



**Nineteenth Annual Report
Of the
Geriatric and Long Term Care
Review Committee
To the Chief Coroner
For the Province of Ontario**

September 2009

Table of Contents

Introduction	1
Methodology and Case Review Process	2
Recommendations Process	2
Geriatric and Long Term Care Review Committee Activities - 2008	3
2008 Case Review Summary	4
Recommendations	
Medical / Nursing Management	5
Communication and Documentation	7
Use of Drugs in the Elderly	9
Admissions / Discharge/ Transfer Procedures	10
The Acute Care and Long Term Care Industry and the Ministry of Health and Long-Term Care	10
Summary of Recommendations from Cases Reviewed - 2008	14
Case Reviews	
Case 1	16
Case 2	21
Case 3	26
Case 4	30
Case 5	35
Case 6	41

Analysis of Recommendations	46
Summary	48
General Comments	48
Acknowledgements	48

Introduction

Originally formed in December 1989, the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario has just completed its nineteenth full year of operation.

The current Committee membership is:

Dr. Peter Clark	Regional Supervising Coroner, Committee Chair
Ms. Kathy Kerr	Executive Lead
Dr. Sid Feldman	Family Physician
Dr. Margaret Found	Family Physician/Coroner
Dr. Lynne Fulton	Emergency Room Physician
Dr. Barry Goldlist	Geriatrician
Dr. Michael Gordon	Geriatrician
Dr. Jennifer Ingram	Geriatrician
Dr. Heather Gilley	Geriatrician
Ms. Karen Thompson	Registered Dietician
Dr. Barbara Clive	Geriatrician

When necessary, health care professionals from other disciplines, including psychogeriatrics, gastroenterology and infectious diseases, have assisted the Committee with case reviews.

Methodology and Case Review Process

Geriatric and long term care cases are referred to the Committee from a variety of sources including local coroners, Regional Supervising Coroners, and the Office of the Chief Coroner. In previous years, cases were also referred by advocacy groups and long term care institutions.

The Geriatric and Long Term Care Review Committee conducts an independent review of the available records relevant to the specific case and prepares a final report which may include recommendations aimed towards the prevention of future deaths in similar circumstances.

Recommendations Process

The recommendations suggested by the Geriatric and Long Term Care Review Committee are intended to promote discussion and initiate change. The recommendations are not to be interpreted as policy directives from any agency or ministry of government, including the Office of the Chief Coroner. The recommendations focus on preventing future similar deaths by building awareness and recognition of issues affecting the geriatric and long term care communities within Ontario.

Geriatric and Long Term Care Review Committee Activities - 2008

In 2008, the Geriatric and Long Term Care Review Committee reviewed a total of 18 cases which resulted in 46 recommendations. There were 2 cases reviewed that did not result in any recommendations.

Members participated in the following activities:

- Regular monthly meetings
- Regional Coroner's Reviews
- Speaking engagements at educational forums
- Liaison and communication with:
 - Individuals
 - Government ministries
 - Acute and chronic care general and psychiatric hospitals
 - Public health departments
 - Private industry long term care facilities
 - Medical and nursing associations
 - Advocacy groups
 - Ontario and American Coroners and Medical Examiners
 - Chief Coroners from other provinces and territories
 - Long term care associations and institutions throughout Canada
 - The International Association of Coroners and Medical Examiners
 - Various professional gerontological associations

2008 Case Review Summary

In 2008, the Geriatric and Long Term Care Review Committee reviewed a total of 18 coroners' cases that were referred to them involving residents of long term care facilities and the elderly. Upon reviewing the cases, the committee generated a total of 46 recommendations aimed at preventing future similar deaths. These recommendations focused on issues and concerns relating to:

- Medical and Nursing Management
- Communication and Documentation
- Use of Drugs in the Elderly
- Admissions, Discharge and Transfer Procedures
- The Acute Care and Long Term Care Industry in Ontario, including the Ministry of Health and Long -Term Care

Recommendations will be distributed to relevant individuals, facilities, ministries, agencies, special interest groups, health care professionals (and their licensing bodies) and coroners within the province. Recommendations will also be shared with Chief Coroners and Medical Examiners in other Canadian jurisdictions and to any other individuals or groups upon request.

The Geriatric and Long Term Care Review Committee acknowledges that quality long term care does exist in Ontario. The deaths reviewed represent only a small portion of the total number of cases investigated by coroners that involve residents of long term care facilities and the elderly.

Recommendations from 2008 cases

The following recommendations were made after a thorough review of the 18 cases referred to the Geriatric and Long Term Care Review Committee. These recommendations are not to be interpreted as policy directives. Recommendations are intended to promote discussion and initiate change. Recommendations focus on the prevention of future similar deaths.

Medical / Nursing Management

- 1 Health care professionals caring for the elderly demented should be reminded of the importance of customizing interventions according to the needs and capabilities of these residents. For example, while the use of “education” of the resident may be the initial recommended intervention, education may not be effective in an elderly demented resident given their neurological impairment.
- 2 Regulated nursing health care professionals working in the long term care setting should be reminded of their obligation to supervise unregulated staff in the performance of their duties. Similarly, unregulated staff need to be reminded of the limitations of their scope of practice.
- 3 Health care professionals should be reminded that the abnormal behavioural manifestations of dementias may require the use of medications to relieve suffering in terms of improved behaviours, but side effects may develop in terms of gait abnormalities.
- 4 Health care professionals should be reminded that serious fractures can occur in the elderly in the absence of major trauma. The importance of maintaining a high index of suspicion for the presence of a serious injury in the elderly in the absence of major trauma should always be considered.

- 5 Health care professionals should be reminded of the importance of aggressively managing elderly patients with risk factors for the development of osteoporosis.
- 6 Principles of palliative/terminal care must become core and central values if we are to meet the frail elderly population of long term care facilities who should be allowed to age in place and, when deemed appropriate, die in place.
- 7 Health care professionals should be reminded that disease presentation in the elderly may be typical but, not infrequently, is atypical and may vary greatly from patient to patient. The underlying cause(s) of disease presentations may be missed if the investigator does not obtain an appropriate history, conduct a thorough examination, and judiciously utilize available laboratory and imaging resources.

For example, the presence of a progressive microcytic anemia associated with stools positive for occult blood, persistent nausea, vomiting, and abdominal discomfort may be indicative of the presence of underlying gastrointestinal pathology such as a malignancy, peptic ulcer disease, or a diabetic gastroparesis.

- 8 Health care professionals should be reminded that the presence of a progressive microcytic anemia is a symptom not a diagnosis.
- 9 Health care professionals should be reminded of the importance of regularly monitoring the weight of elderly diabetics. A decrease or increase in weight associated with increasing weakness may be indicative of suboptimal blood sugar control for which a comprehensive patient review may be indicated to identify the cause(s) of the suboptimal control and initiate appropriate therapeutic interventions(s).
- 10 Health care professionals should be reminded that recent Type 2 diabetes mellitus outcome trials have demonstrated that tight glycemic control in the elderly offers little or no benefit in the reduction of cardiovascular complications.

- 11 Health care professionals working in the emergency room setting should be reminded of the importance of obtaining all relevant clinical information on elderly patients who present for an emergency assessment. The importance of obtaining specific information, including the events leading up to the transfer and a review of the ambulance transfer record, cannot be overemphasized.
- 12 Health care professionals working in emergency room settings should develop an investigation protocol for elderly patients who present with falls given that the risk for death is increased in those patients as it is for elderly patients who present with chest pain.
- 13 Health care professionals should be reminded that elderly patients who fall and present to the emergency room should have a comprehensive medical assessment, including appropriate laboratory and imaging investigations, to identify both the injury and potential reasons for the falls(s). Documentation of the results of the assessment and investigations on the medical record should be mandatory.
- 14 Health care professionals caring for the elderly should be reminded of the importance of conducting a comprehensive medical assessment when an elderly resident's functional status changes after a fall, especially if there is no apparent injury.

Communication and Documentation

- 15 Health care professionals should be reminded of the importance of adhering to hospital policies and procedures for the performance of medical acts such as the insertion of a nasogastric tube.

For example, health care professionals working in diagnostic imaging units should be reminded of the importance of directly communicating abnormal and especially critical results to the ordering physician and/or the nursing unit in a timely fashion. Of equal importance is the need for the ordering physician to follow up on the results of investigations ordered.

