A REVIEW OF THE POLICIES, PRACTICES, AND PROCEDURES OF WATERFORD HOSPITAL'S FORENSIC INPATIENT UNIT

Report of the External Review Committee

September 2015

Mr. Jim McNamee, Executive Director, Centre for Addiction and Mental Health

Mr. Remar Mangaoil, Advance Practice Nurse, Centre for Addiction and Mental Health

Dr. Treena Wilkie, Psychiatrist, Centre for Addiction and Mental Health

Dr. Sandy Simpson, Chief of Forensic Psychiatry, Centre for Addiction and Mental Health

Ms. Nina Flora, Research Analyst, Centre for Addiction and Mental Health

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Centre for Addiction and Mental Health

TABLE OF CONTENTS

1.0 Executive Summary

This review was commissioned by Eastern Health to support their efforts to enhance the inpatient forensic unit and develop its integration with the wider forensic and mental health community. The reviewers were provided access to a number of Eastern Health documents including policies, incident data, financial information, and internal planning documents. The reviewers completed a site visit on August 17th and 18th, 2015, with some additional interviews by videoconference. Multiple stakeholder groups were engaged and their observations, concerns, and comments have helped to inform this review.

The reviewers used a framework that investigated the existence of a shared vision of the service, the adequacy of resources (from both a financial and a skill mix perspective), staff skills, knowledge and attitudes, coordination and leadership, an evidence based approach to structured decision making, and an approach to review, research and evaluation. The unit has experienced significant change, stressors, and staff turnover during the past number of years. This has highlighted the need for effective teamwork and communication. It is recommended by the reviewers that intentional interventions and forums for communication be initiated or re-initiated.

The forensic inpatient unit is a component of a larger forensic mental health system and receives clients from three different referral streams; assessment clients from the courts, rehabilitation clients from the Criminal Code Mental Disorder Review Board, and clients transferred from Her Majesty's Prison under the Prisons Act. This complexity highlights the need for a shared vision and agreement on the mission of the unit. The development of this shared vision and mission is a recommended strategy to improving alignment of purpose and activity, engaging staff, and integrating them into the forensic process.

We found the staffing levels were generally adequate. However, we thought that there would be some benefit to increasing the use of security personnel on some of the more environmental security-oriented tasks that are currently performed by nursing staff.

The physical layout, decoration, and general ambience of an inpatient unit all play a role in fostering a safe and therapeutic environment. There are a number of relatively inexpensive strategies that could improve the unit environment including repainting, putting up posters and artwork, and clearing areas of clutter. Replacing worn out furniture on the unit and improving amenities in the forensic compound would improve the usability of these areas.

We found a number of improvement opportunities to enhance team communication and function. The unit has initiated an end of shift debriefing process led by the Patient Care Facilitator. This process could be expanded to include disciplines other than nurses, a focus on discussion and remediation of safety issues on the unit, and reinforce safety protocols.

The management and staff on the inpatient forensic unit have worked diligently to improve the quantity of therapeutic programming on the unit. These efforts are in their early stages and they are encouraged to continue these programs. Given the forensic mandate of this unit, there also needs to be a focus upon interventions that are risk reducing as well as recovery enhancing. Developing an improved process for the identification and referral of clients who would benefit from specialized services would be beneficial. The Forensic Steering Committee should be a key driver in continuing these therapeutic developments.

Another intervention that can increase the integration of activities on the unit, improve clinical functioning, and enhance the safety of the unit, is the development of standardized descriptions of expected clinical activities, standardized approaches to risk assessment, communication and management, and standardized workflow and templates for the development of forensic reports.

The reviewers produced 5 major recommendations:

1. Resume the operation of the Forensic Steering Committee.
2. Develop a culture that considers the assessment and management of risk while safeguarding the recovery and dignity of forensic clients.
3. Improve team communication through structured processes.
4. Intentionally seek out opportunities to facilitate a shared understanding of inter disciplinary roles and responsibilities.
5. Improve the physical environment of the inpatient unit and surrounding area.

Based upon the review of policies, other information provided for the purposes of this review, and stakeholder interviews, the reviewers made an additional series of recommendations. These are found in the body of the report.

2.0 Background

This review was commissioned by Eastern Health to assist in the development of their inpatient forensic unit and its links to the wider forensic and mental health community. There was a recent tragic incident on the Forensic Unit at Waterford Hospital that provided a context for seeking this review.

The primary goals of this review are to offer recommendations to: i) improve safety and security for patients and staff; ii) enhance assessment/treatment programs; iii) enhance processes around court proceedings; and iv) determine experience and educational requirements of staff.

2.1 General Approach

In conducting this review, we come to address the issues of how a forensic service should be structured from the perspective of the following key points. We will return to address these in greater detail in section 7.0 of this report.

A. Vision, or More Properly, a Shared Understanding of Roles and Responsibilities

Forensic services are composed of multiple elements provided by staff from a range of disciplines. Indeed, given the range of age, gender, and ethnic backgrounds of our patients, it is vital to have a diverse staff who can work with them. But with diversity comes complexity, and forensic patients, because of the pathway they are on, also need consistency and coherence in their care and progress.

A shared understanding is central to this process. This includes a shared set of values about the purpose of the service, a commitment to understanding what the Forensic Mental Health Service does and why, and a shared set of values about how it works.

B. Resources

'Resources' refer to the size of the budget in relation to the task at hand, and its adequacy. Resources include staffing levels and the mix of professional groupings employed, as well as the design and adequacy of the facilities provided. Facilities must be designed in a manner that supports the model of care employed.

C. Staff Skills, Knowledge, and Attitudes

Equally important to the size of the resources available is the nature of the skill mix of staff employed in the forensic service, their attitudes and beliefs, and the degree of training they have undergone. These include vital relationship skills, information gathering, therapeutic skills, risk assessment, and risk communication and management.

D. Coordination and Leadership

Ensuring integration and coherence across the elements of the care pathway for a forensic patient is very important. Policies and procedures are essential to guide staff in their care of patients, in a way that is coherent and stepped across the person's care journey, as they respond to treatment and as their risk and recovery needs change. Communication and integration at the clinical level through the coordination of the care system is very important. Leadership must provide structure and oversight of such care pathways and support clinicians in the care of persons who pose risk to others.

E. Structured Decision Making

Structured professional judgment tools are now standard practice in forensic mental health services internationally (Singh et al., 2014). They provide for consistency of approach and clarity of risk assessment understanding and risk communication. Tools such as the HCR-20 (Webster et al., 1997; medium to longer term decisions) and the START (Nicholls et al., 2006; shorter to medium term decisions) have been designed to assist clinicians and review boards in making decisions by, amongst other things, identifying modifiable clinical risk factors or protective factors that can assist in treatment planning and decision making about leave status or setting levels of security. More recently, structured professional judgment tools have emerged to help guide a forensic service in making admission, security and clinical progress decisions. The DUNDRUM (Kennedy, O'Neill, Flynn, & Gill, 2010) and SNAP (Collins & Davies, 2005) are examples of these types of decision support tools.

F. Review, Research and Evaluation

Any forensic service must ask questions of itself and evaluate its own success. Tools such as benchmarking or systems of key performance indicators may allow a service to track its own performance against industry set targets.

3.0 Terms of Reference

The External Review Committee from the Centre for Addiction and Mental Health (CAMH) was asked to review Eastern Health's policies, practices and procedures, and make recommendations regarding:

- The population being served;
- Assessment processes relating to the assessment of risk factors for aggression, elopement, self-harm, and suicide;
- Safety/risk policies particularly relating to level of observation, surveillance, searching belongings, management of behavioural and medical emergencies including the use of seclusion and restraints (chemical and physical);
- Treatment plans;
- Therapeutic programming for patients;
- Continuum of care.

The External Review Committee was also asked to review and make recommendations on the following:

- Clinical team composition;
- Role of clinical team members (nursing staff – Registered Nurses and Licensed Practical Nurses, Psychiatrists, Family Practitioners, and Support Staff);
- Admission, inter-professional plans of care, discharge planning and discharge process;
- Role of security services within the inpatient unit;
- Communication and processes utilized with court, Her Majesty's Penitentiary (HMP), City Lock Up, Police, NL Review Board, and Corrections Canada.

4.0 Composition of External Review Committee

The External Review Committee from CAMH consisted of a team of qualified professionals with expert knowledge in forensic mental health. The Committee included an Administrative Lead (Mr. Jim McNamee), a Clinical Lead (Dr. Treena Wilkie), and a Clinical Programming Lead (Mr. Remar Mangoil). The External Review Committee also received assistance and support from Dr. Sandy Simpson and Ms. Nina Flora. A brief profile of each member of the External Review Committee, as well as the supporting team members are provided below.

Mr. Jim McNamee is an Executive Director of the Complex Mental Illness Program at CAMH and is responsible for forensic acute services, court-based services, jail-based services, and outpatient services. He was previously the Administrative Director of the former Law and Mental Health Program. He has 25 years of experience in the forensic field and has worked as a clinician and manager in both inpatient and outpatient forensic settings. He has Master of Social Work degree and an Executive Master of Business Administration

Dr. Treena Wilkie is a Senior Psychiatrist at CAMH. Dr. Wilkie is also an Assistant Professor in the Department of Psychiatry at the University of Toronto, and the Inpatient Head of rehabilitative services in the Complex Mental Illness program at CAMH. She has been qualified as a Specialist in Forensic Psychiatry by the Royal College of Physicians of Canada. Dr. Wilkie is an educator and senior clinician on the inpatient forensic unit, sexual behaviors clinic, forensic outpatient service, and brief assessment unit. She has been involved in research focused on resident education in violence risk assessment, the multi-rater reliability of the HCR-20, and absconding in mental health services. She has contributed to the development of several quality improvement initiatives on the rehabilitation units at CAMH and has been involved in Quality of Care reviews. She is a supervisor of medical students, residents, and fellows in the Forensic Program.

Mr. Remar Mangaoil is an Advanced Practice Nurse (APN) at CAMH. He is also an Adjunct Lecturer at the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto and a Psychiatric Crisis Consultant at the Grand River Hospital in Kitchener, Ontario. He has been a

practicing clinician for the past seven years, working as a Psychiatric Crisis Consultant at Grand River Hospital. He has been working full-time in CAMH's Complex Mental Illness Forensic Program as an APN for the past two years. His work as an APN focuses on the implementation of best practice standards to meet the needs of frontline staff, clients, families, and the organization as a whole. Mr. Mangaoil's work primarily revolves around enhancing the risk assessment and management of aggressive clients in forensic settings.

Dr. Sandy Simpson is Associate Professor and Head of the Division of Forensic Psychiatry of the Department of Psychiatry at the University of Toronto, and is Chief of Forensic Psychiatry and Clinician Scientist at CAMH. He is an Advisory Board member of the International Association of Forensic Mental Health Services, is Vice President of the Canadian Academy of Psychiatry and Law, and is a member of multiple Committees of the American Academy of Psychiatry and Law. He is also a member of the Editorial Board of Criminal Behaviour and Mental Health and the Canadian Journal of Psychiatry. Dr. Simpson's academic, teaching and research interests are in the area of the interaction of the law and people with serious mental illness (SMI), particularly how we understand pathways to risk into criminal justice system and for therapeutic intervention and recovery. He is committed to improved understandings, services, outcomes, and jurisprudence for persons with SMI who are criminal justice involved.

Ms. Nina Flora (Hons. B.Sc.) is Research Analyst at CAMH. She has worked as a Research Analyst at CAMH for eight years, having spent the last year working in the Complex Mental Illness Forensic Program. She has worked on several research projects that have focused on issues relating to the social determinants of health, access to mental health care, health inequities, and pathways to care. More recently, Ms. Flora was involved in developing a report outlining best practices for delivering mental health services in federal prisons. She is currently working on a program evaluation of the newly implemented Forensic Early Intervention Service at the Toronto South Detention Centre.

5.0 Procedure

The External Review Committee conducted a two-day site visit of the Forensic Unit at Waterford Hospital (August 17th and 18th, 2015). During the two-day visit, the Committee met with key internal and external stakeholders. These included members of the senior management team, clinical team, clients of the Forensic Unit, as well as members of community partners/agencies, the Review Board, and courts. Furthermore, the External Review Committee met with members of the security team via videoconference (August 31st, 2015). Additional meetings were also held with RN staff (September 2nd, 2015) due to low attendance during site visit and with Forensic Unit clients (September 3rd, 2015). Attempts were made to schedule an additional meeting with LPNs due to low attendance during the site visit, however, due to time constraints, the meeting could not be scheduled.

