Legal Series:
Use of Restraints in Ontario Hospitals

Legal Issues related to Restraint Use in Hospital

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Agenda

- Foundation: Key principles governing restraint use
- Legal Framework:
  - Common law
  - Legislation:
- Case law considering Restraint practices
- Risk issues associated with Restraint
- Best practices and documentation
Absent emergency, a competent adult must authorize any contact with his or her body by a health care practitioner; consent for touching is required or the practitioner may face a claim for tort of battery.

Exception: capable, involuntary psychiatric patient who is detained in psychiatric facility pursuant to a Form 1 or a Form 3 or 4 - may be restrained under MHA authority.

In an emergency, restraint may be used where urgently required to prevent serious bodily harm to the person or others, regardless of patient’s status or capacity.

“Others” includes patients, health care providers, hospital staff and visitors.

Emergent restraint does not require consent of patient or SDM.
Foundation: Key Principles

- Restraint is a duty of health care provider when immediate action is necessary to prevent serious bodily harm to the person or to others
  - Duty to provide safe environment and protect patient
  - Once restrained, caregivers have duty to document, monitor and reassess

- Non-emergent situations in both acute care and psychiatric facilities: may restrain in accordance with HCCA, MHA and PRMA

Legal Framework

- *Health Care Consent Act:*
  - Section 7: “This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.”
  - This section “codifies” the common law duty to take action in emergent situations to prevent harm
Legal Framework

- **Mental Health Act:**
  - Section 1: “Restrain” means to place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient.
  - Section 14: Nothing in the MHA authorizes a psychiatric facility to detain or to restrain an informal or voluntary patients.
  - Section 15(5): A Form 1 is authority to detain and restrain the person who is the subject of the Form for not more than 72 hours.
  - Section 20(4): A Form 3 or 4 provides authority to detain and restrain for currency of certificate.

Legal Framework

- **Mental Health Act cont’d**
  - Section 25: MHA authority to restrain a patient applies to forensic patients detained in a psychiatric facility under Part XX.1 of the *Criminal Code*.
  - Section 53: The use of restraint on a patient shall be clearly documented in the patient’s record by the entry of a statement that:
    - The patient was retrained
    - By what means, when and for how long
    - Description of behaviour of patient requiring restraint
    - If chemical restraint used: the chemical employed, the method of administration and dosage
Legal Framework

- **Patient Restraint Minimization Act:**
  - Applies to all public hospitals, even schedule 1 psych facilities
  - **Section 1:** definition essentially same as MHA but without serious bodily harm component;
  - **Section 2(2):** PRA does not apply where MHA is relied on to restrain involuntary patient
  - **Section 3:** Purpose is to minimize the use of restraints on patients and to encourage hospitals and facilities to use alternative methods, whenever possible, when it is necessary to prevent serious bodily harm by a patient to him or herself or to others.

Legal Framework

- **Patient Restraint Minimization Act cont’d:**
  - **Section 5** provides that restraint may be authorized by a plan of care, if certain conditions are met and the plan of care has been consented to by the patient or his/her SDM, if applicable
    - Conditions: necessary to prevent serious bodily harm AND it gives the patient greater freedom or greater enjoyment of life;
  - **Section 6** provides authority to a hospital or facility to restrain or confine a patient where:
    - It is necessary to prevent serious bodily harm to the patient or to another person
  - **No restraint under PRMA if it doesn’t fall within sections 5 or 6 above**
Legal Framework

- Requirements for Restraint under PRMA:
  - Restraint must be ordered by MD, but order may be retroactive
  - Hospitals must have policy re restraints/monitoring devices, which must encourage use of alternative methods when reasonably available
  - Hospitals must monitor restrained patient
  - Staff must receive training on the use of restraints
  - Must document in patient record

Case Law re Restraint practice in Hospital setting

- Where there is a failure to document restraint of psychiatric patient, the Court of Appeal has found that hospital committed tort of battery against the patient and awarded damages against the Hospital
  - Illingworth Estate v. Humber Memorial Hospital, [1999] O.J. No. 4217 (C.A.),

- The actions of a Code White Team may be considered assault where no lawful authority to restrain the patient – in this case a person transferred to another hospital under a Form 1
  - R. v. Webers, 1994 CanLII 7552 (N SC)
Case Law re Restraint practice in Hospital setting

- **R. v. Webers cont’d:**
  - “The team’s action amounted to nothing less than unauthorized treatment in the guise of restraint, and as such it was a violation of [the patient’s] civil rights and a breach of s. 7 of the Charter.”
  - The force used by Code White team was an assault since:
    1. She was unlawfully and arbitrarily detained: no notice of fact of or reasons for detention
    2. She had not consented to the treatment forced on her.

- **Lessons learned from Webers:**
  - Importance of compliance with procedural protections in MHA
  - Restraint only when necessary
  - If necessary, minimal means and reasonable in circumstances

Case Law re Restraint practice in Hospital setting

- In some circumstances, it is lawful to restrain an incapable patient in order to facilitate the administration of treatment:
  - **S.M.T. v. Abouelnasr,** 2008 CanLII 14550 (ON SC)

- In the S.M.T. case, the patient was both involuntarily admitted and incapable with respect to treatment; SDM consent had been obtained for an IM injection of anti-psychotic medication.

- Judge: “It is a necessary implication that a health care professional may have to restrain [an incapable] person in appropriate circumstances in order to administer non-consensual treatment safely.”
Other legal risk issues associated with restraint

- Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint
- ‘Restraint creep’ (i.e., increasing use of restraints following a period of time during which restraint minimization has been emphasized)
- Medical management of restraint required to ensure least restraint and avoidance of serious health consequences, such as stroke or pulmonary emboli,
- Deploy risk management strategies for safe restraint

Best practices and documentation

- Best practice in emergency restraint:
  - Understand and act on different roles and responsibilities of team members
  - Determine who is team leader; if police are involved – determine who leads – Team lead or Police lead?
  - Communicate and document clearly
  - Acknowledge questions but defer to team leadership in emergency
**Best practices and documentation**

- **Best practices in non-emergent restraint**
  - Ensure procedural safeguards are provided: has the patient been advised of their detention / restraint and attendant rights?
  - Has physician authorized restraint as per PRMA, if patient is not detained under authority of MHA?
  - Comply with Hospital’s Least Restraint policy
  - Meet medical and physical needs of patient during restraint episode
  - Reassess need for restraints at least once per shift or as required by Hospital policy

- **Charting specific to Restraint:**
  - Describe means of restraint: what, when and how
  - Chemical restraint: must include the type of medication, method of administration and dosage (MHA, s. 53)
  - Describe behaviour of patient that required use and/or continuation of restraint: why
  - Document time restraint initiated and discontinued and frequency of observation during restraint period:
  - Document effect of restraint on patient
Thank you!

This presentation is meant to provide general information only, and is not intended to replace legal advice. If you require legal advice about a specific issue, please contact your legal counsel or a member of BLG’s Health Law Practice Group.

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