- 16 The hospital should conduct an internal review on the circumstances surrounding this case for the purpose of ensuring the communication of abnormal diagnostic imaging results to the front line health care professionals.
- 17 Health care professionals should be reminded of the importance of good communication amongst ALL members of the health care team including family members in situations where a patient's clinical condition suddenly, unexpectedly, and unexplainably changes, and/or when family members have expressed concerns regarding the patient's clinical course. The importance of documenting the information communicated, and with whom the communication has occurred, cannot be overemphasized.
- 18 Health care professionals should be reminded of the importance of good communication amongst ALL members of the health care team including the patient (if competent), family members, or the substitute decision maker. In particular, the need to ensure that all parties maintain perspective and that plans for regular follow up of the results of a therapeutic trial are made, cannot be overemphasized. This is equally important when there is agreement on plans and, especially, when there is not. Documentation of the entire process on the medical record should be mandatory.
- 19 Health care professionals should be reminded of the importance of ensuring that elderly patients and their families are included in treatment planning and care decisions. Implicit in this recommendation is the need to ensure that communication is bidirectional, frequent and repeated, thorough, and documented in the health care record, especially when the elderly patient's clinical circumstances are changing and especially when they are deteriorating.
- 20 All acute care general hospitals in the Province of Ontario should be reminded of the importance of providing a comprehensive information documentation package when frail elderly patients are transferred to another care facility.
- 21 Health care professionals should be reminded of the importance of directly reporting clinical laboratory and imaging results to the most responsible physician or his/her designate in a timely fashion.

Use of Drugs in the Elderly

- 22 Health care professionals should be reminded that the decision to prescribe antipsychotic medications for demented patients requires careful consideration of the benefits of using these medications and the potential for the development of side effects. Rarely, if ever, are dopaminergic or anticholinergic medications of value in the management of the side effects or antipsychotic medications prescribed for elderly demented patients. Rather, discontinuation of the medications or alternative medication strategies should be pursued.
- 23 All acute and long term care institutions in the Province of Ontario should have a policy and procedure to calculate the appropriate dosing of medications for ill elderly patients with renal impairment. The importance of utilizing a pharmacist in establishing and adjusting the dosages of medications for ill elderly patients cannot be overemphasized.
- 24 The hospital should develop and institute a professional practice policy to identify medications requiring careful clinical monitoring at the time of discharge from the intensive care unit. The importance of direct physician to physician communication as part of this policy cannot be overemphasized.
- 25 Health care professionals should be reminded of the importance of monitoring medications prescribed in the elderly. Even when medications such as analgesics are required in the elderly, toxic side effects may still occur.
- 26 Health care professionals should be reminded that the commonly prescribed oral hypoglycaemic medication Glyburide may cause hypoglycaemia in the elderly even in the presence of frequently high blood sugars.
- 27 Health care professionals should be reminded that the abrupt discontinuation of beta blockers should be done with extreme caution.

Admission, Discharge and Transfer Procedures

- 28 Health care professionals should be reminded that frail elderly patients who are totally functionally dependent and have significant care needs are not appropriate for placement in the private care homes. While awaiting placement in a Ministry of Health and Long-Term Care licensed long term care home, these frail elderly patients should remain in a setting that is as resource intensive as a licensed long term care home.
- 29 All general hospitals in Ontario, and specifically this general hospital, should be reminded of the importance of carefully evaluating the types of frail elderly patients being considered for placement in private care homes (retirement homes). Clinically stable patients with minimal care and supervision needs are usually the most appropriate for programs in private care homes.

The Acute Care and Long Term Care Industry in Ontario - including the Ministry of Health and Long-Term Care

- 30 Programs in private care or retirement homes in the Province of Ontario providing care to frail elderly residents awaiting placement in a licensed long term care home should be held to the same standards for care and services as a licensed long term care home. Implicit in this recommendation is the need to ensure the same regulations and inspections with regular public reporting of findings that exists for licensed long term care homes.
- 31 Private care homes or retirement homes in the Province of Ontario should be subject to regulations, oversight, and regular inspection by a public sector agency in order to ensure that care and safety needs are met. The guiding priority should be the **care and safety needs of the frail elderly**, and not the type of facility in which the placement occurs.
- 32 All long term care homes in Ontario should require health care professionals who operate mechanical lifting devices to transfer or bath elderly residents to undergo initial training, certification and periodic recertification in the operation of these devices.

- 33 All long term care homes in Ontario should review their Policy and Procedure for the use of mechanical lifting devices for bathing and transfers. To maximize resident safety, the presence of two staff persons for transfers should be mandatory.
- 34 Licensed long term care homes in the Province of Ontario are being asked to manage increasing numbers of elderly residents with dementia complicated with behavioural disturbances. Education and skill-building workshops within the existing staffing model are insufficient to assist the staff in meeting the care and safety needs of this resident population. Given the above, the Ministry of Health and Long-Term Care should urgently examine the issue of staff-mix and staff-to-resident ratios for the purpose of ensuring that sufficient, adequate, appropriate, and safe care can be provided to elderly residents in licensed long term care homes.
- 35 Recognizing that the availability of specialized mental health units to urgently assess and treat the elderly with psychogeriatric conditions continues to be a significant issue, the Ministry of Health and Long-Term Care should take steps to ensure that the capacity of these mental health units is sufficient to meet the needs of the citizens of Ontario.
- 36 The Ministry of Health and Long-Term Care, in consultation with provincial long term care associations, should investigate the issue of incidents associated with the use of mechanical lifting devices in the long term care setting. Implicit in this recommendation is the need to identify why these incidents continue to occur when there are less than the recommended and required number of trained staff available to perform the transfers.
- The safety of frail elderly long term care residents who require mechanical lifting devices for transfer should never be compromised by the presence of an insufficient number of staff persons.
- 37 The Ministry of Health and Long-Term Care should take steps to ensure that all licensed long term care homes must have adequate resources to protect aggressive residents from harming other residents and long term care home staff. In addition, elderly residents who exhibit aggressive behaviours need to be protected from retaliation. Implicit in this recommendation is the need to ensure that all licensed long term care homes have an adequate and safe physical environment, and adequate numbers of suitably trained nursing staff.

- 38 Licensed long term care homes in the Province of Ontario should be reminded of the importance of having effective policies to manage elderly demented residents with abnormal behaviours including wandering. The use of electronic monitoring devices is often an effective addition to these policies. In addition, licensed long term care homes would benefit from the presence of secure outdoor spaces.
- 39 The Ministry of Health and Long-Term Care, in consultation with appropriate stakeholders in the long term care industry, should establish standards for medical, nursing, and laboratory services for convalescent care units located in licensed long term care homes in the Province of Ontario.
- 40 The Ministry of Health and Long-Term Care should recognize and ensure that convalescent care facilities are adequately resourced to provide for the care and safety needs of the frail elderly.
- 41 The Ministry of Health and Long-Term Care, in consultation with stakeholders in the long term care industry, including medical and nursing health care professionals, should investigate the feasibility of linking long term care health records to the universal Electronic Patient Record to assist in the management of elderly patients with complex medical conditions.
- 42 The long term care home should take steps to ensure that staff nursing health care professionals are knowledgeable about, and in compliance with, the physician notification requirement of the home's Incident Policy.
- 43 All licensed long term care homes in the Province of Ontario should have ongoing education programs regarding the prevention of falls and the use of restraints to ensure compliance with Bill 85, the Patient Restraints Minimization Act.
- 44 All licensed long term care homes in the Province of Ontario should ensure that mobility aids, such as wheelchairs, are appropriate for the residents using them and the mobility aids are properly maintained.

- 45 The professional, clinical, legal and regulatory framework for palliative/terminal care should be part of inservice programs for all long term care homes and educational materials should be made available for all long term care homes across the province. Until such time as there is a defined resource guide to palliative/terminal care in the Province of Ontario, long term care homes should explore resources already available such as that developed by the NICE network from the University of Toronto. An example of a palliative care medication handbook, developed at Baycrest for its medical trainees and medical staff, is also available for reference purposes.
- 46 Long term care homes must have the resources necessary to achieve the palliative/terminal care needs of their resident population. Those resources should be defined by those who would be responsible for providing them and would include the human resources, as well as the technical and pharmacological resources, to achieve these goals.