Extensive notes were documented by the External Review Committee during meetings with each of the key stakeholder groups. Key issues and concerns raised by each stakeholder group are described in section 6.0.

In addition to the two-day site visit, the Committee undertook a detailed review of Waterford Hospital's key policies and procedures pertaining to the Terms of Reference described above. A critique of each policy reviewed by the External Review Committee is described in section 8.0.

6.0 Interviews with Key Stakeholders

6.1 Senior Management

External Review Committee member(s) present: Mr. Jim McNamee, Dr. Treena Wilkie, and Mr. Remar Mangaoil

The management group provided an overview of some of the current issues related to the forensic inpatient unit. These included low occupancy with the unit generally operating at 40-60% occupancy. The reasons for this were not clear to the group but could include increased diversion at the mental health court, a decrease in remands, and a decrease in referrals from the prison. One of the challenges associated with this lower occupancy is labour challenges related to a minimum staffing agreement and an inability to adjust staffing based upon the census.

The group acknowledged that this has been a difficult period for the inpatient unit, with challenging clients, the addition of security personnel, the anxiety related to the pending model of care change, and significant disciplinary interventions. There have been recent critical patient events that have resulted in significant disciplinary action, including termination. It was felt that the intentions of management were misunderstood and that the point of care staff were suspicious of management actions and were concerned that the goal was to "clean up the unit." There was a perception that frontline staff believed that part of this "clean up" includes a plan to replacing full-time nurses (particularly Licensed Practical Nurses) with security guards and casual nurses.

Members of the group alluded to the challenges working with the two unions, particularly when implementing changes to clinical practice on the unit. There was also a suggestion that there is a lack of collaborative relationships with and between members of the inter-professional team. It was felt that the inter-professional team was not functioning optimally and was not integrated adequately. While the unit manager meets with the Patient Care Facilitator several times daily regular communication with the rest of the team has not been consistent.

There was a concern expressed that patient care on this unit is "custodial" rather than recovery oriented and that nurse-patient interactions are very limited. It was noted that the day-to-day

nursing activities primarily revolve around the observation and completion of activities of daily living (e.g., supervising hygiene care, use of compound, and meals). It was suggested that the clinical assessment of patients was sub-optimal and needing particular attention. The assessment of risks is often based on observations from the nursing station rather than through an interactive dialogue between the nurse and the patient. It was reported that despite the addition of security guards on the unit, the level of engagement or interaction between nurses and patients has not improved.

It was reported that the unit has historically had a sense of family and closeness but that now the "morale is shaken." The morale has reportedly been impacted upon by the above factors including the recent adverse clinical events and staff turnover.

Effectively managing women on a mixed gender unit was also raised as an issue.

The group felt that the forensic inpatient unit was well respected and valued by the organization.

Major Elements to Note:

- The past year has been a challenging time for the inpatient unit.
- Morale is poor and clinical functioning is sub-optimal.
- Referrals and occupancy have decreased.
- There is heightened discomfort and suspicion from point of care staff due to recent patient events and staff termination and limited opportunities for staff on how these emotions can be supported or processed during clinical working hours.
- There is a lack of formal, scheduled meetings to ensure adequate communication about the unit (e.g., safety issues) is maintained and relayed to the rest of the team.
- Even though there is a process for staff performance review, it is not regularly conducted. The manager stated that 80% of his time is spent on disciplinary follow-up.
- There are limited educational opportunities on the unit. Currently, there are two clinical nurse educators for the entire hospital. The clinical assessment skills of nurses have been identified by the unit manager as a significant area for improvement.

6.2 Forensic Unit Staff

Nursing Group: Registered Nurses

External Review Committee member(s) present: Mr. Jim McNamee, Dr. Treena Wilkie, and Mr. Remar Mangaoil

The External Review Committee met with two Registered Nurses (RNs), including the Patient Care Facilitator during the site visit, and also interviewed three additional RNs via videoconference.

The Patient Care Facilitator (PCF) functions as the Charge Nurse on the unit, working Monday through Friday, from 08:00 to 16:00 hours. The discussion started with a brief description of the PCF role and the current culture of unit N4B. One of the initial remarks was that staff morale, particularly that of nurses, has been very low, and that frontline staff have been reluctant to make any clinical decisions on the unit. This reluctance was attributed to the lack of staff support and guidance from the management team when a critical incident occurs.

When asked about the relationship between the nurses and other members of the team, the response from one of the RNs was that the nurses do not have a collaborative relationship with the allied staff, and the participation of this group (allied staff) in the day-to-day activities on the unit could be improved.

Communication is one of the biggest challenges for one of the participants interviewed. She expressed that management has been very supportive of the unit leadership roles (e.g., PCF); however, it was disclosed that most of the interactions with the unit manager have often been about practice and staffing issues. The participant noted the lack of regular staff meetings on the unit, and the recent changes to clinical practice and staffing levels were not clearly communicated to frontline staff.

One of the participants described the provision of care on the unit as “limited to no engagement with patients…they [nurses] are just doing tasks all the time”. She was unclear how the nurses are conducting mental status examinations and risk assessments, but was certain that they are not using any structured guidelines or standardized process for assessing, reporting, and mitigating risks on the unit.

One of the RNs spoke about the limited learning opportunities on the unit. The participant felt that the orientation to the forensic system (including working with forensic clients) was not particularly thorough, and noted that the staff changes on the unit (increased casual nursing staff and licensed practical nurses (LPNs) being replaced by security guards) are negatively affecting the regular frontline staff. She described the unit as having “low morale”, and had commented that there are times when she does not feel safe working on the forensic unit due to the current level of staffing mix and shortage.

One of the RNs noted that the mental status examination is conducted at least once per shift and “as needed” (whenever there is a change in the patient’s baseline or previous mental status). She spoke about the use of continuous (constant) observation on patients who are in locked seclusion, describing the practice as having little interactions with the patient (“we’re not doing much during obs”). Only RNs and LPNs conduct continuous observation. She also talked about patient care plans being updated 2 to 3 times per week (primarily done during team rounds), but noted that nursing is not fully involved in this endeavour. In general, she felt comfortable with how clinical assessments and patient care plans are done on the unit. When asked about the recent use of security guards, she expressed a concern about their knowledge

and skills around crisis intervention and providing therapeutic relationship with the clients on the unit.

Some nurses who recently joined the team expressed their reluctance to work on the forensic unit. They spoke about an overall sense of negativity and demoralization amongst staff. “It’s like walking on eggshells” was one of the comments made about their work environment, where nurses are afraid of making any clinical decisions as they are fearful of losing their jobs and professional license. The negativity on the unit, as one of the participants described, has changed the way they function at work; instead of supporting each other, they are now just looking out for themselves.

A discussion around the use of security guards revealed two themes: i) nurses are unclear about their role with security, and ii) there is a lack of communication between security guards and nursing staff. The RNs spoke about the difficulty with delegating tasks to security guards as they are unaware of the guards’ scope of practice. Furthermore, the RNs felt that security guards should receive additional mental health and de-escalation training prior to working on the unit. One of the RNs shared that she is concerned about security’s limited training around working in a forensic unit and interacting with acutely ill patients. She indicated that the scope of the security guards on the unit remains unclear to both frontline staff and the guards themselves. There also seems to be no formal handover process between nursing staff and security guards (during and after a shift). Risks are communicated on an ‘as needed basis’ rather than a routine check-in with each other. Similar to the nurses’ sense of having low morale, they also noted that the guards’ morale on the unit has been low as well.

The PCF and the unit manager had implemented a new initiative whereby the PCF debriefs with the day staff at 15:30 hours. In addition to the handover report that the nurses provide, the PCF inquires about individual and team functioning, particular concerns, and accomplishments on that day. So far, nurses have found this initiative to be positive.

Major Elements to Note:

- The RNs expressed a desire to know more about the forensic system (e.g., visiting community services, mental health court, local penitentiaries, etc.).
- Main communication with nursing staff is through email. One of RNs noted that the last staff meeting they had was approximately one year ago (staff meetings used to happen on the unit every two months). White board in the nursing station has not been formally implemented.
- An RN stated that family visits do not happen regularly on the unit. She indicated that the patients’ family members often live far from the hospital.
- One of RNs found the team debriefing at the end of the day to be helpful, stating “I like how she [PCF] asks us what we didn’t like about our day so we don’t take these at home with us”.

- The care and rehabilitation of forensic clients were not articulated or communicated in a recovery-focused approach.
- Given the recent events that have transpired on the unit, the RNs thought that a face-to-face communication or a supportive “defusing” session from the organization would have been beneficial for staff.
- An orientation guideline specific to forensic mental health care and recovery-focused care should be provided to all staff (including security guards). This guideline should be developed and delivered by the clinical nurse educator (or a practice leader in the hospital) to ensure consistency and quality of content. Additionally, educational sessions for staff on the role of security should also be considered.
- Rules and guidelines are not easily accessible and clearly communicated to staff.
- The RNs expressed having no motivation to work on the forensic unit, and felt that they are “not doing much for patients” here compared to other units in the hospital. One of the participants commented “When I work on other units, I love it and get excited; but when I’m working here [forensic unit] I can’t wait to leave”.
- The PCF is a very demanding role and it is vital to the day-to-day functioning of the team. There is a palpable reliance (perhaps an over-reliance) on the PCF for handover reporting, attending team rounds, and debriefing with frontline staff.
- The PCF, although optimistic about the roll-out of the new model of care in September 2015, expressed that this new model might not fully address the needs of forensic clients. The PCF also shared her concerns about how this model will be implemented and who will lead this endeavour in their unit.
- The PCF acknowledged the hard work and dedication of the frontline staff and unit manager in keeping the unit safe, but feels that there is more work to be done.

Nursing Group: Licensed Practical Nurses (LPNs)

External Review Committee member(s) present: Mr. Jim McNamee, Dr. Treena Wilkie, and Mr. Remar Mangaoil

Only one LPN was present at the meeting. The Committee members inquired if he would prefer to reschedule another interview with the rest of his colleagues, but indicated that he needed to express some of his concerns with us at the time. A videoconference was arranged for additional LPN input. Unfortunately, the reviewers were unable to conduct this follow-up meeting with this group.

The LPN stated that communication from management needs to be improved. He noted that the purpose of this external review remains unclear to him, and with the recent termination and suspension of frontline staff, he feels very suspicious of the external reviewers’ presence in the hospital.

The LPN talked about working on this unit a few years ago when “everyone [staff] helped each other…but now we’re divided”. He noted that the manager’s presence on the unit is lacking, stating “he only comes to the unit if he wants something started then leaves”.

When asked about risk assessment, the LPN stated “we see things as they go”. Discussions around client risks are passed on during shift handover report. He indicated that staff, particularly new or casual nursing staff and security guards, have very little skills and confidence utilizing de-escalation and hands-on techniques during Code White events.

Major Elements to Note:

- The LPN expressed concerns in regard to the information and support provided to frontline staff surrounding the recent staff termination and suspension.
- The LPN feels that the unit (N4B) has turned into a place where they need to change how they provide care to clients and “bend rules to make our job work”. He then stated that “management is setting us up for another incident”.
- In order to restore this camaraderie back on the unit, the LPN felt that efforts should be made to promote regular communication and collaboration between frontline staff and management.

Psychiatrists

External Review Committee member(s) present: Dr. Treena Wilkie, Mr. Remar Mangaoil, Mr. Jim McNamee

The External Review Committee met with the two psychiatrists in the forensic unit. They are referred to as Physician 1 and Physician 2 throughout the document. Of note, Dr. Wilkie also met with one of the psychiatrists on a second occasion to clarify some information.

The physicians reviewed the development of the forensic assessment unit. There was a perception that the unit was not adequately serviced or valued in the hospital, perhaps due to relatively low patient numbers; however, it was noted that the acuity on the unit can be high and that the needs of the clients on the unit are varied and can be intense. There had been inattentiveness to some aspects of the unit, for example a fence was not fixed for a lengthy period of time, which compromised the use of the compound. The view was expressed that management was assuming primary responsibility for decision making and service development. There was little communication between the physicians and the manager, who was described as primarily engaging in independent program development.

