Residents with Dementia Action Statements

COMPLETED ACTIONS

- The department has incorporated Alzheimer and related dementia training in personal care home standards measures and will monitor compliance during standards reviews.
- The department and regions have established standardized definitions for specialized environments in personal care homes.

SHORT-TERM ACTION STATEMENTS

- The team will develop alternate support protocols to be used if demand is greater than capacity as the system develops specialized environment infrastructure and in locations across the province where staff recruitment may be a challenge to operate a specialized environment.
- The team will develop alternate support protocols to manage aggressive and violent behaviours for residents/clients awaiting placement in a specialized environment.
- Regions will develop a protocol for tracking/reporting aggressive incidents in personal care homes.
- Regions will develop protocols/policies to support staff reporting dangerous situations in facilities.

MEDIUM-TERM ACTION STATEMENTS

- The team will develop a protocol to determine when residents/clients are to be placed in a specialized environment, when residents/clients will require a locked unit, and when a physician/psychiatrist is to be consulted. The protocol will outline a process to alert staff when a resident has had an aggressive incident or is refusing medications.
- The department will study the feasibility of creating specialized environments for residents with dementia in each personal care home in the province.
- The department and the regions will analyze current and future needs for specialized environments annually, and incorporate this analysis in the planning for any renewal or new construction of personal care homes.
- The regions will:
  - track the use, demand and wait times for specialized environments and report to the department on a monthly basis.
  - implement alternative support protocols to manage aggressive and violent behaviors within facilities while residents wait for specialized environment placement.
  - implement policies requiring personal care homes to review placement options for a resident following an aggressive/violent incident in their facility. This policy will also outline the reassessment process in the region.
  - develop and implement a protocol that outlines how personal care homes apply for funding for residents with aggressive/violent incidents. This protocol/policy will provide increased guidance to help facilities manage these residents while confirming all other options of behavioral interventions have been exhausted.

- establish a specialized panel process to provide placement advice for residents/clients with known aggressive/violent tendencies.
- assess the feasibility of conducting specialized panels twice per month.
- work with personal care homes to implement dementia training for all staff.

LONG-TERM ACTION STATEMENTS

The department and regions will study the feasibility of a target that clients should wait no longer than 60 days for placement in specialized environments.

Health Care System and Home Care Services Action Statements

SHORT-TERM ACTION STATEMENTS

- The regions will determine a process incorporating a three-month follow-up for client situations where home care services/assessment has been refused and the client has dementia.
- Regions will develop a process/system to track the client situations requiring three-month follow-up.

MEDIUM-TERM ACTION STATEMENTS

- A plan will be developed by the department and regions to improve public awareness about life in personal care homes.

Justice Action Statements

MEDIUM-TERM ACTION STATEMENTS

- The team will establish a sub-group with representatives from the department, the regions and Manitoba Justice to develop a protocol to outline supports for long-term care residents/home care clients with dementia who are charged with a criminal offense.
- The protocol will address:
  - assessments for individuals and considerations for accommodating the health-care and justice requirements.
  - assessment requirements for the full details of the events before incarceration as well as events that have occurred since incarceration.
  - the sharing of custodial records, health records and crime reports.
- To develop the protocol, the sub-group of the team will seek privacy and legal expertise, and consult with law enforcement agencies to discuss dementia education for front-line officers.
- Regions will institute policies that indicate all staff members have the right to call police when residents exhibit violent behaviour. This policy will include education for staff on police discretion and the potential outcomes of police involvement.

Conclusion

This public report and the action statements serve as the implementation plan for the recommendations contained in Judge Chartier's report on the tragic death of Mr. Frank Alexander. Updates on the progress of achieving completion of the recommendations will be made available on a periodic basis in the future.

The situation that led to the death of Mr. Alexander was tragic. Manitoba Health, Healthy Living and Seniors, Manitoba Justice, the regional health authorities and the implementation team are committed to working together to make changes to better protect residents/clients while ensuring quality care is available for residents/clients with dementia and behaviour issues.

Accomplishing this task will require significant efforts from health care providers, staff and stakeholders throughout the province to accomplish change within the timelines noted in the report to prevent similar situations from happening in the future.

Appendix A

Frank Alexander Inquest Report Recommendations (Lines 251 to 282)

1) ..the focus of these events and the resulting recommendations revolves around the City of Winnipeg. These recommendations, however, are, in large part, applicable provincewide (Line 253).

2) There must be a substantial increase in the number of beds dedicated to people with violent or aggressive tendencies (Line 255).

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3) The WRHA and the Department of Health increase the number of behavioural units in order to ensure that the maximum wait for such a bed be no more than 60 days (Line 256).

4) Creative solutions must be found to accommodate persons with violent/aggressive tendencies. All facilities should have this capacity to address urgent circumstances of the sort described. There must be a solution when all other methods fail and pending alternative placement in an appropriate facility (Line 257).

5) The Court recommends that the WRHA and the Department of Health be directed to work with all PCHs to create a unit within each PCH to address the needs associated with persons exhibiting violent and aggressive behaviour (Line 258).