Summary of Recommendations from Cases Reviewed - 2008

Issue	Number of Cases where issue relevant *	Number of recommendations
Medical / Nursing Management	7 41%	14 30%
Communication and Documentation	6 33%	7 15%
Use of Drugs in the Elderly	5 28%	6 13%
Admission, Discharge and Transfer Procedures	2 11%	2 4%
Acute Care and Long Term Care Industry, Including the Ministry of Health and Long-Term Care	1 6%	17 38%

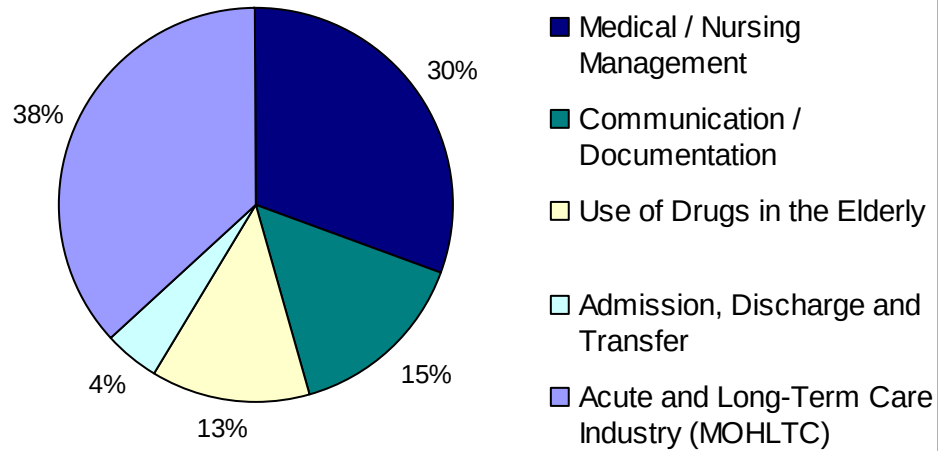
* Some cases may involve several issues. Percentage is based on the number of cases that involved a particular issue in relation to the total number of cases.

Total number of cases reviewed 18

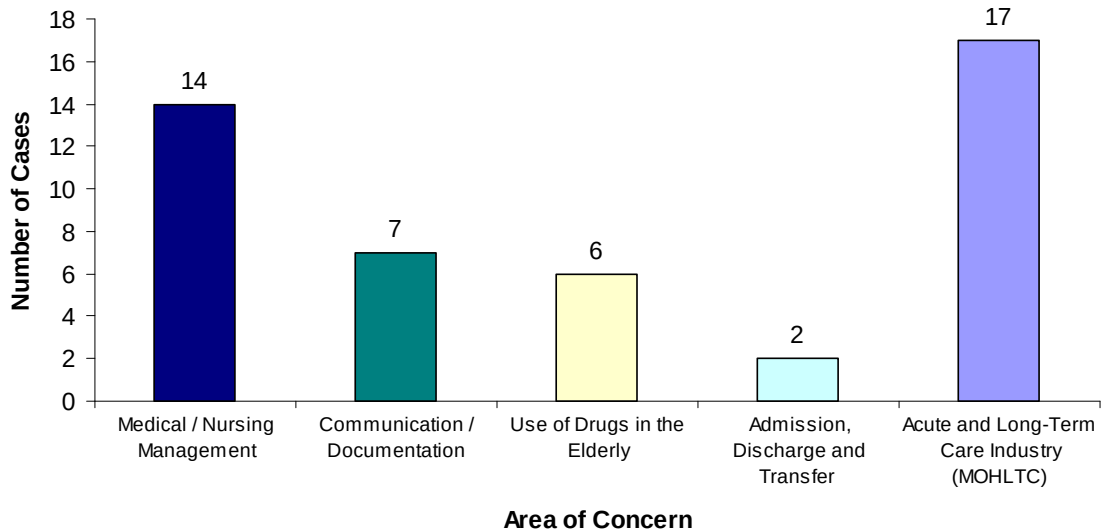
Total number of recommendations made 46

Total number of cases with no
recommendations 2

**Percentage of Recommendations
Based on Area of Concern - 2008**



**Number of Cases
Based on Area of Concern - 2008**



Case Reviews

To help demonstrate the complexity of issues examined by the Geriatric and Long Term Care Review Committee, 6 of the 18 cases reviewed in 2008 will be presented in their entirety. The selected cases demonstrate the comprehensive and thorough review and recommendation process undertaken by the Committee, as well as highlight some of the general themes of concern that are consistent throughout the cases reviewed.

Case 1

Reference: 0802-0379

Issue

The use of a mechanical lifting device.

Background and History

In 2000, this elderly woman was admitted to the long term care home primarily because of advanced dementia. Other medical diagnoses included: transient ischemic attacks, undiagnosed gastrointestinal bleeding, osteoporosis, osteoarthritis, and hypertension.

In April 2007, her updated Care Plan noted the following:

1. Required total assistance with feeding and dressing;
2. Wheelchair dependent and required a seatbelt restraint;
3. Doubly incontinent;
4. Required two staff persons for positioning;
5. Required a mechanical lifting device for transfers and bathing;
6. Had bilateral knee contractures and leg edema;
7. No expressive language;
8. No behavioural issues;
9. Large woman with a BMI of 30.5.

Her Advance Directive included the following:

1. Acute care hospitalization if required,
2. No cardiopulmonary resuscitation (CPR), and
3. No coronary care to be provided in the coronary care unit.

As of April 2007, the woman's regular medications included:

1. Clopidogrel Bisulfate 75 mg od,
2. Diltiazem Hydrochloride SR 90 mg od,
3. Furosemide 40 mg od,
4. Metoprolol Tartrate 50 mg bid,
5. Ramipril 10 mg od, and
6. Sertraline Hydrochloride 50 mg od.

Her "prn" medications included:

1. Acetaminophen 325 mg qid,
2. Bisacodyl suppository 10 mg od,
3. Milk of Magnesia 15-30 ml od,
4. Sodium Phosphates enema,
5. Standardized Sennosides 8.6 mg 1-4 tabs od,
6. Methylcellulose 0.5% 1 drop each eye bid,
7. Miconazole Cream 2% for abdominal rash, and
8. Fluocinonide Cream 0.05% for skin rashes.

Upon review of the woman's long term care records, it would appear that there was good attention given to her needs, including physiotherapy, nutrition and swallowing assessments, continence assessments, pain assessments, skin assessments (including the Braden Scoring Scale), and regular documentation of her medical care. An order for a seatbelt restraint while in the wheelchair was present for positioning because of her contractures. It was noted that there was documentation indicating that alternatives to restraints had been attempted and the use of restraints was reviewed on a regular basis.

The attending physician's periodic health review completed in December 2006 noted the presence of the resident's advanced dementia, pain on movement related to her osteoarthritis and progressive contractures despite regular physiotherapy.

On April 27, 2007, the attending physician examined the woman because of a mild cough and noted that her chest was clear on auscultation.

At 0700 hours on April 28, 2007, the personal support worker (PSW) performing the woman's tub bath requested assistance. The registered practical nurse (RPN) and registered nurse (RN) responded quickly noting that the tub chair was on its side with the woman in the chair on the floor in front of the tub. She was noted to have a 1.5 cm laceration to her right forehead which "appeared deep." Her eyes were open and she appeared scared. No loss of consciousness was documented. Her vital signs were recorded as: Blood Pressure - 197/116, Pulse 58-60 and Respiratory Rate 20-28.

911 was called and the ambulance arrived within seven minutes.

The following details of the event were documented in an Occurrence Report by the investigating police service:

“After her bath was completed, the woman was lifted out of the tub by the attending PSW. The resident was in the bathtub lift chair, with a lap belt on and the sidebars down, with her back to the tub. The attending PSW then wheeled the woman to the end of the tub and wrapped her in towels to begin to dry and stay warm. The tub chair was at a height of two and a half feet according to the PSW, at a height of one metre according to another health care team member. The tub chair was quite close to the edge of the tub. The PSW then turned to rinse the tub with her back to the woman. It was the standard practice of this PSW to raise the tub to rinse it as it emptied more efficiently while raised. She simultaneously held the rinsing hose in her left hand while raising the tub with her right hand. With her back to the resident, she heard the sound of the chair hitting the ground. The attending PSW thought that perhaps the chair had tipped sideways. Prior to the fall, she felt that the woman had appeared comfortable and was “sitting well that day”, nor was she slouching forward. She did not recall any distress or restlessness.

Another PSW, who had just left the tub room seconds before, confirmed that the tub was raised approximately one and a half feet higher than when she had seen it seconds earlier. The second PSW confirmed that the chair had been “close” to the edge of the tub, but denied that it had been touching the edge of the tub.”

In the emergency room, the woman’s vital signs were recorded as: Blood Pressure 143/72, Pulse 73, Respiratory Rate 18, Temperature 36.5° C and Oxygen Saturation 97% on room air.

Laboratory investigations revealed the presence of an elevated white blood cell count of 17.0 with a neutrophilia of 13.7. Cardiac enzymes were not done.

X-rays of the cervical spine revealed the presence of osteopenia and no fracture. There was a transverse fracture of the right distal radius and ulnar metaphysis. The CT scan of her head was reported as follows:

“Moderate to severe cortical and subcortical atrophy. Soft tissue swelling over right frontal bone without underlying fracture. Symmetrical ventricles. No intracranial hemorrhage. Small hypodensity in the left basal ganglia possibly corresponding to a remote infarct. Some hypodensity of the left occipital lobe suggestive of previous ischemic insult as well. Cerebellar atrophy.”