Staff “tension” was described, which was attributed to a discrepancy between the needs of the unit and the available staff resources. The unit has a difficult time maintaining a consistent staff; an example was given that there had been seven different social workers in a relatively short

period of time. Educating the staff had therefore been somewhat problematic. Both physicians highlighted the contributions of the "very astute and able" PCF as being integral to unit functioning. The role of security on the unit was not clear to the physicians, and there was discrepancy between the two physicians as to the utility of the security on the unit.

The flow of patient care through the unit was discussed. Both physicians have a regular presence on the unit, and both also work on the rehabilitative unit in the hospital. Physician 1 works with the ACT team, as well as consulting in the lock-up and in the prison. Physician 2 has outpatient clients. Physician 1 has reached out to the Review Board and Corrections about offering educational sessions. She spoke of the need to view the forensic clients as moving through a coherent service.

There were differences, however, in the views of the psychiatrists regarding some issues. Physician 2 highlighted the use of clinical assessment as the primary process of risk assessment and formulation, and questioned the utility of standardized tools and reports to the Court as this could result in a loss of flexibility. Physician 1 has been using the START on the rehabilitation unit, and regularly completes standardized risk assessments, and Review Board and Court reports.

The physicians spoke about the Forensic Steering Committee, and the utility of this group as having the potential to better focus the service.

Major Elements to Note:

- Client assessment and formulation with the resultant trajectory appears related, in large part, to physician assignment.
- A challenge in developing a coherent vision for the forensic service may be the divergent opinions and practices regarding risk assessment, risk management, and standardization of reports.
- The physicians have a meaningful and regular presence on the unit.
- Physician 1 is engaged in many different elements of the forensic service, and is actively engaged in offering educational opportunities to other stakeholders in an attempt to improve communication and a shared understanding of risk assessment/management.
- Both physicians are committed to the improved use of the Forensic Steering Committee.

Allied Health Staff

Allied Health Staff present: Social Worker (2), Forensic Coordinator, Occupational Therapy, Psychologist, and Therapeutic Recreation

External Review Committee member(s) present: Mr. Jim McNamee, Dr. Treena Wilkie, and Mr. Remar Mangaoil

The allied health session was well attended. The allied health professionals included: 0.6FTE Social Worker, 1.0 FTE Social Worker, Forensic Coordinator, 0.7FTE Occupational Therapist, 1.0FTE Psychologist, and a 0.5FTE Therapeutic Recreation.

Allied health staff work with both physicians. Physician 2 holds rounds three times a week and Physician 1 holds rounds once a week. They described the team as "well-functioning" and felt that they were well respected by their nursing colleagues. The two disciplines that do not regularly attend inter-professional rounds felt "less connected" to the team than the other disciplines. One individual, commenting on the differing styles of the two physicians, stated that "our role is to be as adaptable as possible. We're the same team but have to change our approach."

The group described their roles and how they determine how to allocate their clinical resources.

The social workers reported that they screen each client admitted to the unit, provide discharge planning services, provide referral services for follow up, support clients in accessing legal services, and provide individual support. The social worker will also liaise with community service providers and HMP staff when HMP inmates are admitted. They attend all rounds and will complete psycho-social assessments for Review Board clients. The social worker on secondment also conducted an addictions group in the past. One social worker also functions as the Forensic Coordinator, a role that was created 7 to 8 years ago. In this role, the social worker compiles community information (presumably for those clients not followed by the ACT Team and for clients located in communities outside the St John's area) and submits reports.

The psychologist on the unit indicated that most clients admitted to the unit are there for fitness assessments and that she will often provide "fitness coaching" to these clients. It was reported that many of the clients are "revolving door" clients and are thus known to the service. The psychologist will not see all clients, especially those known to her, but will review files and assess current needs. The psychologist reports that she completes psychological assessments including the Psychopathy Checklist Revised. She will complete reports as appropriate. Her therapeutic interventions are generally individual rather than group based. In terms of risk assessment, it was reported that as Physician 1 prefers to complete the risk assessment of her clients herself. The psychologist does not complete risk assessments on Physician 1's clients. She indicated that she does complete risk assessments on Physician 2's clients upon request. Apparently, there was START training approximately two years ago but the team has not "been told to begin."

The occupational therapist and the occupational therapy assistant report that they receive referrals from the team. They do not attend team rounds and tend to become clinically involved only with NCR clients. They commented that there seemed to have been a recent decrease in

referrals and that they had not received any in the past 6 weeks. They were unsure as to the reasons for this decrease.

The recreation therapist (RT) reported that the RT regularly assigned to the unit attends the unit 3 times a week. Recreation services are accessed through formal referral. The RT reported that they have only recently begun to receive referrals.

There was reportedly a recent increase in group programming on the unit, although there appears to be a limited focus upon risk reducing interventions. There was consensus in the group that the compound was under-utilized and one staff member commented that this was "about staffing and not willingness." There appeared to be some concerns about the safety of the area.

Allied health staff appear to rely on nursing staff to assess acute risk on the unit and believe that they use unstructured clinical assessment to assess risk. When the adequacy of this form of risk assessment and communication was discussed, one staff member commented that they "trust every member of the team implicitly." It was reported that allied health staff do not have their own personal alarms and "borrow" them once they get to the unit.

A number of staff commented on a lack of clarity about decision making: who makes them, how they get communicated, and how those decisions can be appealed. There appeared to be some frustration that "ideas seem to get stopped" with little explanation. One allied health staff commented that frontline staff are enthusiastic but not recognized or appreciated. This comment was not challenged by other participants.

There do not appear to be regular staff meetings. There is a Forensic Steering Committee that involves allied health staff, the physicians, the manager, and the PCF but we were told that this group rarely meets.

The allied health group appeared to be split on the issue of security on the unit, with some having strongly negative perceptions, feeling that security staff are not adequately trained and that their role is not clear. One participant commented that they "just showed up one day" and that their presence and role was never explained. Other staff felt they appreciated the responsiveness and willingness of security to be present or vigilant if requested.

Major Elements to Note:

- The differing styles and practices of the two physicians result in some degree of ambiguity about the functions and activities of some of the allied health disciplines. It was not clear what impact these differing styles had upon treatment planning.
- It was not clear that there was a clear understanding, knowledge or appreciation of the risk assessment and risk management process.

- There appeared to be frustration related to the perception the administrative decision making process was not transparent or well communicated.
- There does not appear to be any formal process of clinical supervision or systematic deployment of clinical resources.
- There appears to be a lack of a coherent forensic focus related to program planning and clinical intervention.
- Fitness coaching is conducted by the psychologist. This function is completed by nursing staff in many other forensic settings.
- The group appeared committed to improving the functioning of the Forensic Steering Committee.
- The group held divergent opinions on the benefit of having security staff on the unit.

Internal Stakeholders

Internal Stakeholders present: ACT, Social Worker Community Liaison, Strengths Program, Concurrent Disorders, and CMHA housing program

External Review Committee members present: Dr. Treena Wilkie and Mr. Remar Mangaoil

Of note, the individuals who attended this session were not aware of the purpose of the meeting, and thus did not appear, at least initially, to have formed opinions on the issues being discussed.

Each individual summarized the contact between the program they were involved with, and the forensic service.

The Strengths Program has one forensic client; it was noted that most forensic clients do not meet their program criteria. They are a case management service that is recovery and goal focused.

The ACT service reported having a “seamless” transition for clients between inpatient and outpatient services. Physician 1 works with forensic clients on the ACT Team, and there was noted to be good communication with the unit social worker. The services available through the ACT service were discussed. A ‘risk assessment’ document is completed prior to discharge, which details a clinical risk assessment and an environmental risk assessment, so that available services can be tailored to the individual’s living circumstances. Physician 1 had also been using the START risk assessment tool for her clients.

The Concurrent Disorders program had limited collaboration with the forensic unit, although a group was to be starting on the inpatient unit.

The MHC program was described as having had one to two referrals from the forensic service. A community initiative was discussed pertaining to individuals who are difficult to serve using conventional programs, and are difficult to house. This is a voluntary service. The utility of barrier-free shelters and flexibility with regard to serving a 'justice-based' population were noted.

The CMHA services were described. There are 166 beds available in thirteen 24-hour staffed homes. Individuals are followed by an ACT team.

There was a general discussion about the lack of a coordinated forensic service when individuals return to Court, and about the difficulties encountered in accessing housing and psychiatric care when individuals are involved in the criminal justice system. It was noted that, in general, waiting lists had been improving for access to community services.

Major Elements to Note:

- The internal stakeholders communicated in language that was recovery-focused and highlighted the need to be client-centered and flexible with regard to assisting clients who are involved in the criminal justice/forensic system.
- There was good understanding and communication of available community services and housing, as well as acknowledgement of some of the systemic problems which can be barriers to access.
- The role of the forensic unit/service in the pathway of care, and the unique needs of forensic clients were not well understood.
- There was limited information being discussed about risk assessment or risk management when forensic clients were being triaged or transitioned to community resources.

6.3 Forensic Unit Clients

External Review Committee member(s) present: Dr. Treena Wilkie and Mr. Remar Mangaoil

Six clients from Unit N4B were interviewed as a collective group. The purpose of the interview was provided prior to the discussion with a focus on their experience on the unit and recommendations for improvement.

Two of the clients reported that they would only go out and use the compound once every two to three weeks. A particular client expressed his frustration, stating that back when he was in the penitentiary, he was able to enjoy fresh air out in the yard daily. He then added "I had to be good to do that…back there, if you're good then you get to use the yard, but when you're bad then you don't get to go out…but here [Unit N4B] you don't get to go out at all". The clients did not refer to any formal programs or staff-led groups on the unit, but spoke about watching TV, playing card games with other clients, and playing videogames as their primary activities throughout the day.

Another client thought it would be a good idea to have an exercise room on the unit. He commented gaining about 60 pounds since his admission to the unit (11 months ago). The clients expressed boredom and frustration on the unit, and these are worsened by their inability to use the compound on a daily basis.

A follow-up videoconference with three clients and a social worker (SW) from the rehab unit was also conducted. These clients were initially admitted to unit N4B prior to their transfer to the rehab unit. Their unique experience provided our review with a significant comparison between the two inpatient wards.

The clients felt that their experience in the forensic unit was much more challenging than the rehab unit. Two themes emerged from this interview: a lack of activities on the unit and a sense of "being in a prison rather than a hospital".

Firstly, the clients indicated that interactions with frontline staff in the forensic unit were very limited. They described their typical day as "boring", which involves hygiene care, bed-making, reading magazines, and watching television. Unit-based groups were only offered once a week. The clients also disclosed their frustrations about acquiring hospital ground privileges (which take about six to eight months to get approved), seeing their psychiatrist only once a week, and not being able to use the compound regularly. In contrast, the rehab unit offers both group and individual programming to their clients on a daily basis. The SW indicated that all inpatients in the rehab unit are screened for individualized programming according to their needs. All three clients agreed that they are more satisfied with the level of engagement and communication they receive from staff on the rehab unit.

Secondly, all three clients agreed that the forensic unit feels more like a prison than a hospital. When asked to elaborate, the clients spoke about rigid unit rules and practices that are particularly demoralizing and intrusive. For example, they found the searching and checking (observation) procedures to be distressing as they felt a loss of their privacy. They also felt unsafe being on the unit with aggressive clients, and that the physical unit (e.g. furniture) is in "rough shape". In the rehab unit, however, they stated that staff members are "nicer…because they don't talk to you like you're a criminal". The SW added that the rehab unit seems to be more "recovery-focused" when it comes to client care, while the forensic unit has a more "militant" approach.

Major Elements to Note:

- The lack of compound use is a source of frustration and boredom for inpatients. They did not put any blame or address any particular displeasure towards the clinical staff about this issue, but emphasized the importance of going out to the compound more often.

- Programming on the rehabilitation unit is inclusive and recovery-focused, but it is only available to clients who are admitted on that unit. There is also a Community Council where frontline staff and clients gather together every Monday to review the programs on the unit.
- Approaches to client care differ significantly on the two units. The clients' overall experience of receiving care in the forensic unit has been mostly negative, describing the environment as prison-like.

6.4 External Stakeholders

External Stakeholders present: Sheriff's Representative, Chair of the Review Board, Provincial Corrections, CMHA, Stella's Circle, Channel Peer Support, and Manager Provincial Support

External Review Committee member(s) present: Mr. Jim McNamee

Each member introduced themselves and indicated the context in which they interacted with the inpatient forensic unit.

