The Use of Restraints: Recommendations from a Recent Inquest

The use of mechanical restraints in psychiatric facilities, as well as the possible relationship between pulmonary embolism and restraint use, was explored in detail during a recent coroner’s inquest.¹ The inquest was held into the death of an in-patient detained on a forensic mental health unit at a psychiatric facility pursuant to a disposition of the Ontario Review Board. Prior to this patient’s unfortunate death, there was an acute decompensation of his psychiatric condition that included a violent attack on the hospital staff. The patient was placed in four-point mechanical restraints and, tragically, died six days later.

During the inquest, the coroner’s jury heard from healthcare practitioners involved in the treatment and care rendered to this patient, as well as from experts retained by the coroner. This jury concluded that the patient died of natural means as a result of “acute pulmonary thromboembolism in a man with medical restraint.” The jury rendered an extensive list of recommendations.

The recommendations resulting from this inquest, while specifically applicable to Schedule 1 psychiatric facilities, may also be of interest to other healthcare organizations utilizing restraints in their treatment of patients and clients. While the Hospital’s efforts to monitor and reduce restraint use were commended during the inquest itself, a dominant theme of the recommendations is that healthcare facilities are encouraged to move towards a restraint-free environment. This is consistent with the principles guiding the use of restraints set out in both the legislation and common law in Ontario.

The specific recommendations by the coroner’s jury are directed at various organizations, including Schedule 1 psychiatric facilities, and address the use of mechanical restraint as well as physical, chemical & environmental (seclusion) restraint. These recommendations include:

- considering alternatives to physical restraint and using restraint for the shortest period of time possible;
- tracking episodes of physical restraint;
- conducting in-person physician assessments of the restrained patient’s physical health every 24 hours;

¹ Inquest into the Death of J. J., verdict received on October 10, 2008.

continued on page 2
ambulating the patient every 8 hours of continuous restraint where this can be safely accomplished; 
• reviewing, by an external source (i.e. a physician who is not on the unit), the use of restraints every 72 hours; and 
• conducting a debriefing following restraint use.

Significantly, this coroner’s jury recommended that the Office of the Chief Coroner conduct inquests into the deaths of psychiatric patients who die while in mechanical restraints, commencing October 10, 2008. Such inquests are discretionary under the Coroner’s Act, which cannot be changed without legislative amendment. In recent years this discretion was challenged as being discriminatory, as inquests are mandatory into the death of prisoners in custody. The Ontario Courts have determined that the provision of the Coroner’s Act that allows the Coroner discretion in whether to hold an inquest into the death of a psychiatric patient is not discriminatory.\(^2\) What is not known is how the Office of the Chief Coroner will choose to exercise this discretion, particularly given this recent coroner’s jury recommendation.

This coroner’s jury also made several recommendations about the role of The Psychiatric Patient Advocate Office (PPAO), including that rights advice be available 24 hours a day, 7 days a week at all Schedule 1 psychiatric facilities. These recommendations also suggest an expanded role for the Patient Advocates from the PPAO, as well as more institutional independence from the Ministry of Health & Long Term Care for the organization itself.

Other organizations towards which recommendations have been directed by this coroner’s jury include: the Registered Nurses Association of Ontario, for the development of a nursing best practice guideline for the use of restraints in psychiatric patients; Accreditation Canada, to develop standards around reporting and practices for the use of mechanical restraints with psychiatric patients; the Ministry of Health and Long-


**Final Comment**

The scope of the recommendations is very broad and advocates a multi-faceted approach to restraint reduction in accordance with leading international initiatives. Psychiatric facilities would be well advised to review the use of restraints in light of these recommendations.

The jury’s recommendations are available on-line at [http://www.ppaao.gov.on.ca/pdfs/sys-inq-jam.pdf](http://www.ppaao.gov.on.ca/pdfs/sys-inq-jam.pdf). Please feel free to contact us to obtain a copy.

Tanya Goldberg
Partner, Health Law Group
Katharine Byrick
Partner, Health Law Group
Borden Ladner Gervais LLP

**HIROC’s 22nd Annual General Meeting and 7th Annual Risk**

Registration for these events, scheduled for April 27th, 2009, are now available online. As registration is filling up quickly, register early to avoid disappointment.