Treatment in the emergency room consisted of suturing the forehead laceration. Tetanus immunization and consultation with an orthopaedic surgeon resulting in the application of a dorsal radial plaster slab following a closed reduction under a hematoma block.

The woman was returned to the long term care home by ambulance at 1240 hours. On arrival, the RN noted that she was cold and clammy. Subsequently, the resident vomited 30 ml of dark brown fluid and was moaning. Nursing staff called the emergency room to inquire if any analgesia had been given and was advised that none had been administered. At 1349 hours, a call was placed to the attending physician. At 1430 hours, the physician ordered the woman to be transferred back to the emergency room. At the time of the transfer her vital signs were: Blood Pressure - undetectable, Pulse - 114, Respiratory Rate 20 and irregular and Oxygen Saturation - 84-91% despite being on Oxygen at 2 L/minute by nasal prongs.

At 1510 hours, the woman arrived in the emergency room and was noted to be unresponsive and moaning slightly. Vital signs were recorded as: Blood Pressure - 52/29, Pulse - 108, Respiratory Rate - 33, and Oxygen Saturation - 96% on maximal Oxygen.

The attending physician discussed and confirmed the “Do Not Resuscitate” (DNR) order with the resident’s family and the decision not to proceed with critical care, consistent with the signed directive from the long term care home dated September 25, 2006. Comfort measures were instituted and death was pronounced at 0715 hours on April 29, 2007.

Post Mortem

A post mortem examination was done and the following findings were noted:

1. Traumatic injuries consistent with a fall including:
 - a) a fractured right wrist,
 - b) facial and extremity contusions,
 - c) a recently sutured laceration,
 - d) a slight retroperitoneal hemorrhage, and
 - e) minimal (2-1 mL.) bilateral temporal fossa subdural hemorrhages.
2. Focal acute bronchitis,
3. Calcified nodules in the lung, liver, and spleen consistent with senescent granulomas,
4. Nonspecific cerebral cortical atrophy, and
5. Cholelithiasis.

The pathologist was of the opinion that the fall-related injuries were not sufficient enough to be considered a direct cause of death as determined by the anatomic findings.

The coroner retained an independent expert to complete an assessment of the bathtub lift system to determine if the equipment met the manufacturer’s specifications and if the

equipment was in good working order. The conclusion was that the lift system was fully operational at the time of the incident.

The manufacturer's Operating and Product Care Instruction Manual was included in the documentation submitted to the Geriatric and Long Term Care Review Committee for review. The manual included the following key comments:

"To avoid the possibility of injury from tipping or other misuse, always ensure that the (lifting device) is lowered immediately after removing the resident from the bath and that footcare is provided with the (lifting device) in a lowered position." "WARNING! Always remove residents from the bath by completely lowering the tub and raising the (lifting device) only to the extent necessary to clear the tub. Make sure the (lifting device) is at least a foot away from the bathtub or other devices. Always lower the (lifting device) promptly after removing the resident from the bath."

The long term care home's Nursing Policy and Procedure for Showering and Bathing dated January 17, 2005 was also reviewed. The document related primarily to residents who would be able to sit independently in a tub. The document did state, "Do not leave the resident unattended while she/he is in the tub."

Discussion

The post mortem examination revealed the presence of traumatic internal and external injuries consistent with the history of the fall. While the examining pathologist did not feel that the injuries were sufficiently severe to directly cause the death, it is felt that in the absence of an alternative hypotheses to explain the death, the fall related injuries did contribute to the death.

Bathing of elderly long term care home residents with significant cognitive and physical impairment is a high risk activity that requires vigilance on the part of health care professionals.

In this specific case, it is likely that the bath chair was left elevated instead of being lowered as recommended in the manufacturer's manual. When the attending PSW turned away from the resident to raise the tub and drain it, the lift chair tipped, resulting in the fall and injuries to the resident.

Mechanical lifting devices are commonly used in long term care homes throughout Ontario. While there are Ministry of Health and Long Term Care and industry requirements for the safe use of these devices, long term care homes must be adequately resourced with trained staff skilled in the operation of these devices.

Recommendations:

1. All long term care homes in Ontario should review their Policy and Procedure for the use of mechanical lifting devices for bathing and transfers. To maximize resident safety, the presence of two staff persons for transfer should be mandatory.
2. All long term care homes in Ontario should require health care professionals who operate mechanical lifting devices to transfer or bath elderly residents to undergo initial training, certification, and periodic recertification in the operation of these devices.

Case Two

Reference 0805-0382

Issue

The provision of palliative care in the long term care setting.

Background and History

This is the case of an 88 year old female resident of a long term care home where she had been a resident for about three months, from the time of admission until her death on January 9th, 2008. Her major underlying medical condition responsible for admission was end/late stage heart failure with the primary cause being coronary heart disease and aortic stenosis.

The patient's clinical decline, with associated mental confusion and clearly documented severe dyspnea, occurred over a period from January 2008 and progressed to the point where it was felt by her family physician and son (who was also a physician), that she was in the process of dying from her heart failure and that palliative/terminal care was desired and should be implemented. The latter choice was based on the clear belief by the son and the family physician that she did not want to be transferred to an acute hospital which she had

experienced in the past and that under the circumstances, she would want to be made as comfortable as possible in the end-of-life terminal period.

The course of events included a change from oral Hydromorphone Hydrochloride, which she had been on for many months previously for her severe dyspnea as well as what appears to be musculoskeletal pain, to parenteral (subcutaneous) Hydromorphone Hydrochloride in gradually increasing doses. It became clear that giving the Hydromorphone Hydrochloride subcutaneously was not the ideal way of administering the drug for the purposes of what in essence was palliative/terminal care. On the evening of January 9, 2008, the family doctor obtained equipment for setting up an IV at the local hospital in which he was a staff member. A local nurse from the hospital volunteered to assist the doctor in setting up the IV equipment as he had not done such a procedure in many years.

The IV was successfully set up and over the following two hours, starting just after 9 p.m., the patient received a number of small doses of Hydromorphone Hydrochloride and Haloperidol in an attempt to control what were clearly symptoms of dyspnea and apparent “terror” as she struggled for breath. The family physician expressed that the patient seemed to be more distressed than any patient he had ever treated previously. The patient showed evidence of Cheyne-Stokes respirations. After approximately two hours of the Hydromorphone Hydrochloride (total of 6 mg in three injections) and Haloperidol (total dose of 5 mg), the patient seemed to become more comfortable. Forty-five minutes later, in a state of comfort, the patient died with the family by her side.

Discussion

With regards to the concerns raised and identified by the long term care home staff, the Geriatric and Long Term Care Review Committee had the following comments:

- 1) The first issue was addressed by the coroner in his explanation of the philosophical and clinical concept of “double effect” by which the desired primary outcome which would be, in this case and in most cases of palliative/terminal care, a reduction of suffering both physical and mental. If as a secondary effect, such as a diminishment of respiratory efforts perhaps leading to death somewhat earlier than if the primary goal were not adequately addressed, the secondary effect is accepted as an event that cannot be avoided and therefore acceptable in order to achieve the primary goal. The main issue legally and ethically is that of “intent” which was the relief of suffering.

Of interest in the practice of palliative care, many practitioners have gone away from even using the concept of “double effect” which has its roots in philosophical and religious disclosure and have focused on the goals of treatment as the driving force of intervention. There are many palliative care physicians who believe that the clinical concept of “double effect” does not occur very often and if the drugs are used in an incremental fashion, the depressed respiration issue becomes almost irrelevant. That being said, the approach to the patient’s comfort care, in clearly a

terminal state of her illness, was the compassionate and clinically appropriate approach.

In extreme cases, palliative care physicians sometimes resort to what is called “palliative sedation” in which the suffering is extreme and control cannot be achieved by the usual cocktails of analgesics and sedatives. In such situations, attempts may be made to induce a state of stupor/sleep in the person in order to relieve the otherwise irremediable suffering while the illness takes its course until death occurs.

There is nothing in the clinical scenario presented and the steps taken by both the power of attorney (the son of the deceased) and the attending physician, to suggest that the health care professionals acted inappropriately in meeting the palliative/terminal care needs of this patient.