It was suggested that referrals had decreased over the last period of time because more assessments are occurring at various stages of detention and that the increase in community supports for this clientele has had a positive impact. From the Corrections perspective, there was some concern that referrals to the inpatient unit had been declined as "too dangerous", which, from a system perspective, raised the question as to where these clients could be treated if not the forensic inpatient unit. Members of the group wondered if staff had received adequate "use of force training" or other training to effectively manage the risk of violence presented by forensic clients. A number of group members commented on a need to improve the relationship between HMP and the unit. Most particularly, it was felt that communication between the two institutions when clients are transferred and then an ongoing communication when HMP clients are admitted to the inpatient unit needed to be improved.

There were some concerns from the court based members of the group that clients do not always arrive back at court with adequate reports, sometimes "one page fitness assessments-even for seven day remands". There was also a comment made that extensions to the remand are sometimes sought because the physician has not seen the client. The Sheriff's Office representative commented on the challenges related to transporting clients in custody to and from the unit. He indicated that clients are shackled and then have to walk through a general programming area. When they arrive at the unit there is no private area to have the shackles removed and they are removed in a public area.

The representative of the Review Board expressed satisfaction with the role of the forensic coordinator, a position created at the Waterford Hospital 7 to 8 years ago, that helps support NL Review Board processes for forensic clients attached to the hospital.

Community partners described generally positive relationships but did express some anxieties about safety on the unit. Specifically, these concerns included the lack of an interview room, inconsistencies on the process for entering the unit and a perception that staff do not supervise or intervene when they are approached by unknown clients.

There was a perception that there is a lack of programming on the unit and that the environment is “impoverished.” While acknowledging the limitations of the physical plant, partners would encourage the inpatient team to consider what “they can do with what they have” and attempt creative solutions. There was also a suggestion from a number of group members that the team needs to focus more comprehensively on the recovery of their clients.

There was an eagerness on the part of participants to engage in ongoing dialogue with the Waterford Hospital forensic leadership, with a focus upon problem solving and system development, and suggested a system focused forensic mental health committee be struck with a broad range of members.

Major Elements to Note:

- There is some degree of dissatisfaction with the fitness reports received at Court.
- There is an opportunity to improve the working relationship and clinical collaboration between the inpatient unit and HMP, and to develop more standardized processes.
- The Sheriff’s representative expressed concern about the safety and dignity of the current mechanism for bringing remand clients on and off the unit.
- Participants described the need to improve therapeutic programming on the unit.
- Community partners experience some anxiety about their safety on the unit and protocol inconsistencies.
- Participants were very interested in the development of ongoing dialogue and consultation.
- There exists an apparent interest in improved collaboration.

6.5 Security

Security Team members present: Director, Manager (2)

External Review Committee member(s) present: Dr. Treena Wilkie and Mr. Remar Mangaoil

It was reported that, prior to approximately two years ago, there was no dedicated security on the forensic inpatient unit and that the unit was supported by site security. The site security would do regular patrols and respond to situations as required. After a series of violent incidents a couple of years ago, dedicated security was placed on the unit. Currently, there are two security staff on each shift throughout the week. The placement of security on the unit was controversial because of the potential impact upon unionized employee job security and an

expressed lack of clarity regarding their role. It was suggested that the reception of security on the unit by existing staff was less than welcoming.

The security personnel are the employees of Paladin Security. This company is contracted by Eastern Health and has a role in a number of Eastern Health sites. The training of these security staff is largely conducted by Paladin. The security staff receive training on “healthcare use of force”, non-violent crisis intervention, and some degree of mental health orientation. Reportedly, they also receive some form of hospital orientation and education around the confidentiality requirements related to working in a healthcare environment. They do not receive the therapeutic crisis intervention training provided to Eastern Health clinical staff. They meet with the clinical manager to review their roles and responsibilities. They work under the direction of clinical staff.

During a standard day, the security personnel will monitor the unit, watching for “situations or objects”. They receive a handover report from the security staff they are replacing. They carry notebooks where they document observations. They will advise clinical staff if they observe a client escalating towards aggression or other problematic behavior. Security will intervene if required and/or if they observe an immediate risk situation. They will talk to clients but will not otherwise interact with them. The participants also reported that security staff will participate in rounds if requested and will accompany housekeeping staff around the unit if requested to do so. When the reviewers were on the unit, security staff were observed sitting in chairs, placed so they could observe lounges and the two client hallways.

The participants in this group felt that the role of security could be expanded to increase the value of their activities to the unit and improve the security and safety of staff and clients. It was suggested that security staff could expand their role by managing the entry and exit of individuals to the unit, monitor the CCTV (currently a clinical function), count sharps, provide increased supervision during mealtimes, maintain accurate security records and logs, and provide security oversight of the compound area. Currently, the security staff do not participate in searches and this could be another function. The participants suggested that there was a need to provide increased rigour to the search procedures and the monitoring of visits. It was also suggested that it would be helpful to know who is on the unit at any given time (e.g., clinical staff, housekeeping, visitors, etc.).

The group felt that there might be union opposition to any increase in the role of security.

The Director commented upon the security challenges of working with the population on the forensic inpatient unit because of the necessity of mixing remand clients, rehabilitation clients, and clients referred from HMP.

The Director commented that given the age of the inpatient unit and the physical plant is difficult to “engineer in safety.” Over the past number of years, the use of CCTV monitoring on the unit

has increased (although the monitors are in the nursing station without staff dedicated to that function).

Major Elements to Note:

- Eastern Health has a very limited role in the training of security personnel.
- The use of security was not necessarily welcomed by unionized clinical staff and this has resulted in tensions on the unit, and potentially an underutilization of security staff.
- The integration of security into the functioning and processes of the unit is limited and it does not appear that they are conceptualized as members of the "team."
- The security management team feels that the security personnel on the unit are underutilized and that there are many additional security responsibilities that they could assume. This would likely make the unit more secure and safer for clients and staff and arguably free up clinical staff to focus more upon their clinical duties.
- The physical plant of the unit limits environmental changes to enhance security

7.0 Review of Practices

7.1 Vision, or More Properly, a Shared Understanding of Roles and Responsibilities

i) The Forensic Service as a Component of the Larger Forensic Mental Health System

The forensic mental health system is a complex one characterized by multiple intersections between the mental health system and the criminal justice system. As a result of these multiple intersecting points, the risk is that the system can become fragmented with negative impacts upon the quality of clinical care, integration of services, and communication. In a fragmented system, the risk is that components work in isolation and focus upon immediate tasks rather than upon contributing to the functioning of the system in a purposeful manner. A number of these risks were described to us as being issues for the forensic unit. The forensic inpatient unit at the Waterford Hospital is a key component of that system with significant resources and expertise. It is felt that the forensic inpatient unit could both improve the clarity and impact of its interventions, and improve system functioning by clearly defining its role within the system and supporting other stakeholders in defining their roles in the system.

ii) Development of a Unit Based Mission Statement

There are a number of situations that have contributed to concerns about the functioning of the forensic inpatient unit. These are described below.

1. During interviews with internal stakeholders, there was no clear consensus on the larger “purpose” of the forensic inpatient unit. While many groups were working hard to improve the functioning of the unit, these groups tended to be working in isolation from each other with limited coordination or collaboration.

2. The personnel attached to the forensic inpatient unit have experienced significant stress over the past number of years. These stresses have included negative clinical events, staff turnover, labour-relation tensions, suspensions and terminations, and a lack of clear unit based processes. It is felt that these factors have contributed to a staff group and unit functioning characterized by poor morale, sub-optimal communication, and limited integration and alignment of the personnel attached to the inpatient unit.

3. The mandate of the forensic inpatient unit at Waterford Hospital is complicated by its need to provide service to three streams of referrals with potentially disparate clinical needs. The three groups of clients include: i) clients from court referred for assessment, ii) rehabilitation clients under the jurisdiction of the NL Review Board, and iii) clients transferred under the Prisons Act. The heterogeneity of these clients presents a challenge to the coordination of clinical services and to an aligned purpose for the unit.

4. The provision of security staff occurred in response to violent incidents but there is a lack of integration of them into the system or model of care. It is not clear to us that the factors that gave rise to the violent incidents have been addressed by the employing of security staff.

One potential strategy for improving alignment of purpose and activity, coordinating improvement efforts, engaging staff, and improving the integration of forensic inpatient unit staff, is the development of a mission statement.

Mission statement are intended to promote alignment of purpose, provide a framework for decision making and provide a sense of meaning and purpose to employees. Mission statements generally consist of an aspirational vision, a statement of goals, a statement of purpose, and identification of an organization’s key values (Braun, Wesche, Frey, Weisweiler, & Peus, 2012). The process of developing the mission statement will help bring staff together and agree on a shared set of values and vision for the unit. It needs to address both therapeutic and security needs of the unit, and move away from the overly custodial client experience that was described to us.

Recommendations:

1. Engage all forensic staff in the development of a mission statement.

2. Ensure that frontline staff have input into the development of mission statement.

3. Use the mission statement development process in an intentional manner as a mechanism to engage and motivate staff, foster a sense of “clinical identity”, and as a strategy for aligning the various initiatives within the forensic service.

4. Obtain input from external and internal stakeholders as well as clients of the service.

5. Post the mission statement in areas visible to staff and clients.

6. Complete regular reviews of the mission statement with all stakeholders.

7.2 Resources

i) Staffing

The level of nursing staff on the unit appears adequate. However, it does appear that nursing staff are overly engaged in task- and custodial- oriented activities. If security guards are to be employed, it is recommended that the use of security guards be effectively integrated into the activities of the unit. As a guiding principle, nursing and clinical staff should be the lead on all client contact related activities to promote safety. If security guards are to be employed, they may take on roles of environmental security, such as checking the physical integrity of the unit, general ward observations, and ward searches. Such activities could include participating in unit searches, conducting security checks and in collaboration with clinical staff, supervising clients using the common spaces, monitoring meals, counting cutlery, accompanying staff on rounds, etc. Nurses could then be utilized in more clinically oriented activity. One such possible activity would be “fitness coaching” of unfit clients. This is apparently conducted by the unit psychologist.

ii) Physical Plant

The physical layout, decoration and ambiance of an inpatient unit all play a role in fostering a safe and therapeutic environment for both clients and staff. The reviewers found consistent concerns from staff and clients related to the physical environment of the forensic unit. Some of these concerns included worn-out furniture in common areas, gloomy atmosphere (e.g., lack of pictures, posters, or lively wall colours), and a lackluster compound (e.g., lack of tables and chairs, no basketball net, unmaintained grass).

While staff voiced appreciation of a number of safety features on the unit (e.g., CCTV monitoring, use of personal alarms and two-way radios), they felt that the use of these devices could be improved. For example, there is no formal delegation of CCTV monitoring. This activity is typically conducted by nurses who are in the nursing station. However, as

one of the nurses described, “most of us are busy doing other things when we’re in here [nursing station]…so we can only watch the monitors when we have some free time”. Also, the use of personal alarms and two-way radios has been inconsistent. For instance, during the reviewers’ tour of the unit and interview with the clients, personal alarms were not provided. Hence, these areas of practice, crucial to enhancing the safety of an inpatient forensic milieu, should be emphasized to all staff and visitors on the forensic unit.

Recommendations:

1. Consider painting or decorating a wall in a common space that signifies a welcoming and therapeutic environment, such as motivating murals or posters inspiring hope and recovery (client involvement should also be considered in this activity).

2. Remove clutter in the hallways leading up to the forensic unit (staff and visitor entrances). There needs to be a culture on the unit where the physical environment and personal spaces (of both staff and clients) are respected. This expectation, a shared common value, should be clearly displayed on the unit through posters or in the welcome package, and imparted to clients who have been recently admitted to the unit.

3. Consider adding stationary tables and benches in the compound. Safety measures should be considered such as placing furniture far from the fence to prevent absconding, and using furniture that will not be easily damaged and/or used as a potential weapon.

4. Identify ‘hot spots’ on the unit where adverse events could potentially occur. Any safety issues on the unit should be part of the discussion during shift handover report and staff meeting. We also recommend that periodic reviews of the unit and its surrounding environment (e.g., compound, entrances, and hallways) should be considered, whereby a dedicated team evaluates the appearance and safety issues of their work environment. It is also worthwhile to involve clients in this discussion/activity to foster an inclusive and collaborative culture within the forensic unit and program.