Please register for each event you plan to attend, through the following link: [http://www.hiroc.com/agm/](http://www.hiroc.com/agm/)
The WHO Surgical Safety Checklist: A Tool for Safer Surgery

According to the World Health Organization (WHO), approximately 234 million surgeries are performed worldwide every year. From this total, a minimum of one million patients die each year from complications. Additionally, a minimum of seven million patients suffer complications following surgery, half of which may be preventable.

To promote public health and to reduce surgical complications and deaths, the World Alliance for Patient Safety, as part of the WHO, launched a Safe Surgery Saves Lives Campaign in 2008. Part of this Campaign consists of using a surgical safety checklist.

This checklist was developed by a group of surgeons, nurses, anesthesiologists and patient safety experts from around the world. The checklist identifies three stages in care that must be confirmed in every surgical procedure regardless of the setting or type of surgery.

The three stages consist of: 1) a sign-in period prior to the induction of anesthesia; 2) a time-out period immediately prior to skin incision; and 3) a sign-out period prior to the patient leaving the operating room. Each stage has corresponding questions that must be asked and answered before moving to the next step.

For example, during the sign-in period, a patient must confirm his or her identity, surgical site, procedure and consent. A check is conducted to ensure that the pulse oximeter is on the patient and is functioning. Also, an

PATIENT SAFETY
The WHO Surgical Safety Checklist: A Tool for Safer Surgery

continued on page 4
anesthesia safety check is conducted. During the time-out period, a confirmation takes place where all team members introduce themselves by name and role. Additionally, the surgeon, anesthesiologist and nurse verbally confirm the patient’s identity, surgical site and procedure. The team also reviews anticipated critical events such as blood loss, sterility concerns and equipment issues. During the sign-out period, the nurse verbally confirms with the surgical team that the instrument, sponge and needle counts are correct. Also, the team reviews key concerns regarding the patient’s recovery and management.

One of the critical components of the surgical checklist is an emphasis on communication amongst the operating team. Therefore, surgeons, anesthesiologists and nurses must communicate and coordinate with one another during all three surgical stages.

According to WHO, certain components of the checklist have been routinely adhered to in some hospitals. The WHO, however, determined that few surgical teams complete all checks consistently. For example, many hospitals use their own version of a time-out to confirm the patient’s identity, procedure and surgical site. These hospitals can improve their process by using the checklist which superbly incorporates checks for all three surgical stages. The WHO’s goal is to ensure all hospitals use the checklist during every surgical procedure.

Does the checklist work?

The answer is a resounding yes.

Data was derived from a study carried out between October 2007 and September 2008, conducted in eight pilot hospitals in eight different countries. The countries included the U.S., UK, Canada, New Zealand, Jordan, Philippines, India and Tanzania. This cross section represented a variety of economic settings and diverse patient populations. The University Health Network-Toronto General site was the participating Canadian hospital.

Data was collected prior to, and after, the introduction of the surgical checklist. A study, published in the New England Journal of Medicine in January 2009, concluded that the checklist led to significant improvements in surgical outcomes. Postoperative complication rates fell, on average 36%, and death rates had a similar reduction.

Why does the checklist work?

The checklist clearly was successful as it addresses a multitude of problems which can occur during surgery. Typical surgical challenges concern teamwork and communication, infection risks and ensuring the correct patient, procedure and site.

A study conducted by the Joint Commission determined that almost 70% of events reported to the Commission were caused by faulty communication. The checklist emphasizes the importance of effective communication during each stage of the surgical process.

Providing antibiotics within one hour prior to incision can reduce the risk of a surgical site infection by 50%. During the time-out stage, the checklist seeks confirmation of whether an antibiotic has been given within the past hour.

Each year in the U.S., between 1500 and 2500 wrong-site surgery incidents occur. Additionally, the Joint Commission’s Sentinel Events Statistics show that in a survey of 1050 hand surgeons, 21% reported performing wrong-site surgery at least once. These alarming numbers can be mitigated by using the checklist. The checklist seeks confirmation of the patient’s identity, site and procedure both during the sign-in and time-out stage.

Since the checklist is a tool to promote safer healthcare, HIROC has incorporated the surgical checklist into the 2009 revised version of the Risk Management Self-Appraisal Modules (RMSAM™). The RMSAM™ Surgical Module has a section devoted to questions addressed in the checklist.

The surgical safety checklist can be used by your organization to save lives and reduce complications. Medical costs related to surgical errors also will be reduced, distinguishing your organization as a leader in patient safety.