- 2) The second issue is whether the hospital nurse who came in from the acute hospital setting to assist the attending physician by putting in an IV acted professionally or not. Again, as documented in the coroner’s statement, all the steps taken by the attending physician and the nurse were clinically appropriate. If the nurse was a registered nurse (which appears to be the case), inserting an IV is within her scope of practice. She also received a physician’s order to do so, which is all that is required professionally. Whether the long term care home had, or should have, a method of providing a registered external health care provider with some sort of ad hoc or temporary privileges in order to undertake such a task, is a minor administrative issue. If the long term care home doctor were also the medical director, presumably they could provide verbal temporary privileges to undertake the task. If the long term care home does not have a mechanism to allow such an undertaking to happen, it should explore steps to allow for it under urgent circumstances which could occur in individual patient circumstances (such as occurred in this case) or when there is a larger event such as a mass emergency when many external health care professionals might have to provide care and services within the home.

The important issues outlined in this case should be communicated to all of those responsible for providing quality long term care, including during the terminal phase of life in long term care homes. Those in the field recognize that many physicians and Directors of Care are uncomfortable with the use of opiates and may experience uneasiness when these drugs are used, especially if the doses required to achieve comfort appear to be high. Many physicians and/or health care providers struggle with the issue of “proper” dose for symptom management when there is a concern of hastening death. This issue has been addressed in the discussion of “double effect”. This is an issue particularly for those who are not well experienced in the principles and practices of palliative and terminal care. The stringent regulations on the use of this class of medications are a reflection of the concern that society and the regulatory professional colleges have on the inappropriate use of such drugs.

Gaining the knowledge of narcotic and other symptom management drug therapy should be an important goal of all physicians and other health care providers who might become involved in end-of-life and palliative care. This is especially the case in the long term care system where we should expect that most residents who develop malignant disease would prefer to die rather than being moved to a specialized palliative care or “hospice” unit. It should become a rare occurrence to transfer long term care residents in need of palliative care to special units or programs.

In addition, physicians need to be aware that regulatory bodies understand that the process of palliative and terminal care requires appropriate use of opiate medications and, at times, very large doses of narcotics might be necessary. Generally, when regulatory bodies are looking to ensure that physicians are fulfilling their ethical, professional, and legal responsibilities, they should consider the grounds and basis by which the narcotic dosage was achieved, rather than the specific dose provided at any given time.

The concept that death may be hastened by the provision of appropriate narcotic palliative pain management has long been accepted as ethically and legally sound. The crux of the argument is the “intent” of the drug provision. Giving a patient with palliative care needs, but not previously exposed to narcotics for pain management, a very large dose that clearly resulted in a rapid demise, would be looked upon with some concern, especially if there was inadequate documentation as to the goals of therapy and the process by which the goals were to be achieved. However, if the basis of the dosing was clearly noted, and the dosage itself incrementally arrived at, with documented results of the preceding doses, the finding would be one of appropriate care.

It is known that many patients in need of end-of-life pain management did not receive such care. Despite much being written on the subject and initiatives taken to rectify the situation, we have not yet reached the point that we can assure our physician population that their patients do not need to suffer. Just as surrogates are required to adequately represent the wishes of the patient; it is the physicians’ ethical and professional responsibility to heed these wishes when they are reasonably expressed, and to have the knowledge to implement the appropriate and agreed upon care. The physicians’ and surrogates’ common goal should be to take the necessary steps to assure that one’s end-of-life experience is relieved of suffering and pain whenever possible so that physicians can feel that they have fulfilled their professional duties, and families their familial and loving obligations.

In summary, there was nothing to suggest that the treatment provided by the primary care physician was unprofessional or clinically unsound. The physician acted in a most compassionate and supportive manner to meet the dire clinical needs for appropriate palliative/terminal care of this patient and also fulfill the request of her power of attorney, who clearly represented her expressed wishes. The issue of an external nurse providing assistance to the attending physician poses at most, a minor administrative issue of how such privileges are approved for external registered health care professionals by the home under routine and emergency situations. The nurse’s role was merely supportive to the physician and all that she did was within her scope of practice, as ordered by the physician.

Recommendations:

1. Principles of palliative/terminal care must become core and central values if we are to meet the frail elderly population of long term care facilities who should be allowed to age in place and, when deemed appropriate, die in place.
2. The professional, clinical, legal and regulatory framework for palliative/terminal care should be part of inservice programs for all long term care homes and educational materials should be made available for all long term care homes across the province. Until such time as there is a defined resource guide to palliative/terminal care in the Province of Ontario, long term care homes should explore resources already available such as that developed by the NICE network from the University of Toronto. An example of a palliative care medication handbook developed at Baycrest for its medical trainees and medical staff is also available for reference purposes.
3. Long term care homes must have the resources necessary to achieve the palliative/terminal care needs of their resident population. Those resources should be defined by those who would be responsible for providing such care and would include the human resources as well as the technical and pharmacological resources, to achieve these goals.

Case 3

Reference 0807-0384

Issue

Emergency room management of the elderly.

Background and History

This is the case of a 78 year old man who lived with a boarder in a two storey home. He lived independently with the assistance of Meals on Wheels and daily visits arranged through the Community Care Access Centre (CCAC). He used a walker and hired individuals to assist him with housework. In May 2007, he was admitted to hospital with pneumonia. The admission assessment noted that he had “little contact with his children.”

The patient’s past medical history included:

1. A cerebrovascular accident;
2. Chronic obstructive pulmonary disease;
3. Diabetes mellitus;
4. Gastroesophageal reflux disease;
5. Prostatism;
6. Coronary artery disease with a myocardial infarction;
7. Congestive heart failure;
8. Anemia, and
9. An appendectomy.

The patient’s medications included:

1. Clopidogrel Bisulfate;
2. Ferrous Gluconate;
3. Acetaminophen with Codeine 30 mg;
4. Furosemide;
5. Finasteride;
6. Metformin Hydrochloride;
7. Metoclopramide Hydrochloride,
8. Oxybutynin,
9. Pantoprazol Sodium,
10. Trazodone Hydrochloride,
11. Terbinafine Hydrochloride, and
12. Mometasone Furoate.

On August 18, 2007 at 0058 hours, the ambulance service received a call to respond to the man's residence where he had fallen. Assessment notes by the ambulance indicated that the man had fallen from a standing height, struck the wooden arm of a chair and was found lying on his side on the living room floor. It was noted that he had not lost consciousness, however this was apparently his third fall in three days. The patient was complaining of right shoulder and right rib pain. Vital signs were noted as: Blood Pressure - 148/98, Pulse - 108 and Respiratory Rate - 12.

The patient was transported to the emergency room and arrived at 0209 hours. The nursing note recorded at 0215 hours indicated that the man had fallen backwards from a standing height while using his walker and struck his head on a rocking chair. He was complaining of pain in his right shoulder, neck, and chest. He had been incontinent of urine and stool at the time of his arrival.

At 0306 hours, the physician assessed the man who stated that he had gotten up, fallen backwards and struck his right shoulder and chest on a chair. The man claimed not to have lost consciousness. The man complained of pain over the right side of his chest with deep breathing, but did not have shortness of breath. On examination, the patient was tender over the right ribs in the anterior axillary line. No laboratory investigations were done. X-ray examination of his chest and right ribs revealed the presence of a fractured ninth rib. Acetaminophen with Codeine 30 mg was given for pain. At 0705 hours, the patient's vital signs were: Blood Pressure - 117/67, Pulse -99 and Respiratory Rate - 16.

The patient was discharged from the emergency room at 1035 hours. The nursing notes stated that he was feeling better after receiving the analgesic. Discharge instructions included taking Acetaminophen with Codeine 30 mg, deep breathing exercises, and direction to return to the emergency room if he developed shortness of breath.

At 1409 hours on the same day, the ambulance service received a call regarding a "collapse" at the patient's residence. The man was apparently being assisted to the washroom when he collapsed on the carpeted floor. Initially he had shallow respirations, but ceased breathing while the 911 call was being made. CPR was in progress when the ambulance crew arrived. At 1428 hours, the EKG monitor showed asystole. The patient was intubated at 1432 hours. Epinephrine and Atropine Sulfate were administered. The endotracheal tube became dislodged and was repositioned at 1447 hours. Following the administration of a 250 cc. bolus of normal saline and three doses each of Epinephrine and Atropine Sulfate, a pulse was obtained. The patient's initial blood pressure was 100/71, but this dropped to 58/30. A Dopamine drip was started.

At 1522 hours, the patient arrived in the emergency room having received 1400 cc. of normal saline. His blood pressure was 40/30. A chest X-ray and laboratory investigations were done and reported as: Hemoglobin -77, Glucose - 17.8, Sodium - 126, BUN - 5.1, Creatinine - 126, Potassium - 4, Chloride -94 and INR - 1.3. A toxicology screen was done as there were concerns that the man wanted to harm himself. Subsequent results for the screen were negative.

The patient's Power of Attorney was contacted and the patient was subsequently disconnected from the ventilator. Death was pronounced at 1636 hours.