6) A system needs to be designed to track these types of situations so as to regularly follow-up with individuals afflicted by dementia and who refuse assistance, as was the case with Mr. McLeod (Line 260).

7) There is a definite need for better communications amongst all of the stakeholders (Line 261).

8) The Court's recommendation is that once a request has been declined, that the home care office leave the file open to be revisited (by the home care case coordinator) every three months in order to determine whether matters have worsened, thereby making home care a necessity (Line 264).

9) The Court recommends that the Department of Health develop a protocol with the Departments of Justice and Corrections to accommodate persons charged with criminal offences who are suffering from dementia. There must be a coordinated approach between these departments. That protocol ought to address where such an individual should be housed, how such a person should be assessed (both from a health-care perspective and from a justice perspective) and what arrangements could be made to accommodate both the health-care and justice systems (Line 267).

10) The protocol should require that any assessment undertaken for the health-care system include a review of the records from the WRC. In the Court's view, there must be a recognition that a person housed in the WRC, accused of a violent crime, may well not be suitable for a regular placement in a PCH. Any assessment undertaken for a PCH must take into consideration the full details of the incident in question. As an adjunct to this recommendation, the WRC records must be provided and reviewed by a PCH when making its assessment of the suitability to be admitted to a PCH (Line 268).

11) There needs to be a better interplay between the legislation that governs privacy and the need of coordination to access vital information on a timely basis (Line 269).

12) As further part of this recommendation, the issue of assessment by the WRHA for a violent/aggressive person ought to be undertaken by a specialized panel. The Court heard evidence about the TAP Panel. It is the Court's recommendation that this panel be the required assessor of persons coming into the PCH system with known aggressive/violent tendencies (Line 270).

13) Training in this regard for all staff must be mandatory (Line 271).

14) The Court recommends that PCHs be mandated to increase the scope of training for **all** staff who have interaction with residents so as to include mandatory training in dealing with violent/aggressive individuals. This training needs to be repeated regularly. The Court heard much evidence regarding P.I.E.C.E.S. For the safety and protection of all staff and all residents, this training ought to be mandatory, uniform and ongoing. Education in this regard for all staff must also be mandatory (Line 272).

15) The Court recommends that PCHs be required to develop a safety protocol to protect patients and staff from acts of aggression from violent patients. The protocol ought to include strategies that would include the following:

    i) a determination of when patients should be placed in a secure unit;

    ii) when a patient should be prevented from wandering unrestricted throughout a facility;

    iii) a protocol to alert other staff when a person is refusing medications;

    iv) a protocol for requiring intervention by a physician or psychiatrist when a person is refusing medications; and

    v) a protocol to ensure that knowledge of violent/aggressive incidents is brought to the attention of all staff, including management, supervisors and floor staff (Line 273).

16) It is the Court's view that the recommendations made by Ms. Trinidad ought to be considered by the systems as a whole. Ms. Trinidad recommended:

    a) There must be a process to track aggressive incidents in order to permit a quick response by a facility;

    b) There must be a process that requires a PCH to notify the appropriate Access Centre when it cannot safely manage a resident's care;

    c) There must be a requirement that nurses receive greater training regarding psychotropic drug use and maintenance of appropriate therapeutic levels;

    d) There must be a process to notify physicians when a patient is not taking medications;

    e) There must be a secure unit that prevents aggressive patients from wandering; and

    f) There must be appropriate supervision of residents (Line 274).

17) The Court recommends a direction be given to the WRHA that the TAP Panel be scheduled to meet twice monthly and that there be a requirement that a hearing by the TAP Panel be convened within a period of 35 days from the date of application (Line 275).

18) The Court recommends that a protocol be developed that would require a PCH to apply for one-on-one funding when an appropriate level of violent/aggressive incidents have taken place and that other methods of behavioural intervention have failed. This protocol would also require that the WRHA intervene in a PCH when occurrence reports have been received regarding an individual that exceeded the accepted levels of violent/aggressive incidents (Line 276).

19) The protocol for dealing with violent/aggressive individuals ought to include a clear statement that all staff at a PCH home have the right to contact the local police force to assist in care of violent behaviour by a resident. Any attempts by a PCH to limit or to prevent staff from contacting the police must be barred (Line 277).

20) The Court recommends that an automatic review of the suitability of a resident be undertaken by management each time that such an occurrence is reported. This would assist management in assessing the suitability of residents for the PCH (Line 278).

21) Measures must be taken to ensure that staff have the ability to report dangerous situations immediately within the facility. In some PCHs, all staff are supplied with "code white" buttons that allow staff to report emergency situations immediately (Line 279).

22) A protocol should be developed to assist the public in better understanding a PCH environment. This protocol would address issues such as safety and the reality of the varying degrees of mental competence one would expect to encounter in a PCH (Line 280).

23) Police forces cannot be expected to "care" for persons afflicted by dementia. That said, they should give some consideration to incorporating an educational component into their respective training programs relating to dealing with persons afflicted by dementia (Line 281).