5. The use of personal alarms and two-way radios on the unit should be reviewed, and a formal guideline (e.g., Safe Work Practice and Procedure) should be in place.

7.3 Staff Skills, Knowledge, and Attitudes

Forensic clients have unique clinical and rehabilitative needs. These needs include management or treatment of acute symptoms, pharmacotherapy, vocational support, relapse prevention (substance abuse), community reintegration, and recidivism reduction, to name but a few.

Through the review, it was learned that there has been a decrease in referrals from the forensic unit for therapeutic programming. The allied health group was unsure as to the reasons why this is the case. Since consultations are triggered by formal referrals initiated by nurses, it would be worthwhile to determine nursing staff's level of understanding (and appreciation) of rehabilitative programming, and their ability to assess the needs of their clients.

The review also found differing opinions about individual and group programming that are available on the forensic unit. There were comments about a recent increase in programming; however some of the staff members were unsure if these programs have actually been implemented on the unit. Most of the programming identified by staff was activity-based (e.g., cooking group, arts and crafts). Although a vital recreational resource, we believe incorporating programming that aims toward risk reduction and specifically focuses upon criminogenic risk factors and developing strengths that are unique to a client should be considered.

Recommendations:

1. Improve screening and referral process for more effective and individualized programming. This might also include a general overview of the available programming on the unit.

2. Utilize rehabilitative programming which aims to reduce recidivism and other risky behaviours, but at the same time recognizes clients' personal strengths and aspirations – balance between risk assessment / mitigation and recovery principles.

3. Compound use should be regarded as a daily activity on the unit, and that a structured process (e.g., risk assessment and documentation, compound search, client search pre- and post-compound use) should be consistently conducted by staff.

4. Forensic Steering Committee to review its scope and deliverables, and to align its purpose to the broader Forensic Program

7.4 Coordination and Leadership

Communication

The extant literature suggests that effective staff communication fosters collaboration and transparency within the care team (O'Daniel & Rosenstein, 2008). Similarly, efforts to provide a safe and therapeutic milieu for patients are often jeopardized by the communication barriers that exist between clinical staff (Leonard, Graham, & Bonucom, 2004).

One key theme that emerged from our stakeholder interviews was the gap in communication amongst the members of the inter-professional team. Although it was very clear that particular individuals and groups are motivated and active in their clinical role, they are currently functioning independently rather than working collaboratively as a team.

Given the wealth of evidence linking ineffective team communication and collaboration with increased clinical practice issues, misinterpretation of clinical and administrative decisions, patient and clinician dissatisfaction, and poor patient health outcomes (O'Daniel & Rosenstein, 2008; Sherwood, Thomas, Bennett, & Lewis, 2002), the necessity of addressing gaps in communication is of the utmost importance.

Recommendations:

1. Creating or maintaining regular opportunities for clinicians from various disciplines to get together as a collective group is an effective strategy for enhancing communication and collaboration. These group interactions can be either formal (e.g. weekly team rounds, Forensic Steering Committee, nursing council) or informal (e.g. unit potluck, individual or team celebrations, team building retreat).

2. Formal meetings should be consistent and organized. The terms of reference should be clearly stated, and the agenda and recording of minutes should also be maintained.

3. Staff debriefing should be continued, but consider expanding the timeframe and content of this activity to facilitate a more meaningful discussion with the team. Other members of the clinical team should also be invited to join this debriefing with the nursing staff.

4. Focused team training or workshops have been shown to be of particular value. Topics could include: fostering an environment of trust and respect, facilitating team communication and collaboration, accountability, conflict management, and shared decision-making.

5. The shift handover report should be conducted face to face by the nurses. This could be done one-to-one (nurse-nurse) or reported as a group (nurse-incoming shift staff). A structured communication tool, such as the SBAR (Situation, Background, Assessment, Recommendation), should also be considered to facilitate a focused and timely handover report.

7.5 Structured Decision Making

Research has consistently shown that structured risk assessments that identify static risk variables are strong predictors of long-term violence risk, and that identification of dynamic

variables, which are associated with short-term violence risk, are key points for intervention in terms of the development of a risk management plan (Douglas, Hart, Webster, & Belfrage, 2013). As noted earlier, structured professional judgment tools are now standard forensic practice internationally (Singh et al., 2014). They provide for consistency of approach and clarity of risk assessment understanding and risk communication. They can identify modifiable clinical risk factors or protective factors that can assist in treatment planning and decision making about leave status or setting levels of security

We found a noted lack of consistency within members of the inter-professional team as to the utility of structured risk assessments. As a result, there appears to be very limited risk-informed monitoring of a clients' mental state, and limited communication between team members regarding the development of a risk management plan. This applies to both short term risk levels (within the unit) and medium to longer term risk levels (relevant to setting rehabilitative and recovery goals). Without a clear strategy for monitoring or communicating risk, the team appears to have difficulty differentiating who needs more or less intervention at any given time, and therefore policies and practice can default into provision of a standard level of increased supervision or monitoring which may not be in alignment with an individual's risk profile. For example, all shaves are supervised for all clients, yet this is likely not necessary for all clients. This non-individualized approach will contribute to the client experience that the unit lacks fairness and is custodial in its orientation.

Health care staff employed on the forensic service (e.g., RNs, LPNs, allied health) are not regularly educated on risk assessment or risk management practices. The inability to recognize or communicate changes in dynamic risk variables can have an impact on the confidence of staff in interacting with, or assessing, clients, and can lead to avoidance or misinterpretation of clinically relevant statements or behaviors.

Recommendations:

1. Staff orientation should contain information and education on risk assessment and risk management.

2. There should be regular opportunities for staff to access educational materials/programs to enhance understanding of risk assessment and risk management.

3. The forensic unit should consider implementing a standardized tool (i.e., DASA) to assist in daily assessment of dynamic risk indicators and to facilitate the use of a common language to discuss client status and appropriate points for management / intervention.

4. All clients should have a risk assessment and management plan which is derived from an understanding of static and dynamic risk using principles of structured professional judgment.

5. All forensic clients under the Review Board should have a completed risk assessment using structured professional judgment tools, and actuarial tools as appropriate.

7.6 Standardization

The structure of a Court or Review Board report, the assessment of risk, and a clients' trajectory through the forensic service including care upon discharge appear to be dependent on factors such as physician assignment or whether they had previously been on the forensic unit.

The importance of a standardized report to the Court and/or Review Board is that this can allow for the establishment and communication of expected categories of information, which will assist in targeting the salient issues. Further, standard methods of communicating information about risk can assist in establishing a common language that spans between the psychiatric system and the criminal justice or Review Board system. Moreover, standardization of client assessments, including the assessment of mental state, risk, psychosocial history and needs, is an important mechanism to facilitate communication between staff members, as well as the development of a coherent plan of care. Expectations of individuals involved in patient care can be measured, in part, in terms of adherence to these standard practices.

Recommendations:

1. There should be standard templates for court reports and Review Board reports which formalize the categories of information that can be expected by the receiving party.

2. External stakeholders may benefit from education about the types of information contained (and not contained) in the reports and the utility of same.

3. Standards of care in terms of frequency and quality of mental status examinations, assessment of risk, communication of information and development of a care plan should be made explicit to individuals involved in client care.

7.7 Review, Research, and Evaluation

Any forensic service must ask questions of itself and evaluate its own success. Tools such as benchmarking or systems of key performance indicators may allow a service to track its own performance against industry set targets.

The implementation of specific recommendations from this review should be organized in a work plan that could be framed as a quality improvement (QI) project. This work plan should include time frames, budget needs, specific activities, and identify key individuals and their roles in the planning, implementation, evaluation, and sustainability of the project. The project team should meet with the forensic leadership team (or members of the Forensic Steering Committee) to provide a report on the progress of the work plan. Pre- and post-implementation data should be collected, and results should be presented to frontline staff as well as the leadership team. The experiences and results from this QI project, including challenges and accomplishments, should also be presented at educational forums at the Waterford Hospital, local or national health care conferences as a poster presentation, or submitted to online journals for publication. We suggest that these activities include point of care staff (nursing and allied health), an advanced practice nurse (who could take a lead on the project), psychiatrist(s), and management to facilitate an ongoing collaboration within the forensic team.

8.0 Review of Policies

8.1 Policy Approaches in Other Jurisdictions

As described in Section 2.1 above, forensic services require a consistent vision and policies to guide staff in the consistent delivery of care. This must include the vision and values of the service which are reflected in the policies. Policies and procedures are essential to guide staff in their care of patients across a care pathway and as the person's risks and needs change. Policies need to structure communication and integration of clinical care from the front line to leadership.

8.2 Observation and Surveillance

This policy is comprehensive and well-organized. It clearly describes the process of initiating and conducting the different levels of surveillance within the Mental Health and Addictions Program. While the overview of this policy declares its commitment to safety through the care and monitoring of clients, we recommend the integration of additional values and procedures that will guide the conception and practice of surveillance. We recommend that throughout the entire process of constant surveillance (i.e., initiating, implementing, discontinuing), staff will be attentive to (or consider) the client's preferences or requests, gender, culture, and trauma history.

We recommend providing staff with safe and practical activities or conversations when conducting constant surveillance. For example, the nurse and the client review or update the care plan together. Despite the challenge of communicating with the clients in seclusion, the ongoing dialogue and supportive presence by staff must be maintained. We also recommend that the handover report given by nurses who are designated to continuous surveillance be

included in this policy. The content of this handover should include the client's physical and mental status, identified risk(s), personal strengths / protective factors, and other needs. The use of SBAR (Situation, Background, Assessment, Recommendation) should be considered to facilitate a more consistent, focused, and efficient handover report.

In the forensic unit, consider two staff conducting routine and close surveillance. Having two staff conduct these rounds instead of just one nurse could add another level of safety on the unit. The literature on constant surveillance shows that despite its intended clinical benefits, it carries unforeseen challenges for nurses who are directly observing highly acute clients. These challenges include burnout or compassion fatigue (Westhead, Cobb, Boath, & Elaenor, 2003), hypervigilance and feeling unsafe (Cleary, Jordan, Horsfall, & Mazoudier, 1999), and other complex reactions due to sustained or prolonged proximity to particular clients (Bowers & Park, 2001; Fletcher, 1999). Thus, we recommend a supportive forum for staff, such as clinical supervision, where such clinical challenges can be processed as a team. Further details about clinical supervision (e.g., frequency, duration, content, facilitator, etc.) are available from the reviewers should Eastern Health choose to implement this particular recommendation.

8.3 Forensic Search Policy

The Forensic Search Policy describes the various contexts under which searches will be conducted and the procedures to do so.

The Policy statement has correctional rather than mental health overtones. It can be helpful to align this policy with therapeutic principles to minimize correctional language where possible. For instance, items are not subject to "search and seizure" rather client belongings are searched, and items not required for the admission or items that place the safety of the unit at risk are placed in storage for safekeeping or disposed of as per policy.

The structure of the policy is somewhat confusing and it is recommended that the admission process be removed and left as a stand alone policy / process. The policy then identifies that clients are subject to search upon return to the unit from pass and where concerns exist that they may have contraband in their possession. The policy indicates that searches of all rooms on the unit occur three times a week on "bed linen changing days." If it is felt that the three times a week frequency is adequate, there may be some benefit to randomizing the searches. The circumstances under which unit searches may be implemented could be simply stated as 'any situation where it is suspected that contraband that compromises the security of the unit is present'.

The Forensic Compound policy indicates that clients returning from the compound are subject to a metal detecting wand process. This should be referenced in this policy.

The “Exception” section on page seven of the policy appears misplaced and it would be helpful to more clearly describe the process by which clients are identified as at risk of self-harm or aggressive behaviour, and the rationale for an increased use of searches.

There is no link to the “forensic lockdown protocol” which is referenced in the policy.
It is recommended that a list with examples of prohibited items be added to the policy as an appendix.

It is also recommended that security staff be integrated into the search processes.

8.4 Administration of Meals and Snacks (Safe Work Practice and Procedure)

This guideline briefly outlines the safety precautions that should be taken by staff members when providing meals and snacks on the forensic unit (particularly in the kitchen and dining room area). We recommend that the use of personal alarms should always be in possession of the two staff assigned to meal supervision, and that one of them should have a two-way radio in hand. This expectation should be included in this guideline.