It was noted that the man had a urinary tract infection. The chest X-rays were reported by the radiologist on August 20, 2007, two days after the death. Neither X-ray demonstrated the presence of a hemothorax. Nondisplaced fractures of the 8-9-10 right ribs were noted with a small right sided pneumothorax. The latter film showed a small amount of subcutaneous emphysema on the right lateral chest wall

Post Mortem

The post mortem examination revealed the presence of a 400 ml right-sided hemothorax, fractures of the 8-9-10 right ribs, pulmonary congestion, severe triple vessel coronary artery disease, and an old left ventricular myocardial infarction. The pathologist concluded that death was due to acute coronary insufficiency with blood loss from the right sided hemothorax being a contributing factor.

Discussion

The Geriatric and Long Term Care Review Committee continues to see cases involving the emergency room management of the elderly. This case is another example of the complex medical issues faced by emergency room health care professionals when presented with what initially appears to be a simple and isolated medical complaint.

This 78 year old man presented to the emergency room of a general hospital following a fall at home. Of concern was the fact that the ambulance attendants noted that the patient had three falls in three days and this information was not documented in the nursing notes or by the emergency room physician. Frequent falls in the elderly may be indicative of a change in function which should trigger an investigation looking for a cause of the falls. In addition, the onset of frequent falls in an elderly person should result in consideration being given to a home safety assessment to determine if adjustments of the home environment or additional home support services might be required.

It is not surprising that the hemothorax was not identified by the radiologist and the emergency room physician. Approximately 15% of rib fractures are routinely missed on plain X-ray films, especially in the elderly. Undisplaced fractures are more easily missed than fractures which are displaced. In this case, three fractures were identified by the radiologist and only one fracture was seen by the emergency room physician.

Eleven days prior to this event, the man's hemoglobin was 126 g/L. At the time of the post mortem examination, only 400 cc. of blood was detected in the thorax. The hemoglobin of 77 g/L reported after the death was surprising given that one unit of whole blood is equivalent to 450 cc. and the administration of one unit would only raise the hemoglobin by 10 g/L. Given this fact, the loss of a similar amount of blood, as was the case in this man,

should result in a drop in the hemoglobin of 10 g/L. This would mean that the man's hemoglobin, without another source of blood loss, would be expected to be in the range of 116 g/L., not 77 g/L.

If laboratory investigations had been done at the time of the patient's first emergency room visit, the lowered hemoglobin might have been identified and a comprehensive assessment could have been completed. This assessment may have been helpful in identifying the cause of the patient's falls and preventing future falls.

In the absence of the reporting of abnormal laboratory investigations at the time of his first presentation to the emergency room however, admission to the hospital was not indicated.

Recommendations:

1. Health care professionals working in the emergency room setting should be reminded of the importance of obtaining all relevant clinical information on elderly patients who present for an emergency assessment. The importance of obtaining specific information including the events leading up to the transfer and a review of the ambulance record cannot be overemphasized.
2. Health care professionals should be reminded that elderly patients who fall and present to the emergency room should have a comprehensive medical assessment, including appropriate laboratory and imaging investigations, to identify both the injury and potential reasons for the fall(s). Documentation of the results of the assessment and investigations on the medical record should be mandatory.
3. Health care professionals working in emergency room settings should develop an investigation protocol for elderly patients who present with falls given that the risk for death is increased in those patients as it is for elderly patients who present with chest pain.

Case 4

Reference 0812 – 0385

Issue

Management of elderly, demented residents with abnormal behaviours in the long term care setting.

Background and History

This is the case of a 78 year old woman who had resided in a long term care home for six months at the time of her death. Her past medical history included:

1. Cholecystectomy;
2. A fractured coccyx due to a fall in 2002;
3. Osteoporosis;
4. Osteoarthritis;
5. Shingles complicated with post-herpetic neuralgia in 2001, and
6. Dementia diagnosed in 2007 as Alzheimer's with prominent frontal lobe features.

Prior to August 2006, the woman resided in the community with the support of her two nieces. Due to safety concerns for wandering and burning pots and food on the stove, poor nutrition, anemia, and weight loss, she was hospitalized in the general hospital. She was thoroughly investigated, including consultation with a geriatric psychiatrist from the Geriatric Psychiatry Outreach Service from the Regional Geriatric Psychiatry Program. She was diagnosed with:

1. A myelodysplastic syndrome with her hemoglobin ranging from 80 – 100 gm/L, and
2. Alzheimer's disease with anxiety and behavioural manifestations of wandering, agitation, and verbal and physical aggression.

On November 9, 2006, the woman was admitted to the long term care home. Nursing staff noted that she was independently mobile, required the assistance of one staff person for all of her activities of daily living, and was incontinent of bladder and sometimes bowel. Medications included:

1. Acetaminophen prn.;
2. Risendronate Sodium Hemipentahydrate 35 mg weekly;
3. Donepezil Hydrochloride 10 mg od;
4. Ferrous Gluconate 300 mg tid;
5. Omeprazole 20 mg od;
6. Acetyl Salicylic Acid/Caffeine/Butalbital 1 table tid;
7. Risperidone Tartrate 1 mg bid and 0.5 mg at noon;
8. Citalopram Hydrobromide 10 mg od;
9. Folic Acid 5 mg od;

10. Vitamin B12 injection monthly;
11. Trazodone Hydrochloride 12.5 – 25 mg tid prn;
12. Docusate Sodium, and
13. Standardized Sennosides.

Following a comprehensive assessment by the long term care home health care team, the woman commenced recreational programs and activities. During her first two months in the long term care home, her behaviours fluctuated and included:

1. Wandering around the home and entering rooms of other residents;
2. Following staff into other residents' rooms;
3. "Hovering" over staff as they completed their work;
4. Verbal aggression, including shouting in the dining room, and
5. Yelling and spitting at other residents.

The woman was visited by her attending physician and the Geriatric Outreach Psychiatry Service. Her medications were adjusted from time to time.

On January 24, 2007, the woman fell and was found on her back on the floor beside her bed. She sustained a small laceration to her left eyebrow which was steri-stipped. There were no other injuries.

On the evening of January 31, 2007, a personal support worker (PSW) was working on the floor caring for 25-30 residents. The PSW was working alone as her two colleagues were gone on their supper break. There was a registered nurse (RN) on duty, but she was on another unit in the home. The woman and another resident were walking together in the hall and they were both agitated. Both of the residents wanted the other to go with the PSW to a different location. When their disagreement escalated to shouting, the PSW left the resident she was attending and entered the hallway. The PSW deemed that the residents should be separated and called for the assistance of second PSW from another area to escort the women from that end of the hallway. When the PSW went to provide care to a sick resident in another room, she seated the other resident in a chair outside the room. The second PSW returned to her regular unit and the woman returned.

The PSW sat the woman in a chair across from the other resident and asked both women "to give me five minutes." The PSW returned to provide care to another sick resident. The verbal agitation increased between the woman and the other resident and they both left their chairs and came to the door of the room where the PSW was providing care. The PSW observed both of them shouting and pulling each other's arms. The PSW put down what she was carrying to go to the door and assist the residents when she saw the other resident push the woman to the floor. Other long term care home staff were immediately summoned. As the woman was complaining of severe right shoulder, arm, and hip pain, arrangements were made to transfer her to the local general hospital.

At the general hospital, the diagnoses were made of an undisplaced proximal mid-shaft fracture of the right humerus and an intertrochanteric fracture of the right hip. Following discussion with the nieces who were the woman's Powers of Attorney, the woman was

transferred to the regional general hospital where she underwent an open reduction and internal fixation (ORIF) of the fractured hip. The fractured humerus was treated conservatively with immobilization.

On February 5, 2007, the woman was transferred back to the long term care home. Thereafter, her clinical status gradually declined until her death on May 22, 2007 from a presumed pneumonia.

Pain control was initially an issue due to the fractured humerus, but this was appropriately managed by the long term care home health care professionals. The woman initially regained some mobility with the services of physiotherapy and nursing staff, but this was short lived as she gradually became less willing and able to walk. She had a significant decline in her appetite with no medical cause evident. This was managed with a program of dietary intervention, nutritional supplements, and one-to-one staff assistance at meal times. Despite this intervention, the woman lost 10 – 11 kilograms from January 31, 2007 until the time of her death on May 22, 2007.

The other resident involved in this altercation was a 69 year old woman who was admitted to the long term care home with the diagnosis of Alzheimer's disease with prominent psychotic and behavioural features including wandering, visual hallucinations, verbal aggression (e.g. shouting and swearing), and shadowing or hovering over others, including staff. She was seen in consultation by the Regional Geriatric Psychiatry Outreach Team approximately every two weeks. Her medications were often adjusted. The consultant psychiatrist determined that the resident would benefit from admission to the regional teaching mental health hospital for assessment and medication adjustment.