Mitra Nadjmi
Senior Risk Management Specialist
HIROC

In March 2009, over 150 health professionals, healthcare leaders, and quality and safety specialists met in Toronto for the first Safe Surgery Saves Lives workshop. Dr. Atul Gawande, Dr. Bryce Taylor and Dr. Chris Hayes were featured speakers and participants discussed the practical aspects of implementing the checklist. The Canadian Patient Safety Institute (CPSI) is planning a second national workshop, tentatively scheduled for the fall of 2009. In the following weeks, the in-country working group will finalize the implementation and measurement tools, create an online community of practice, and offer mentoring and support for organizations interested in implementing the checklist. For more information please visit www.safesurgerysaveslives.ca.
**BRIEFING – Before induction of anaesthesia**

### Hand-off from ER, Nursing Unit or ICU
- Anesthesia equipment safety check completed
- Patient information confirmed
  - Identity (2 identifiers)
  - Consent(s)
  - Site and procedure
  - Site, side and level marked
  - Clinical documentation
  - History, physical, labs, biopsy and x-rays
- Review final test results
- Confirm essential imaging displayed
- ASA Class
- Allergies
- Medications
  - Antibiotic prophylaxis: double dose?
  - Glycemic control
  - Beta blockers
  - Anticoagulant therapy (e.g., Warfarin)?
- VTE Prophylaxis
  - Anticoagulant
  - Mechanical
- Difficult Airway / Aspiration Risk
  - Confirm equipment and assistance available
- Monitoring
  - Pulse oximetry, ECG, BP, arterial line, CVP, temperature and urine catheter
- Blood loss
  - Anticipated to be more than 500 ml (adult) or more than 7 ml/kg (child)
  - Blood products required and available
  - Patient grouped, screened and cross matched

### Surgeon(s) review(s)
- Specific patient concerns, critical steps, and special instruments or implants
- Anesthesiologist(s) review(s)
  - Specific patient concerns and critical resuscitation plans
- Nurses(s) review(s)
  - Specific patient concerns, sterility indicator results and equipment / implant issues
- Patient positioning and support / Warming devices
- Special precautions
- Expected procedure time / Postoperative destination

**TIME OUT – Before skin incision**

- All team members introduce themselves by name and role
- Surgeon, Anesthesiologist, and Nurse verbally confirm
  - Patient
  - Site, side and level
  - Procedure
  - Antibiotic prophylaxis: repeat dose?
  - Final optimal positioning of patient
- “Does anyone have any other questions or concerns before proceeding?”

**DEBRIEFING – Before patient leaves OR**

- Surgeon reviews with entire team
  - Procedure
  - Important intra-operative events
  - Fluid balance / management
- Anesthesiologist reviews with entire team
  - Important intra-operative events
  - Recovery plans (including postoperative ventilation, pain management, glucose and temperature)
- Nurse(s) review(s) with entire team
  - Instrument / sponge / needle counts
  - Specimen labeling and management
  - Important intraoperative events (including equipment malfunction)
- Changes to post-operative destination?
- What are the KEY concerns for this patient’s recovery and management?
- Could anything have been done to make this case safer or more efficient?

**Hand-off to PACU / RR, Nursing Unit or ICU**

**CHECKLIST SCORE**

Add all checkmarks for 3 sections and enter below

<table>
<thead>
<tr>
<th>Briefing</th>
<th>Time Out</th>
<th>Debriefing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(x)</td>
<td>(x)</td>
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</tr>
</tbody>
</table>

### TOTAL: _____ /26 x 100 = _____

**PATIENT INFORMATION**

Adapted from the WHO Surgical Safety Checklist, © World Health Organization, 2008

Surgical Safety Checklist: Canada

Version 1, January 9, 2009

Available for download from the CPSI website: [http://www.patientsafetyinstitute.ca/SSSL/checklists.html](http://www.patientsafetyinstitute.ca/SSSL/checklists.html)
The New and Revised RMSAM™ Modules

After the successful launch of RMSAM™ (Risk Management Self-Appraisal Modules) in 2007, HIROC began re-development of the Modules to reflect changes occurring in the healthcare environment and in our claims. Information gleaned from a RMSAM™ satisfaction survey and focus group, as well as case law, legislation and leading practices were also incorporated.

What changes have occurred?