We also recommend an ongoing attentiveness or vigilance by the two staff assigned to meal supervision. The indirect assessment of clients’ behaviours and their interactions with others in the dining room is a crucial component in maintaining a safe and therapeutic milieu. It also nurtures a culture where the clinical assessment of risks, either directly (subjectively) or indirectly (objectively), is conducted more frequently. Standards around the reporting and/or documentation of identified risks should also be clearly outlined.

Furthermore, we see an opportunity where security guards could be integrated in this process, utilizing them as one of the staff that would assist with supervising meals in the dining room. We are unsure if this is the current practice on the floor, but this was neither revealed in our stakeholder interviews nor during our tour of the forensic unit.

Similar to our previous recommendation, this practice guideline should reference relevant clinical policies, guidelines, training modules, evidence-based literature, and other supportive documents.

8.5 Forensic Patient Telephone

This policy is clear and well written. It describes the protocol for telephone access and use on the forensic service as well as outlines the limitations and prohibitions which may limit said use. Our only recommendation would be to reassess having a maximum time limit to telephone calls outlined in the policy (10 minutes), as this may not be in keeping with flexibility that is necessary in supporting each client’s individual care plan.

8.6 Code White / Physical Restraint / Seclusion

For the purpose of increasing clarity, it may be helpful to split this into two policies: Code White and Physical Restraint / Seclusion.

We would recommend that the language in the overview/policy sections be revised. Rather than highlighting the impaired insight attributable to mental illness and the loss of behavioral control as signifying a psychiatric emergency, we suggest a stipulation that the policy is articulating the response to a psychiatric emergency that is characterized by an individual's escalation or imminent risk of harm to self or others. In our view, the etiology of the behavioral dyscontrol should not be overtly specified in the policy.

We recommend that the language be changed; rather than stating that 'verbally aggressive behavior' shall be managed using least restrictive measures and 'physical aggression' shall be managed using Code White, Physical Restraint and/or Seclusion, it should be stated that Code White and Seclusion/Restraint procedures will utilize the least restrictive measures to ensure the best safety and security of all concerned (regardless of the mechanism of harm). Further, it should state that a Code White will be initiated to summon immediate assistance from clinical and security staff in the event of a psychiatric emergency that is characterized by imminent risk of harm to self or others.

If the policy includes a maximum number of Code Whites per shift that a person will respond to (4), then the process by which another individual will be assigned to Code White duties should be specified instead of stating that this should be assigned "when possible as determined by PCF/NIC".

To avoid confusion, as a Code White Level 1 appears to be akin to a situation that requires extra clinical assistance, rather than an acute or escalating situation, we would recommend a change in the name of this to "Clinical Assist".

This would leave two levels of Code Whites – a Level 1 (currently referred to as Level 2), which is an internal response, and Level 2 (currently referred to as Level 3) which involves an external response (police). The policy indicates that Level 3 Code Whites are not communicated internally to reduce the number of people exposed to the threat. As the staff directly involved in the escalating situation will likely require extra assistance, a Level 3 Code White should also trigger an internal response, although this should not be overheard via an intercom system, but rather through a radio/pager or other internal system so that extra staff can be onsite and assist although may not be directly involved in a physical intervention until police have arrived. Procedures should the situation progress to a hostage taking should also be explicitly documented, or a policy reviewing same should be referenced.

The Seclusion policy states that orders must be reordered by a physician every four hours, if clients are certified. If in seclusion for more than 24 hours, clients need to be reassessed every 24 hours by a psychiatrist. These timeframes should be re-examined. We would suggest a standard timeframe for re-ordering seclusion (i.e. every 8-12 hours) by a physician for the duration of a seclusion event, and a process for external review of seclusion by a second physician if a client is in seclusion for longer than 72 continuous hours.

The policy is clear regarding expectations for documentation and debriefing. Weekly or monthly opportunities for teams to debrief/review seclusion events as a mechanism for increasing knowledge and/or examining unit/team needs may also be a helpful addition to the debrief process.

8.7 Caring for or intervening when client is in seclusion (Safe Work Practice and Procedure)

This guideline is clearly written, and offers practical ways of maintaining the safety of the staff providing care to forensic clients who are in seclusion. There are a few recommendations we would like to make to instill a more recovery-focused and least-restraint approach to this area of practice.

The term “care” in this document does not encompass the significance of a therapeutic relationship between the staff and the client, rather the focus is on specific interventions (or tasks) around supervising meals, escorts to/from seclusion, and medication administration. We recommend starting this guideline with a philosophy and/or definition of the term “care” when a client is in seclusion.

We recommend that there should be an emphasis on assessing the client to be released from seclusion as soon as clinically possible with reference to the seclusion procedures in the Code White policy. The guideline only highlights reporting the status of the client in seclusion for staffing needs, but not around strategies on how the interdisciplinary team can proactively assist the client to be taken out of seclusion (discontinuing the seclusion order).

We also recommend that the term “individualized/special protocols” should be changed to “individualized client/patient care plan”. The former term has a custodial undertone, while the latter term is more client-centered. In addition, this care plan should be co-constructed with the client as much as possible even if the person is in seclusion.

We recommend that this practice guideline should reflect the “Care in Seclusion” section of the Code White policy. For example, the assessment of clients in seclusion every 30 minutes and the importance of communication between the assigned nurse and the nurse monitoring the client are not included in the guideline.

Client communication and debriefing are also absent in this guideline. Utilizing a trauma-informed lens, we recommend that this guideline explicitly states that staff will communicate the reasons for the use of seclusion, ways to avoid or discontinue the event, and debrief with the client after the seclusion event has ended. These conversations not only facilitate a supportive forum for clients during a potentially traumatizing/re-traumatizing event, but the information gathered from these conversations could also be reviewed by the team or organization on a regular basis (e.g. weekly or monthly) to improve the quality of care provided during seclusion, and to minimize the number of seclusion events on this unit and throughout the hospital.

We also recommend that the practice of constant surveillance on clients in seclusion should be included in this guideline. Constant surveillance should be seen as an opportunity for staff (particularly those who are directly observing the client) to engage with the person in seclusion. The policy on Surveillance (and other relevant policies, such as Code White) should also be referenced in this practice guideline.

8.8 Forensic Compound

The Forensic Compound policy describes the use of the fenced in yard designated for use by forensic clients.

It is widely acknowledged that the compound is a significantly under-utilized resource. It is felt that improvement to the utilization of this area requires management commitment, staff prioritization, and a review of the staffing requirements.

In terms the staffing requirements, it is recommended that the unit based security personnel be used to complete grounds/perimeter checks and in collaboration with a clinical staff member be included in the supervisory complement for clients using the compound.

The use of the forensic compound can be conceptualized as a privilege level to be approved in rounds. It is recommended that this be considered as a standard privilege level that is considered regularly and not only initiated upon client request. As in the current policy, nursing staff need to have the authority to suspend the privilege if clinical/security concerns exist. It would be helpful to have any decision to suspend a compound privilege trigger a review by the larger clinical team and manager to develop an intervention plan to promote a quick return to this privilege level.

It is also recommended that a more standardized process for screening access to the compound be developed. This could be part of a larger risk assessment/management process on the unit. It may be that a tool such as the Dynamic Appraisal of Situational Aggression (DASA) would be effective in this regard.

The current policy indicates that allied health staff will supervise clients where clients have been referred or invited to specific programs but not for “all unit” activities. Any new policy should clarify the differences between the two activities and clarify the role of the allied health in regards to client supervision.

9.0 Recommendations

Over the course of the review, and in conversation with staff, stakeholders and clients, we identified a number of specific actions relevant to our terms of reference. Further, there is quite a large literature of clinical practice standards or guidelines relevant to the functioning of a forensic program. This material will be a helpful resource to any program in developing the quality of their service. The detailed recommendations are presented below as section 9.2 and the resource materials as Appendix B.

Our five major recommendations set out in section 9.1 are, in our view, central to addressing the issues in our terms of reference and are the issues of highest priority. Our first recommendation, for instance, provides a vehicle to oversee the other recommendations or working groups that will need to be established to implement the changes we suggest. We were impressed by the talent, energy, and commitment of staff to developing the forensic unit. We hope these recommendations can help direct a program of quality improvement for the forensic unit.

9.1 Major Recommendations

No.	**The External Review Committee:**
1.	**Recommends the resumption of the Forensic Steering Committee.** This committee is central to the oversight and coordination of the forensic program, *Consider:* ➢ Defining its role and deliverables to improve the forensic mental health program. ➢ Developing a work plan to foster integration with forensic and non-forensic services. ➢ First on the work plan is the development of a mission statement and a vision for the forensic program. ➢ Employing a clinical nurse educator or an advanced practice nurse that is dedicated to the forensic unit that could facilitate forensic-specific initiatives. *Refer to: Recommendations in relation to Forensic Service as a Component of the Larger Forensic Mental Health System.*
2.	**Recommends the development of a culture of structured assessments and management of risks, while safeguarding the recovery and dignity of forensic clients.** *Consider:* ➢ Developing a shared risk assessment methodology and consistent approach to risk formulation and care planning.

	➢ Daily use of a structured risk assessment tool by nursing staff (e.g., DASA). ➢ Staff education on the interaction between mental health and criminal justice processes to assess and manage risk(s) at the individual, interpersonal, organizational, and community level. ➢ Staff workshops on the principles of recovery in mental health and forensic settings. *Refer to: Recommendations in relation to Risk Assessment and Standardization*
3.	**Recommends improving team communication through structured processes.** *Consider:* ➢ Scheduled and recurring formal meetings (e.g., staff meetings with the manager, forensic steering committee, management meetings, unit council) where the agenda and recording of minutes are maintained. ➢ Nurse-to-nurse or nurse-to-staff shift handover report where incoming security guards are also present. ➢ Team building activities and focused staff training/workshops on effective communication and conflict resolution. *Refer to: Recommendations in relation to Communication and Surveillance*
4.	**Recommends that opportunities are actively sought to facilitate a shared understanding of interdisciplinary roles and responsibilities.** *Consider:* ➢ Integrating security guards to improve the safety and functioning of the unit. ➢ Role clarification through integrated care pathways, team building activities, and educational workshops. ➢ Regular performance reviews of staff that proactively evaluates current practice, professional development, and areas for improvement. *Refer to: Recommendations in relation to Communication, Surveillance, and Administration of Meals and Snacks*
5.	**Recommends improving the physical environment of the forensic unit and its surrounding area.** *Consider:* ➢ Painting or decorating a wall in a common area of the forensic unit, as well as de-cluttering the hallways (e.g., staff and visitor entrances) leading up to the unit. ➢ Prioritizing the appearance and daily use of the compound. ➢ Conducting periodic reviews of the unit in regards to its appearance and safety

	measures. *Refer to: Recommendations in relation to Physical Plant and Therapeutic Programming*

9.2 Detailed Recommendations

In addition to the overarching recommendations outlined in section 9.1, we have consolidated recommendations found in the body of the report or derived from the key stakeholder interviews and organized them into the key domains of our review.

A. Vision, or More Properly, a Shared Understanding of Roles and Responsibilities

1. Engage all forensic staff in the development of a mission statement.
2. Ensure that frontline staff have input into the development of mission statement.
3. Use the mission statement development process in an intentional manner as a mechanism to engage and motivate staff, foster a sense of "clinical identity", and as a strategy for aligning the various initiatives within the forensic service.
4. Obtain input from external and internal stakeholders as well as clients of the service.
5. Post the mission statement in areas visible to staff and clients.
6. Complete regular reviews of the mission statement with all stakeholders.

B. Resources

Staff Utilization

1. Reintroduce, in a formal manner, the role of security on the forensic unit to all staff. The integration of security into the functioning and processes of the unit is limited and it does not appear that they are conceptualized as members of the "team."
2. Increase the use of security personnel in non-clinical and security related functions on the unit that are currently being performed by clinical staff.
3. Consider two staff conducting routine and close surveillance. Consider utilizing a security guard as the second staff participating in this activity. The use of two staff in this activity would enhance safety on the unit.
4. Eastern Health should increase its role in training the Paladin security personnel on the forensic unit. Such training should include orientation to the forensic mental health system, mental health issues, the Eastern Health model of non-violent crisis intervention, the procedures on the unit, and the role of security on N4B.
5. Increase the use of security mirrors to decrease the number of blind-spots throughout the unit.
6. The compound should be used at least once daily. Use of the compound should be audited and conditions leading to a lack of use investigated and remediated.
7. The compound should be cleaned up and furniture installed (this furniture could be a sufficient distance from the fence to not be used for AWOLs) to promote use of the area.
8. Review the process by which clients in custody are brought on and off the unit with a specific focus upon dignity and safety.