On July 26, 2006, the resident was admitted to the mental health hospital where she remained until November 2, 2006. The discharge date back to the long term care home was predetermined at the time of admission. Upon her return to the long term care home, the woman was on the following medications:

1. Gabapentin;
2. Trazodone Hydrochloride;
3. Olanzapine;
4. Memantine Hydrochloride, and
5. Galantamine Hydrobromide.

At the time of re-admission to the long term care home, the resident was described as being cooperative with care and having no episodes of aggression towards staff and other residents.

Following her return to the long term care home, her behaviour deteriorated as evidenced by the presence of anxiety and a return to her previous behaviour of following or "hovering" over others, though she did this less often. The resident's first episode of aggression was the altercation with the other woman, now deceased.

Discussion

The main issue in this case is the difficulty in managing elderly, demented residents with abnormal behaviours in the long term care home setting when staff cannot watch them closely due to the need to attend to the care needs of other residents.

Over the last 20 years, the resident population in long term care homes has changed dramatically. There has been a significant increase in the proportion of residents with complex, chronic medical conditions as well as the high prevalence of dementia with both psychiatric and behavioural complications.

In 1998, the Report on Direct Nursing Requirements of Extended Care Residents in Ontario (Ministry of Senior Citizens Affairs, March 1988) stated:

“17% of residents require at least 3 hours of care per day, 55% of the residents required less than 90 minutes of care per day; the remaining 28% required between 90 minutes and 3 hours of care per day.”

In contrast, the recent report titled “People Caring for People: Impacting the Quality of Life and Care of Residents of Long Term Care Homes – A Report of the Independent Review of Staffing and Care Standards for Long Term Care Homes in Ontario (St. Elizabeth Health Care Centre for the Ministry of Health and Long-Term Care, May, 2008)” stated:

“(In Ontario Long Term Care Homes) the average number of paid hours of nursing and personal care per resident is 2.85 hours per day, (and) ranges from 1.9 hours to 5.1 hours.”

This statistic clearly reflects increased resident complexity and care needs over the last 20 years.

The Geriatric and Long Term Care Review Committee has reviewed a number of cases where residents of long term care homes with dementia have assaulted other residents resulting in death. The Committee is aware that the Ministry of Health and Long-Term Care has made efforts to increase the skills of long term care home nursing staff in the management of these residents. Programs such as the “Psychogeriatric Resource Consultants” and the “P.I.E.C.E.S. Program” (www.piecescanada.com), are examples of educational programs available for health care professionals working in long term care homes.

Learning favours the prepared mind and the best practices taught in these education programs are often beyond the capacity of staff to retain or change their practice. No amount of education and skill-building with long term care home staff can substitute for having an adequate number of staff available to provide the care and supervision to meet the care and safety needs of all of the residents, all the time.

If there had been adequate staff on duty at the long term care home on the evening of the assault providing increased direct supervision, staff intervention may have prevented the resident altercation which resulted in the subsequent death. If there had been the ability to engage the woman and the other resident in direct supervision and distraction or other activities, the altercation and assault leading to the death may have been prevented.

This case demonstrates that, even when everything is done correctly in terms of medical and expert management of elderly residents with dementia with psychiatric/behavioural complications, the outcome can still be poor. The issues raised in this case are health system related. The other resident was thoroughly and regularly assessed by the attending physician, had regular and frequent reassessments and care plan changes directed by the Regional Psychogeriatric Outreach Team, and was admitted to a specialized mental health hospital for assessment and stabilization of her symptoms and behaviours for three months before the assault. The other resident's behaviours were well controlled in the hospital setting.

However, the staffing levels in the hospital setting are significantly higher than in a long term care home. When the other resident returned to the long term care home, there were less staff available to manage her needs and her abnormal behaviours returned almost immediately. In addition, there appeared to be minimal transfer of care strategies communicated from the hospital staff to the long term care home staff.

Recommendations:

1. Licensed long term care homes in the Province of Ontario are being asked to manage increasing numbers of elderly residents with dementia complicated with behavioural disturbances. Education and skill-building workshops within the existing staffing model are insufficient to assist the staff in meeting the care and safety needs of this resident population. Given the above, the Ministry of Health and Long-Term Care should urgently examine the issue of staff mix and staff to resident ratios for the purpose of ensuring that sufficient, adequate, appropriate, and safe care can be provided to elderly residents in licensed long term care homes.
2. Recognizing that the availability of specialized mental health units to urgently assess and treat the elderly with psychogeriatric conditions continues to be a significant issue, the Ministry of Health and Long-Term Care should take steps to ensure that the capacity of these mental health units is sufficient to meet the needs of the citizens of Ontario.

Case 5

Reference 0813 – 0390

Issue

Provision of care in an alternate level of care (ALC) setting.

Background and History

This is the case of a 92 year old woman who immigrated to Canada at the age of 82 to be near her daughter. In 2005, while living in a retirement home (RH), the woman was diagnosed with dementia for which she attended a day program, twice weekly.

In October 2007, the woman stopped walking after many months of declining mobility. She began to mobilize in a wheelchair. By December 2007, she was exhibiting significant memory impairment and required Community Care Access Centre (CCAC) support for her basic activities of daily living (ADLs). As the woman was now deemed to be incapable of making decisions, her daughter submitted an application for admission to a licensed long term care home (LTCH). She was placed on the waiting list for the long term care homes of her choice.

By June 2008, the woman was receiving 10.5 hours of CCAC personal care weekly in the retirement home.

On June 28, 2008, the woman presented to the emergency room (ER) of the general hospital with a cough, fever, and leg pain. On examination, she had a temperature of 38.5° C, was lethargic and slow to respond, and had a right heel blister with surrounding erythema and induration. Test results showed:

1. Chest X-ray – clear,
2. White blood count – 5.2,
3. Hemoglobin – 106,
4. Blood sugar – 12.5 mmol/L,
5. Electrolytes – normal, and
6. Creatinine – normal at 69 umol/L.

Medications being taken in the retirement home included:

1. Pantoprazole 40 mg bid;
2. L-thyroxine 0.1 mg od;
3. Furosemide 20 mg od;
4. Acetaminophen prn and
5. Loperamide prn.

The woman was admitted to the general hospital with the diagnosis of an infected right heel ulcer and newly diagnosed diabetes mellitus. Her other medical diagnoses included:

1. Dementia;
2. Chronic diarrhea;
3. Osteoarthritis especially in her shoulders and hips;
4. Macular degeneration with visual impairment;
5. Borderline glucose intolerance (not diabetic);
6. Hypothyroidism;
7. Gastroesophageal reflux disease;
8. Chronic anemia of unknown etiology, and
9. Chronic ankle edema.

The woman was started on intravenous (IV) fluids and antibiotics including Ciprofloxacin and Clindamycin. The Furosemide was held. Consultation with a plastic surgeon resulted in the recommendation for a pressure relieving mattress and a right leg boot. Low molecular weight Heparin Sodium was given for venous thromboembolism prophylaxis. An X-ray of the right foot failed to demonstrate the presence of an osteomyelitis.

Over the next few days, the woman's hydration improved and the heel ulcer deroofed revealing a Stage 3 ulcer. A regular wound protocol was maintained. Acetaminophen 325 mg was given to manage her osteoarthritis movement related pain. On July 3, 2008, she was switched to oral antibiotics. Her hyperglycemia was managed with oral hypoglycemics, long acting Insulin at bed time, and short acting Insulin on a prn basis while her other medications were being adjusted. Her capillary blood sugars were closely monitored. Her nutritional status was assessed resulting in the administration of protein supplements, oral Zinc, and Ascorbic Acid.

The woman developed choking and coughing when swallowing. On July 7, 2008, the Speech Language Pathologist assessed the woman and recommended "nectar thick" liquids and sips of water from a cup.

Functionally, the woman remained very heavy care. She required a mechanical lift for transfers and occasionally could be managed by two staff persons using a transfer belt and a pivot disc. She was incontinent of both bladder and bowel. She required maximum assistance with all of her activities of daily living. She was oriented to person and did not have evidence of agitation, delusions, or hallucinations. She complained of pain while being transferred or being repositioned in bed. She developed urinary retention requiring intermittent catheterization 2-3 times daily when her bladder volume exceeded 400 ml. It became quite clear that she would not be able to return to her previous residence due to her heavy care needs. Accordingly, her long term care home application was updated with the CCAC.