- All existing Modules have been revised, in some cases significantly. Twelve new Modules are also available;
- Expanded content on non-clinical risk issues (e.g. environmental and operation risk issues);
- Several Modules have been streamlined (e.g.– Orientation Module and Pharmacy Module);
- Designed to provide insight to specific Module questions, additional dropdown HINTS AND COMMENTS have been added (see Figure 1);
- A new ‘link’ feature has been added to several Module questions to enable teams and leadership access to pertinent reference material, websites, policy/procedure samples, checklists, etc. (see Figure 2);
- Submission of Evidence Based Criteria is no longer required as of January 1, 2009, Year 1 submissions;
- Due to the diversity of Modules available, organizations have an enhanced ability to tailor the self-appraisal process to meet their unique needs and services.

Is there a fee to participate in RMSAM™?

There is no fee for HIROC subscribers (i.e. organizations insured by HIROC). Organizations are reminded however, that RMSAM™ is not a questionnaire. Formal action plans or strategies are required to respond to identified risks and gaps in policy/practice. For this reason, organizations participating in RMSAM™ will require access to resources, both human and financial, over the four-year cycle.

Organizations not insured by HIROC may participate in RMSAM™ for a fee. Pricing details are available by contacting riskmanagement@hiroc.com.

Figure 1: HINTS AND COMMENTS Feature

2.1 Does Laboratory Services have a formal policy and procedure regarding the receipt of mislabeled specimens?

Add/Modify Action Plan

2.1.1 Does Laboratory Services require two patient/client/resident identifiers to containers?
Add/Modify Action Plan

Figure 2: Links Enabling Access to External Resources

1.4.1 Have thresholds been established to trigger clinical leadership and senior management notification?
Add/Modify Action Plan

1.4.2 Does Emergency Medicine have a process to ensure that each physician arrive at the hospital, when called, within a pre-determined timeframe?
Add/Modify Action Plan
What Modules are available?

Effective January 2009, organizations wishing to participate in RMSAM™ will be required to use the new and revised Modules. The 2003 versions are no longer available.

The new Modules:

1. Boiler and Fired Pressure Vessels Module (V01-2008) *
2. Facilities & Engineering Module (V01-2008)
3. Finance Module (V01-2008) **
4. Fire Prevention Module (V01-2008) *
5. Fuel Tanks, etc. Module (V01-2008) *
6. Hazard Reporting & PM Module (V01-2008) *
7. Human Resources Module (V02-2008)
8. Independent Health Professionals’ Module (V01-2008)
9. Infant and Pediatric Module (V01-2008)
10. Laboratory Services Module (V01-2008)
11. Security Module (V01-2008) **
12. Water Damage & Mould Prevention Module (V01-2008) *

The revised Modules***:

1. Clinical Practice Leadership Module (V01-2008)
2. Credentialing Module (V03-2008)
3. Diagnostic Imaging Module (V01-2008)
4. Emergency Medicine Module (V01-2008)
5. Independent Health Professionals’ Module (V01-2008)
6. Management Module (V02-2008)
7. Maternal-Newborn Module (V01-2008)
8. Mental Health Module (V01-2008)
9. Orientation Module (V02-2008)
10. Pharmacy Module (V01-2008)
11. Point of Care Module (V01-2008)
12. Radiation Therapy Module (V01-2008)
13. Risk Management Module (V02-2008)
14. Surgical Module (V01-2008)

* Organizations have the option of selecting one or more of these Modules or completing the Facilities and Engineering Module.
** Acute care and non-acute care versions are available.
*** Modules developed for midwives in the community setting are not included in this list.

Four additional Modules focusing on long term care, infection precaution/control, dialysis, and governance issues will be available spring/summer 2009.

Joanna Noble
Supervisor, Risk Management
HIROC

Special thanks to my HIROC colleagues and external experts for their assistance in the development and critique of the Modules, as well HIROC subscribers and members who participated in our survey and focus group. Your ongoing feedback is invaluable in the refinement of RMSAM™.

My organization is interested in participating. What are our next steps?

To learn more about RMSAM™, please visit http://www.hiroc.com/rmsam_overview.asp. Module excerpts, promotional information and handouts are available by sending your request to rmsam@hiroc.com or contacting Sara Chow at 416-730-3084 or 1-800-465-7357 x3084.