Improving the physical plant:

1. Consider painting or decorating a wall in a common space that signifies a welcoming and therapeutic environment, such as motivating murals or posters inspiring hope and recovery (client involvement should also be considered in this activity).
2. Remove clutter in the hallways leading up to the forensic unit (staff and visitor entrances). There needs to be a culture on the unit where the physical environment and personal spaces (of both staff and clients) are respected. This expectation, a shared common value, should be clearly displayed on the unit through posters or in the welcome package, and imparted to clients who have been recently admitted to the unit.
3. Consider adding stationary tables and benches in the compound. Safety measures should be considered such as placing these far from the fence to prevent absconding, and the type of furniture that will not be easily damaged and used as a potential weapon.
4. Identify 'hot spots' on the unit where adverse events could potentially occur. Any safety issues on the unit should be part of the discussion during shift handover report and staff meeting. We also recommend that Periodic reviews of the unit and its surrounding environment (e.g., compound, entrances and hallways) should be considered, whereby a dedicated team evaluates the appearance and safety issues of their work environment. It is also worthwhile to involve clients in this discussion/activity to foster an inclusive and collaborative culture within the forensic unit and program.
5. The use of personal alarms and two-way radios on the unit should be reviewed, and a formal guideline (e.g., Safe Work Practice and Procedure) should be in place.

C. Staff Skills and knowledge

1. Develop a "clinical supervision" model. This approach, supportive in nature, involves regular, facilitated meetings of frontline staff (including allied health) designed to support staff and improve clinical management of challenging situations.
2. Reintroduce a rigorous staff performance appraisal process.
3. Increase the unit's access to hospital based nurse educators to provide opportunities for clinical skill development.
4. Increase opportunities for staff to enhance their knowledge of the larger forensic mental health system through site visits and presentations.
5. Provide education related to the processes of structured risk assessment and the development of risk management plans.
6. Develop a coordinated treatment planning approach which takes into account the evidence base and targets both forensic and recovery needs.
7. Enhance the understanding of other care providers within the hospital of the role of the forensic unit/service in the pathway of care and the unique needs of forensic clients.
8. Increase awareness of risk assessment and the risk management needs of forensic clients being transitioned to other areas of the hospital or to the care of community service providers.
9. Increase the expectation and capacity of frontline nursing staff to support the Patient Care Facilitator role.

10. Increase face-to-face communication between the frontline staff and management and decrease the reliance on e-mail communication. One of the key goals of this effort would be to increase the transparency of administrative decision making and engaging staff in decision making where appropriate.
11. Provide education and support to increase the recovery orientation of the all staff. Policies and procedures should be reviewed to insert recovery based and clinical language where appropriate.
12. Develop a procedure reference manual so that all key processes are documented and available to staff for reference. This manual could form the basis for the orientation of frontline staff. The role and responsibilities of the security guards should be included in this manual. The manual should also include protocols for ensuring the safety of community service providers and visitors while on the unit.

D. Standardization of Clinical Processes and Report Development

1. There should be standard templates for court reports and Review Board reports which formalize the categories of information that can be expected by the receiving party.
2. External stakeholders may benefit from education about the types of information contained (and not contained) in the reports and the utility of same.
3. Standards of care in terms of frequency and quality of mental status examinations, assessment of risk, communication of information, and development of a care plan should be made explicit to individuals involved in client care
1. Improve screening and referral process for more effective and individualized programming. This might also include a general overview of the available programming on the unit.
2. Utilize rehabilitative programming which aims reduce recidivism and other risky behaviours, but at the same time recognizes clients' personal strengths and aspirations – balance between risk assessment/mitigation and recovery principles.
3. Compound use should be regarded as a daily activity on the unit, and that a structured process (e.g., risk assessment and documentation, compound search, client search pre- and post-compound use) should be consistently conducted by staff.
4. Integration where possible with civil clients.
5. Forensic Steering Committee to review its scope and deliverables, and to align its purpose to the broader Forensic Program.

E. Communication

1. Create and maintain formal, regular opportunities for all staff, physicians, and management to meet to communicate concerns, problem solve, plan, and coordinate activities. There should be both clinical and administrative meetings.
2. Formal meetings should be consistent and organized. The terms of reference should be clearly stated, and the agenda and recording of minutes should also be maintained.

3. Informal opportunities for the team to interact should be intentionally planned to improve morale, cohesiveness, and communication.
4. Staff debriefing should be continued and it may be beneficial, but consider expanding the timeframe and content of this activity to facilitate a more meaningful discussion with the team. Other members of the clinical team should also be invited to join this debriefing with the nursing staff.
5. Focused team training or workshops have been shown to be of particular value. Topics could include: fostering an environment of trust and respect, facilitating team communication and collaboration, accountability, conflict management, and shared decision-making.
6. The shift handover report should be conducted face-to-face by the nurses. This could be done one-to-one (nurse-nurse) or reported as a group (nurse-incoming shift staff). A structured communication tool, such as the SBAR, should also be considered to facilitate a focused and timely handover report.
7. Increase dialogue and collaboration with community partners including HMP and the courts. There is some degree of dissatisfaction with the fitness reports received at court.
8. Work with HMP to develop more standardized clinical communication and transfer processes for clients moving between the two institutions.

F. Improving Risk Assessment, Risk Communication, and Risk Management

1. Staff orientation should contain information and education on risk assessment and risk management.
2. There should be regular opportunities for staff to access educational materials/programs to enhance understanding of risk assessment and risk management.
3. The forensic unit should consider implementing a standardized tool (i.e., DASA) to assist in daily assessment of dynamic risk indicators and to facilitate the use of a common language to discuss client status and appropriate points for management/intervention.
4. All clients should have a risk assessment and management plan which is derived from an understanding of static and dynamic risk using principles of structured professional judgment.
5. All forensic clients under the Review Board should have a completed risk assessment using structured professional judgment tools, and actuarial tools as appropriate.

G. Specific Policy Review Recommendations

Surveillance

1. Change the term used to identify the activity as ‘constant observation’ or ‘continuous engagement’.
2. Develop procedures to support staff throughout the entire process of constant surveillance (i.e., initiating, implementing, discontinuing) in maintaining attention to the client’s preferences or requests, gender, culture, and trauma history.

3. Provide staff with safe and practical activities or conversations when conducting constant surveillance.
4. The handover report given by nurses who are designated to continuous surveillance should be described in this policy. The content of this handover should include: the client's physical and mental status, identified risk(s), personal strengths/protective factors, and other needs.

Forensic Visitor Policy

1. It is recommended that the policy include an expanded purpose statement that clearly identifies the potential therapeutic benefit of visitors to a client's recovery process. This places the various restrictions and procedures in a clinical context that integrates the therapeutic and security functions of the units. The policy defines the processes and procedures related to various visitor groups and defines how ensure that visits are conducted in a manner that respects client rights/needs and maintains the safety of all.
2. It is recommended that the section related to RCMP, RNC, Wardens and Sherriff's officers be placed in a separate policy related to professional visits. If these are conceptualized as "visits" rather than interviews for a policing/correctional purpose, then this separate policy should include other professional visits including lawyers, legal counsel, and community agents.
3. If the MH&A staff referenced are limited to Waterford staff from other areas of the hospital, then these should not be included in a visitor's policy.
4. It is not clear as to whether this policy also relates to the admission process for clients brought to the unit as a result of a court order or under the Prisons Act. If this process is not covered in a separate policy/procedure, it may be beneficial to separate this process from the "visitors" policy.
5. The policy implies that visitors outside the client's immediate family are prohibited from visiting. Again, this may be overly restrictive and inhibit a client's access to pro-social and valuable social supports. It is recommended that a screening process for visitors be developed. The unit social worker(s) that are accountable for psycho-social assessments, gathering collateral information and liaising with community service providers would be well placed to conduct this screening process. Unit procedures could be reviewed at this time. An approved list of visitors could be developed and visits could be booked through the nursing staff.
6. The list of individuals and groups and the potential limitations to visits can be placed later in the policy (rather than at the start).
7. The visiting hours seem somewhat restrictive and if possible, should be expanded. If the physical plant allows for it and the demand for visits warrant it, it may be beneficial to increase the number of visitors permitted.
8. The term "lockdown" with its correctional overtones should be removed from the second paragraph on page 2.

Telephone

1. Reassess having a maximum time limit to telephone calls outlined in the policy (10 minutes), as this may not be in keeping with flexibility that is necessary in supporting each client's individual care plan.

Restraint

1. Divide this policy into two separate policies: Code White and Physical/Restraint Seclusion.
2. Modify the language in the overview/policy sections so that it focuses upon the response to a psychiatric emergency that is characterized by an individual's escalation or imminent risk of harm to self or others and remove the reference to the possible etiology of the behavior.
3. Modify the language that suggests that verbal aggression shall be managed using least restrictive measures and physical aggression shall be managed using Code White, Physical Restraint and/or Seclusion. It is recommended that in the event of any form of aggression, all responses will utilize the least restrictive measures to ensure the best safety and security of all concerned (regardless of the mechanism of harm). Further, it should state that a Code White will be initiated to summon immediate assistance from clinical and security staff in the event of a psychiatric emergency that is characterized by imminent risk of harm to self or others.
4. If the policy includes a maximum number of Code Whites per shift that a person will respond to (4), then the process by which another individual will be assigned to Code White duties should be specified instead of stating that this should be assigned "when possible as determined by PCF/NIC".
5. Restructure the three levels of Code White so that the current Code White Level 1 becomes a "Clinical Assist". The Current Code White Level 2 (internal response) becomes Code White Level 1 and the current Code White Level 3 (external response) becomes Code White Level 2. The procedures for Code White Level 2 should include notification of internal staff via radio/pager to support the staff involved until the arrival of the police.
6. Procedures for a potential hostage taking should be explicitly described or a policy reviewing same should be referenced.
7. Re-examine the time frames for re-ordering seclusion and reassessment by a psychiatrist. It is suggested that a standard timeframe for re-ordering seclusion (i.e., every 8-12 hours) by a physician for the duration of the seclusion event and a process for an external review of seclusion by a second physician if the client is in seclusion for longer than 72 continuous hours.

Caring for or intervening when client is in seclusion (Safe Work Practice and Procedure)

Instill a more recovery focused and least restraint approach to this area of practice by:

1. Starting this guideline with a philosophy and/or definition of care when the client is in seclusion that includes a more expansive acknowledgment of the therapeutic process rather than a focus on specific tasks.
2. Emphasizing the need to assess the client for reintegration into the unit as soon as clinically possible and potential strategies on how the inter-professional team can proactively engage the client to decrease the amount of time required in seclusion.
3. We also recommend that the term “individualized/special protocols” should be changed to “individualized client/patient care plan”. The former term has a custodial undertone, while the latter term is more client-centered. In addition, this care plan should be co-constructed with the client as much as possible even if the person is in seclusion.
4. We recommend that this practice guideline should reflect the Care in Seclusion section of the Code White policy. For example, the assessment of clients in seclusion every 30 minutes and the importance of communication between the assigned nurse and the nurse monitoring the client are not included in the guideline.
5. Client communication and debriefing are also absent in this guideline. Utilizing a trauma-informed lens, we recommend that this guideline explicitly states that staff will communicate the reasons for the use of seclusion, ways to avoid or discontinue the event, and debrief with the client after the seclusion event has ended. These conversations not only facilitate a supportive forum for clients during a potentially traumatizing/re-traumatizing event, but the information gathered from these conversations could also be reviewed by the team or organization on a regular basis (e.g., weekly or monthly) to improve the quality of care provided during seclusion, and to minimize the number of seclusion events on the unit and throughout the hospital.
6. We also recommend that the practice of constant observation on clients in seclusion should be included in this guideline. Constant observation should be seen as an opportunity for staff (particularly those who are directly observing the client) to engage with the person in seclusion. The policy on Surveillance (and other relevant policies, such as Code White) should also be referenced in this practice guideline.