Applications to start RMSAM™ in 2009 are being accepted. While voluntary, all subscribers are encouraged to consider participating in RMSAM™. Interested organizations are urged to begin planning soon as enrolment is limited. The registration form is available on the HIROC website www.hiroc.com/rmsam.
Safeguarding Your Organization Against Litigation

This conference will deliver practical strategic advice from leading Canadian healthcare experts on how to reduce litigation costs and improve patient safety.

St. Andrew's Club & Conference Centre, Toronto
Subscriber or Member Fee: $495.00
Non-Subscriber Fee: $650.00

Conference Agenda
- So your organization is getting sued? Now what?
- Terminations, Performance Management, Reporting and Privileges
- Class Action Lawsuits – What you need to know!
- Fraud – Important Steps to Protect your Organization
- Orders Issued by the Information and Privacy Commissioner under the Personal Health Information Protection Act, 2004
- Ethics – Emerging issues in Healthcare

Who should attend:
- Senior Directors
- Risk Managers
- Patient Safety Specialists
- Senior Administrators
- Legal Counsel
- Human Resources Directors
- Human Resources Managers

www.hiroc.com
For additional information and registration call 416 733 2773 or visit www.hiroc.com/see_education_and_conferences.asp

Insurance Regulations – Update

HIROC is taking several steps aimed at increasing its Minimum Capital Test (MCT) target. The MCT is a federal regulatory formula applied to commercial insurers that measures available capital against capital required. Capital required is calculated by assessing available capital adjusted by risk plus 50%.

The moves come in response to notification by the Superintendent of Financial Institutions, British Columbia in December 2008 that HIROC had fallen below the 150% threshold that insurers licensed in that province are required to maintain. With the exception of British Columbia, provincial insurance regulators do not require reciprocals to maintain the same amount of capital to be set aside for claims as commercial insurers. This is primarily due to the fact that reciprocals have the unique ability to assess subscribers for additional funds, if required, to pay claims over the premium collected and investments earned. In addition, they have extended cancellation provisions allowing for stability in subscriber membership (commercial insurers generally do not require an advance notice of cancellation). British Columbia, however, requires that all insurers, including reciprocals, licensed in the Province maintain a MCT of 150% and set an internal target above 150% to reduce the likelihood of dropping below the threshold.

In response to the situation, HIROC has committed to achieve a MCT of 150% by December 31, 2010 and set a higher internal target.

Anthony Fuchs
Manager, Communication & Marketing
HIROC
LEGISLATION

Bill C-2: Tackling Violent Crimes Act

When the law against impaired driving was first passed in 1921, not only did the police have very limited means of enforcing this provision, but it was also a relatively insignificant problem at the time. Trends however, have since changed. According to the Canadian Centre on Substance Abuse (CCSA), recent studies indicate that drugs, often in combination with alcohol, are detected in up to 30% of fatally injured drivers. A 2004 survey found 5% of Canadian drivers admitted to driving within two hours of using cannabis – a 50% increase since 1989. Among 16–18-year olds, 21% reported driving after using cannabis, slightly higher than the 20% of their peers who reported driving after alcohol use.

July 2, 2008 saw the enactment of Bill C-2, otherwise known as the Tackling Violent Crimes Act. This new federal legislation has been several years in the making and is a combination of five previously proposed bills amending the Criminal Code with respect to violence involving firearms, dangerous and high-risk offenders, sexual predators and impaired driving.

Impaired Driving

Of particular interest to healthcare organizations is the portion of Bill C-2 that relates to impaired driving. The Bill establishes parity between drug and alcohol impaired driving under the law and expands drug investigation and enforcement capabilities. Prior to July 2, 2008, it had been an offence to drive while impaired by alcohol, a drug, or a combination of both. However, while it was an offence to drive while one’s blood-alcohol level was over the legal limit of .08%, there was not a similar ‘legal limit’ in existence for drugs. The challenge for police, therefore, was in determining drug-impairment with only non-quantifiable symptoms such as erratic driving behavior and witness testimony to rely on. Furthermore, drug tests were inadmissible as evidence in court unless the driver participated voluntarily. Under the new legislation police officers are now able to demand physical sobriety tests and bodily fluid samples for investigation of impairment. Such tests will verify the use of not only alcohol, but also over-the-counter, prescription and/or illegal drugs.

Where there is reasonable suspicion that the driver has alcohol or a drug in his or her body, police officers are now authorized to administer roadside sobriety tests. This physical coordination testing will be used primarily as a screening tool. If the driver fails this test the officer will have reasonable grounds to believe that an impaired driving offence has been committed, and can demand the suspect accompany him/her to a police station for further evaluation.