Forensic Search Policy

The Policy statement has correctional rather than mental health overtones. It helps to align policy with therapeutic principles to minimize correctional language where possible. Items are not subject to “search and seizure” rather client belongings are searched and items not required for the admission or items that place the safety of the unit at risk are placed in storage for safekeeping or disposed of as per policy.

1. The structure of the policy is somewhat confusing and it is recommended that the admission process be removed and left as a stand-alone policy/process.
2. The policy indicates that searches of all rooms on the unit occur three times a week on “bed linen changing days.” If it is felt that while the three times a week frequency is adequate there may be some benefit to randomizing the searches.

3. The circumstances under which unit searches may be implemented could be simply stated as ‘any situation where it is suspected that contraband that compromises the security of the unit is present’.
4. The Forensic Compound policy indicates that clients returning from the compound are subject to a metal detecting wand process. This should be referenced in this policy.
5. The “Exception” section on page seven of the policy appears misplaced and it would be helpful to more clearly describe the process by which clients are identified as at risk of self-harm or aggressive behaviour and the rationale for an increased use of searches.
6. There is no link to the “forensic lockdown protocol” which is referenced in the policy.
7. It is recommended that a list with examples of prohibited items be added to the policy as an appendix.
8. It is recommended that security staff be integrated into the search processes. They could be involved in the actual search procedures or in supervising clients while searches are conducted.

Forensic Compound

1. In terms the staffing requirements, it is recommended that the unit based security personnel be used to complete grounds/perimeter checks and in collaboration with a clinical staff member be included in the supervisory complement for clients using the compound.
2. The use of the forensic compound can be conceptualized as a privilege level to be approved in rounds. It is recommended that this be considered as a standard privilege level that is considered regularly and not only initiated upon client request. As in the current policy, nursing staff need to have the authority to suspend the privilege if clinical/security concerns exist. It would be helpful to have any decision to suspend a compound privilege trigger a review by the larger clinical team and manager to develop an intervention plan to promote a quick return to this privilege level.
3. It is also recommended that a more standardized process for screening access to the compound be developed. This could be part of a larger risk assessment/management process on the unit. It may be that a tool such as the DASA would be effective in this regard.
4. The current policy indicates that allied health staff will supervise clients where clients have been referred or invited to specific programs but not for “all unit” activities. Any new policy should clarify the differences between the two activities and clarify the role of the allied health in regards to client supervision.

Appendix A: References

Bowers, L., & Park, A. (2001). Special observation in the care of the psychiatric inpatients: a literature review. *Issues in Mental Health Nursing, 22*, 769-786.

Braun, S., Wesche, J. S., Frey, D., Weisweiler, S., & Peus, C. (2012). Effectiveness of mission statements in organizations–A review. *Journal of Management & Organization*, *18*(04), 430-444. doi: 10.1017/S1833367200000687

Cleary, M., Jordan, R., Horsfall, J., & Mazoudier, P. (1999). Suicidal patients and special observation. *Journal of Psychiatric and Mental Health Nursing, 6*, 461-467.

Collins, M., & Davies, S. (2005). The Security Needs Assessment Profile: a multidimensional approach to measuring security needs. *International Journal of Forensic Mental Health*, *4*(1), 39-52. doi: 10.1080/14999013.2005.10471211

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H (2013). HCR-20v3: Assessing risk for violence: User guide. Burnaby, Canada, Mental Health, Law, and Policy Institute, Simon Fraser University.

Fletcher, R.F. (1999). The process of constant observation: perspectives of staff and suicidal patients. *Journal of Psychiatric and Mental Health Nursing, 6*, 9-14. doi: 10.1046/j.1365-2850.1999.00181.x

Kennedy, H. G., O'Neill, C., Flynn, G., & Gill, P. (2010). The Dundrum Toolkit. Dangerousness, Understanding, Recovery and Urgency Manual (The Dundrum Quartet) V1.0.21 (18/03/10). Four Structured Professional Judgment Instruments for Admission Triage, Urgency, Treatment Completion and Recovery Assessments. Dublin, Ireland, Trinity College Dublin; 2010.

Leonard, M., Graham, S., & Bonucom, D. (2004). The human factor: the critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care Journal*, *13,* 185-190. doi: 10.1136/qshc.2004.010033

Nicholls, T.L., Brink, J., Desmarais, S.L., Webster, C.D., & Martin, M-L. (2006). The Short-Term Assessment of Risk and Treatability (START): A prospective validation study in a forensic sample. Assessment, 13, 313-327. doi: 10.1177/1073191106290559

O'Daniel, M., & Rosenstein, A.H. (2008). Professional communication and team collaboration. In R.G. Hughes (Eds.), *Patient safety and quality: an evidence-based handbook for nurses: vol.2* (pp. 271-284). Rockville, MD: AHRQ Publication.

Sherwood, G., Thomas, E., Bennett, D.S., & Lewis, P.A. (2002). A teamwork model to promote patient safety in critical care. *Critical Care Nursing Clinics of North America*, *14*(4), 333-340.

Singh, J. P., Desmarais, S. L., Hurducas, C., Arbach-Lucioni, K., Condemarin, C., Dean, K., ... & Otto, R. K. (2014). International perspectives on the practical application of violence risk assessment: A global survey of 44 countries. *International Journal of Forensic Mental Health*, *13*(3), 193-206. doi: 10.1080/14999013.2014.922141

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20: Assessing the Risk for Violence* (*Version 2*). Vancouver: Mental Health, Law, and Policy In-stitute, Simon Fraser University.

Westhead, J., Cobb, S., Boath, E., & Elaenor, B. (2003). Feedback on constant observations. *Mental Health Nursing, 23*(1), 4-8.

Appendix B: Best Practice Guidelines and Literature

Below we have provided a list of best practice guidelines and key literature as additional resources to consult in the development of forensic mental health services.

1. Risk Assessment & Risk Management

a. Aggression & Violence

Best Practice Guidelines

Department of Health, National Risk Management Programme. (2007). *Best practice in managing risk*. London: Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

- Guide created for mental health professionals in all mental health settings.
- Provides practice recommendations regarding risk management for suicide and violence.
- Includes risk management tools

NICE. (May 2015). *Violence and aggression: short-term management in mental health, health and community settings (NG10).* London: NICE. Retrieved from https://www.nice.org.uk/guidance/ng10

- Provides evidence-based guidelines on conducting risk assessments, developing risk management plans, the use of restraints, seclusion, observation, and searching.

Literature

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of psychiatric and mental health nursing*, *21*(6), 499-508. doi: 10.1111/jpm.12129

- Safewards is an evidence-based model that provides a framework for reducing conflict and the use of containment in inpatient settings.
- This paper provides a description of the model and the six domains that contribute to conflict: staff team, physical environment, outside hospital, patient community, patient characteristics, and regulatory framework.
- The authors also have a website that explains the model and offers interventions for managing conflict (http://www.safewards.net/).

Hallett, N., Huber, J. W., & Dickens, G. L. (2014). Violence prevention in inpatient psychiatric settings: Systematic review of studies about the perceptions of care staff and patients. *Aggression and Violent Behavior*, *19*(5), 502-514. doi:10.1016/j.avb.2014.07.009

- Systematic review of studies on staff and patient perspectives of inpatient violence
- Patient-related factors (self-regulation, action and communication)
- Staff-related factors (de-escalation, communication, knowledge and experience, limit setting, intervention timing, containment)
- Organizational/Environmental factors (staff mix, staff training, patient mix, organized activity, physical environment, policy and rules)

Hamrin, V., Iennaco, J., & Olsen, D. (2009). A review of ecological factors affecting inpatient psychiatric unit violence: implications for relational and unit cultural improvements. *Issues in mental health nursing*, *30*(4), 214-226. doi: 10.1080/01612840802701083.

- Systematic review of factors related to inpatient violence including: patient-patient, staff factors, staff-patient interactions, and unit culture.
- Staff factors associated with risk of violence include: attitudes, role competence, patient contact, morale, experience with violence interventions, style of patient interactions, communication skills, emotional and psychological factors.
- Staff-Patient interactions associated with increased risk of violence include: medication administration process, assistance with activities of daily living, limit setting, poor therapeutic alliance, and communication issues.
- Unit Factors associated with violence include: physical environment, quantity and quality of staffing, lack of autonomy, forced containment, seclusion and restraint, placing restrictions on patients (e.g., denial of cigarettes), periods of transition, unmet needs of patients.

b. Suicide & Self-Harm

Best Practice Guidelines

Boyce, P., Carter, G., Penrose-Wall, J., Wilhelm, K., & Goldney, R. (2003). Summary Australian and New Zealand clinical practice guideline for the management of adult deliberate self-harm (2003). *Australasian Psychiatry*, *11*(2), 150-155. doi: 10.1046/j.1039-8562.2003.00541.x

- The guideline is written for specialist mental health-care providers in Australia and New Zealand and may also be useful for emergency department clinicians.

- Includes recommendations regarding assessment (risk assessment, psychiatric assessment, psycho-social assessment), acute management, ongoing care, and treatment.

Department of Health, National Risk Management Programme. (2007). *Best practice in managing risk*. London: Department of Health. Retrieved from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

- See description above

Ministry of Health & New Zealand Guidelines Group (2003). *The assessment and management of people at risk of suicide.* Wellington, NZ: Ministry of Health & New Zealand Guidelines Group. Retrieved from http://www.health.govt.nz/publication/assessment-and-management-people-risk-suicide

- This guide is written for clinicians in emergency departments and in acute psychiatric services.
- Provides guidelines for appropriate assessment and early management of individuals at risk of suicide.
- Focuses on individuals who have made a suicide attempt with intent (or partial intent) of ending their lives and those at risk of suicide.

NICE. (November 2011). *Self-harm: longer-term management (NG133).* London: NICE. Retrieved from https://www.nice.org.uk/guidance/cg133

- Guideline focuses on longer-term psychological treatment and management of single or recurring episodes of self-harm.
- Relevant to all individuals aged 8 years and older who engage in self-harming behavior.
- Provides recommendations to all health and social care professionals that are in contact with individuals that self-harm.
- Covers psychosocial assessment, risk assessment, care plans, risk management plans, and interventions for self-harm.

RNAO. (2009). *Assessment and care of adults at risk for suicidal ideation and behaviour*. Toronto, ON: RNAO Retrieved http://rnao.ca/bpg/guidelines

- Provides evidence-based nursing practice recommendations for the assessment and management of adults at risk for suicidal ideation and behaviour.
- Guidelines have been written for registered nurses and registered practical nurses
- Recommendations cover practice, education and organization and policy.

- Does not provide recommendations for individuals that engage in deliberate self-harm.

c. Absconding

Stewart, D., & Bowers, L. (2010). *Absconding from psychiatric hospitals: a literature review. Report from the Conflict and Containment Reduction Research Program.* Retrieved from http://www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/mhn/projects/litreview/LitRevAbsc.pdf

- Literature review of literature on absconding from inpatient units
- Provides a summary of key characteristics of absconders, risk factors for absconding, and interventions to minimize absconding from inpatient units as found in the literature.

2. Guidelines to Security in Forensic Settings

Kennedy, H. G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. Advances in Psychiatric Treatment, 8(6), 433-443. doi: 10.1192/apt.8.6.433

- Offers guidelines for providing security in forensic settings
- Describes three types of security: (i) **Environmental** – physical design elements of a secure unit; ii) **Relational** – staff-to-patient ratios, time spent with clients, and therapeutic rapport (e.g., trust); and iii) **Procedural** – policies and practices for controlling risk and guidelines for

Department of Health, National Health Service (NHS). (2010). *Your guide to relational security See Think Act*. (210. 298100/B 1p Jan 10). Retrieved from www.dh.gov.uk/publications

- Offers a practical guide to relational security.
- Outlines four domains that help staff maintain relational security: whole care team, other patients, outside world, and inside world.
- This easy to follow guide can be used as a tool to educate and train staff on how to maintain safety on forensic inpatient units.

3. Literature on Recovery in Forensic Mental Health Services

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640-645. http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2006.57.5.640

Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia Research, 75*(1), 119– 128. doi: 10.1016/j.schres.2004.05.009

Shepherd, A., Doyle, M., Sanders, C., & Shaw, J. (2015). Personal recovery within forensic settings – Systematic review and meta-synthesis of qualitative methods studies. *Criminal Behaviour and Mental Health,* doi: 10.1002/cbm.1966

Simpson, A. I. F., Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health, 21*(5), 299-306. doi:10.1002/cbm.823.