This further evaluation, known as Drug Recognition Evaluation (DRE) involves a combination of interviews and physical observations by specially trained and certified officers. If not previously done, a Blood Alcohol Concentration test (Breathalyzer) will be conducted to rule out alcohol impairment. If, in the absence of alcohol impairment, the DRE results indicate a driver is impaired, the officer must identify the class of drugs involved.

Once the suspected class of drug has been identified, the police officer is authorized to demand a blood, urine or saliva sample. The officer may take both the urine and/or saliva samples directly from the suspect, however blood samples are to be taken only by, or under the direction of, a qualified physician who is satisfied this will not endanger the suspect’s life or health. Under Bill C-2 the physician and/or persons acting under the direction of a physician, are immune from criminal or civil liability for anything necessarily done with reasonable care and skill when taking the sample.

It’s important to point out that the results of the bodily fluid testing do not provide evidence of impairment – this is determined in the Drug Recognition Evaluation. Rather, the results of the bodily fluid testing serve to confirm whether the sample contains the class of drugs identified in the evaluation. If no drugs are present, the impaired driving charge will be dropped. In addition, if the class of drugs found in the sample does not match the one identified by the DRE officer, the charge will also be dropped. Thus, a drug-impaired driving charge will only proceed to trial if the analysis of the suspect’s sample confirms the officer’s conclusion about the class of drugs involved.

continued on page 10
A driver’s refusal to comply with a police officer’s request for a physical sobriety or bodily fluid sample test constitutes a criminal offence and will likely result in charges being laid.

The legislation has received strong support from organizations like Mothers Against Drunk Driving (MADD) and the Canadian Automobile Association (CAA). Both organizations advocated for the passage of Bill C-2 and are in full support of these new amendments as a balanced and measured response to the risks posed by the increasing rates of alcohol and drug impaired driving.

However, Bill C-2 has also attracted its fair share of criticism. Many feel there still exists a detrimental effect on driving-related skills even with a blood alcohol concentration registering below the current legal limit of .08%, and recommend lowering the limit to .05%. As well, along with general opposition to using enforcement rather than education to tackle this problem, concerns include the subjectivity of the testing, the accuracy of the equipment, the potential invasion of privacy, and the additional strain the new legislation will place on the courts.

Significant funding will be required to fully implement Bill C-2 due to operational, capacity and resource challenges. Although the province of Ontario anticipated it would need at least 18 months to prepare before full implementation, they currently have officers trained to administer the tests. However, due to worries of overburdening the system, the Ontario Centre of Forensic Sciences, the government-run centre responsible for the testing, is accepting samples under the new federal rules for serious cases only.

The first legal challenge to the new legislation was taken to court on January 12, 2009 in Toronto. The outcome is yet to be determined.

As healthcare organizations, you may already have had to deal with requests for blood samples under Bill C-2. In preparation for full implementation, it’s important that your policies be updated to incorporate this new legislation and that front line staff receive the necessary education.

Donna McBurney
Risk Management Specialist
HIROC

Remembering George Speal
HIROC’s First Chair of the Board

HIROC lost a dear friend and cornerstone of our organization with the recent passing of George Speal, Q.C., who died in his sleep at home with his family. He was 76.

George was a treasured friend to many. A lifetime Kingstonian, he practiced law and served proudly as the City’s Mayor from 1973-1976. As a Governor on the Board of Kingston General Hospital, he was instrumental in the creation of “HIRO” (Hospital Insurance Reciprocal of Ontario) and the first Chair of the Board from 1987 to 1989. In 1989, he lead the Reciprocal into becoming “a truly Canadian healthcare organization” when we welcomed the Province of Manitoba into the subscribership.

George served on the Reciprocal Board for a number of years and then moved on to the Boards of HIROC Management Limited and HIROC Insurance Services Limited, where he completed his term in 2005.

In his first report to subscribers, George wrote: “The completion of HIRO’s first year marks a significant milestone in the history of the hospital industry in Ontario – one that will be of lasting benefit.”

“George was determined to see our organization achieve success and fulfill its mandate of service on behalf of healthcare organizations across Canada”, said Peter Flattery, HIROC’s CEO. “But beyond that, George was a good friend, quick to laugh, and always supportive of HIROC staff. He is deeply missed.”
Ask a Lawyer

Q: I am an emergency department nurse. Occasionally, the police have attended at the department and requested a blood sample or other information concerning a patient (usually where the patient is suspected of driving while intoxicated). What are my legal obligations in such circumstances?

A: Generally speaking, there is no legal obligation to comply with a police request for confidential information which would include blood samples.

While the police may request that a patient provide a blood sample (the circumstances in which the police may request a blood sample have recently been expanded – see article “Bill C-2: Tackling Violent Crimes Act” on page 9 of this issue of The HIROC Connection), the patient has the right to refuse the request if they are competent (the patient may then be charged with refusing to provide a sample but that is an issue for the patient to worry about, not you). You should not attempt to obtain a blood sample from a patient if the patient has not provided his or her consent.

If the patient is unable to consent (either because the patient is unconscious or incompetent) to providing a blood sample, the police must possess a search warrant issued by a Justice of the Peace. A Justice of the Peace will issue a search warrant based on information provided by the police and if the Justice of the Peace is satisfied that appropriate circumstances exist. Search warrants can be obtained by the police very quickly if necessary, so you should not feel pressured into providing a blood sample if the police do not have one. If you are unsure whether a document presented by police is a search warrant or if you are simply uncomfortable with the situation, you should report the matter to hospital administration and request direction. A photocopy of the search warrant should be included in the patient’s health record.

In short, although your first reaction may be to assist the police with their investigation, the general rules regarding consent and disclosure still apply. A blood sample and other patient information should only be provided to the police if the patient consents or the police possess a search warrant.

Gordon Slemko
General Counsel
HIROC

This column is intended to convey brief and general information and does not constitute legal advice. Readers are encouraged to speak to legal counsel to understand how the general issues discussed in this column may apply to their particular circumstances.

Subscribers are invited to submit questions of a general legal nature, to our resident general counsel Gordon Slemko at gstemko@hiro.com. Gord will select from the queries submitted and will provide his corresponding response.
New Subscribers of HIROC

We are pleased to welcome the following new subscribers that have joined HIROC since the December 2008 publication of The HIROC Connection.

ONTARIO

The Royal Victoria Hospital is the only hospital in Barrie serving city residents and patients from a large geographical region, including Simcoe County and the districts of Muskoka and Parry Sound. This state-of-the-art facility specializes in cancer care, surgical services, mental health rehabilitation services and women’s and children’s programs. Ms. Janice Skot is the President and Chief Executive Officer, and Ms. Laura Freeman is the Chief Financial Officer for this hospital.

Villa Charities Inc. provides residential long-term care and community services to seniors in a culturally sensitive environment. It is the umbrella organization to the following affiliates located in Toronto and the surrounding area: Villa Colombo Services for Seniors, Columbus Centre, VITA Community Living Services, Caboto Terrace, Casa DelZotto, Casa Abruzzo, and Villa Colombo Vaughan Di Poce Centre. Mr. Palmacchio (Pal) Dilulio is the President and Chief Executive Officer, and Mr. Paul Pass is the Accounting Manager for this organization.

Shared Services West is a leader in the provision of healthcare supply chain management. Located in Brampton, services are strategically planned and coordinated to specifically meet the needs of organizations providing patient care. Ms. Marianna Lamarche is the SCM Initiative Project Manager.

The Ontario Agency for Health Promotion and Protection (OAHPP) provides scientific and technical support and advice to government, public health units and healthcare providers and institutions. Support is also provided in responding to health-related emergencies and outbreaks. A core function of the Agency is to provide laboratory services and scientific and laboratory expertise. Mr. Norm Rees is the Chief Financial Officer, and Ms. Denise Arsenault is the Vice President and Chief Administrative Officer for the Agency, located in Toronto.

Surgical Research Administration Inc. administers Alternative Funding Plan (AFP) payments to physicians in trust for the AFP Practice Plan, and administers divisional held research accounts in trust for those plans. Located in London, the Business Manager for this organization is Ms. Dinah Frank.

MANITOBA

The Manitoba Association of Optometrists (MAO) is the regulatory and advocacy body in Manitoba for optometrists. Membership is mandatory and the primary functions include the promotion of the importance of eye healthcare and regular, preventive examinations. Located in Winnipeg, the MAO was incorporated by an Act of the Manitoba Legislature in 1909. Ms. Lauren Goodridge is the Executive Director of the MAO, and Dr. David Cochrane, O.D. is the President.