On July 15, 2008, the woman was formally designated as awaiting "ALC" (Alternate Level of Care) placement and was transferred to the "ALC Unit" in the general hospital to wait for a bed in a long term care home. In May – June 2008, the general hospital had recently started a pilot program in partnership with a retirement home, which would accept patients awaiting

ALC placement pending final placement in a long term care home. The daughter consented to her mother entering into the program.

A full assessment of the woman using the Home Care Assessment Instrument (HC-RAI) was completed on July 15, 2008 which included calculations of predictive care intensity scores. Highlights of the assessment findings included:

1. ADL performance ratings 4-5, indicating extensive assistance total dependence;
2. Mobile in wheelchair only;
3. Frequently incontinent of bowel and bladder;
4. Cognitively impaired, requiring cueing or supervision at all times for any decisions;
5. Unstable health status;
6. Dysphagia requiring a modified diet;
7. Pressure ulcer R heel;
8. Transfers with 2-person assist using transfer belt and transfer disc or transfers with mechanical lift.

A MAPLe (Method for Assigning Priority Levels) score was calculated from the data which indicated that the woman's resource allocation was "very high."

On July 17, 2008, the woman was transferred to the retirement home. It would appear that the daughter was very uncertain about the transfer and whether the retirement home would be able to meet her mother's care needs. From the day of admission, the daughter kept detailed notes about her observations of her mother, the care provided by retirement home staff, and various details about her mother's care environment. The daughter's documented description of her mother's status on the day of discharge from the general hospital was at variance with the HC-RAI Assessment.

On admission to the retirement home, a care plan was developed which appropriately addressed all of the woman's needs. Unfortunately, because this was a private unregulated care home (retirement home), there was no initial admission assessment completed by a physician. The general hospital attending physician ordered her medications and asked for the CCAC wound care nurse to assess and consult on further wound management of the right heel ulcer. The only other CCAC involvement appeared to be a Speech Language Pathologist assessment requested to be done 3-4 weeks post admission to the retirement home. All other care was provided by the retirement home.

Over the first 11 days in the retirement home, the woman's clinical status appeared to deteriorate. She grew more tired and complained of more pain. She was not ingesting adequate amounts of food or liquids. Retirement home staff often fed her in a semi-reclining position despite the care plan indicating that feeding had to occur when she was in a 90 degree sitting position. The woman was not toileted and was not examined for urinary retention as retirement home staff documented that this was unnecessary due to her diaper being moist. There were multiple conversations noted between the Director of Care and the daughter regarding concerns pertaining to the care of her mother.

The daughter's notes indicated daily concerns about her mother's care, including:

1. Not being dressed early enough;
2. Being fed the wrong food (e.g. hot dog in a bun and melon pieces);
3. Water and facial tissues being out of reach;
4. Inadequate nursing and physician assessments;
5. Poor pain management;
6. Medications being given too forcefully, and
7. Inattention to her mother's deteriorating status.

Retirement home staff often reported to the daughter that they had to do things a certain way, "because they were short-staffed."

On July 28, 2008, the woman was seen briefly by a physician who documented, "heel ulcer dry ~ 1.5 – 2 cm. dia."

Blood work was ordered and the Furosemide was discontinued. Nursing notes for that day indicated that the resident was not eating much, had a poor appetite and was offered drinks.

On July 29, 2008, a similar nursing notation was recorded, although the notation was extensively focused on the daughter's concern about socks being put on her mother's foot directly over the heel ulcer. That evening, the woman was noted to be lethargic and was drinking only small amounts. Her blood pressure was 100/60 and her pulse was 88 beats per minute. The daughter recorded that she requested for her mother to be transferred to the hospital, but this request was not noted in her mother's retirement home health record.

On July 30, 2008, the woman's laboratory results from two days earlier were reported as follows: Sodium - 166 mmol/L (had been 137-144 7 days prior to hospital discharge), Potassium - 5.2 mmol/L, Chloride - 37 mmol/L and Creatinine - 177 mmol/L (had been 79 on hospital discharge).

The woman was urgently transferred by ambulance to the emergency room of the general hospital where the emergency room physician noted that she was very dry, tachypneic, and had a flat jugular venous pressure. Test results indicated: Hemoglobin - 116, Sodium - 166, Chloride - 135, Carbon Dioxide - 14 mmol/L, Blood Urea Nitrogen - 31.8, Creatinine - 271, INR - elevated at 2.7, Urinalysis - laden with white blood cells growing mixed organisms, Urine culture - positive for multi-drug resistant *Pseudomonas* sp., and Chest X-ray - clear with evidence of severe glenohumeral Arthritis.

The woman was admitted to the general hospital and resuscitated with intravenous fluids, Vitamin K, and IV Cefotaxime. Her hydration status was carefully monitored with IV fluids being adjusted accordingly. She continued not to have anything by mouth until her level of awareness improved.

By August 2, 2008, the woman's sodium had dropped to 144, her blood urea nitrogen was 21.4 and creatinine was 237 and beginning to normalize. Subcutaneous Hydromorphone was ordered for pain.

On August 3, 2008, her hemoglobin fell to 90 g/L resulting in the administration of one unit of packed red blood cells.

Over the next few days, the woman gradually began to take small amounts of thickened fluids orally. The intravenous fluids were continued.

On August 7, 2008, test results indicated: Sodium - 137, Blood Urea Nitrogen - 10.3, and Creatinine - 142.

Pain management continued to be a challenge. The woman's drowsiness was thought to be secondary to the narcotic from the Hydromorphone being discontinued and being replaced with Fentanyl 10 – 20 ug subcutaneously prior to repositioning as needed. The antibiotics were discontinued.

By August 14, 2008, the woman was alert enough to take fluids and solids orally resulting in the discontinuation of her intravenous. She was transferred to the general hospital's ALC unit on August 19, 2008 to await placement in a long term care home. Since her admission on July 30, 2008, she had been on bed rest and required total care. She continued to be doubly incontinent. She complained of pain when her legs and feet were touched and with repositioning.

On August 25, 2008, nursing staff noticed the presence of a small coccygeal pressure ulcer. She remained intermittently drowsy, required total care, and had to be encouraged to take even small amounts of fluid.

From this point on, the woman's clinical status slowly deteriorated. In early September 2008, she was seen by the Palliative Care Service and, after discussion with her daughter, the decision was made to provide palliative care. Death was pronounced on September 10, 2008. The daughter requested that the death be reported to a local coroner who commenced an investigation. A post mortem examination was not conducted.

Discussion

This is the case of a 92 year old woman who died in hospital following a long multi-system illness. She was frail and elderly and her death was to be expected, as was noted by her physicians. The woman received appropriate care in the hospital, including thorough assessments and multidisciplinary team care planning.

The central concern in this case was the care provided in the private care home through the pilot "ALC Program." There were essentially two issues to be addressed:

1. Was the care available and provided in the private care home from July 17 – 30, 2008 sufficient to meet the woman's needs?
2. If the care was insufficient, did it contribute to her health?

From the review, the Committee was unable to ascertain what level of service was offered at the private care home. There was no program description, staffing model, or funding model/sources available for review. The woman had very significant care needs even for a Ministry of Health and Long-Term Care funded long term care home, to meet. In fact, one of the long term care homes in the daughter's preferred geographic area rejected the woman's application due to her high care needs. Upon review, it was evident that the private care home did not possess the expertise, care, and services necessary to provide for the woman's significant care needs. Retirement homes have lower staffing ratios than long term care homes and it is hard to imagine how a private retirement home could meet the care needs of a resident like this woman without significant staffing enhancements.

The lack of staff time may have contributed to the woman not receiving sufficient fluids resulting in the development of hypernatremia and dehydration. The review of the circumstances surrounding this woman's death could not determine if this situation contributed to the woman's death or not. It is unlikely that dehydration played a significant role in her ultimate demise which occurred six weeks later. The woman was 92 years of age with multiple major system pathologies and was completely functionally dependent. These are all the markers of near – term mortality. Unfortunately, the woman was going to die within a short time, regardless of the care provided in the private care home.

The circumstances surrounding this woman's death should alert health care professionals that, despite pressures to move the frail elderly out of hospitals to other settings, such as private care homes to await placement in a long term care home, it is important to remember that these elderly clients are awaiting long term care home placement precisely because their care needs are so heavy that they are difficult, if not impossible, to provide in a community, private care setting.

Recommendations:

1. All general hospitals in Ontario, and specifically this general hospital, should be reminded of the importance of carefully evaluating the types of frail elderly patients being considered for placement in private care homes (retirement homes). Clinically stable patients with minimal care and supervision needs are usually the most appropriate for programs in private care homes.

2. Health care professionals should be reminded that frail elderly patients who are totally functionally dependant and have significant care needs are not appropriate for placement in the private care homes. While awaiting placement in a Ministry of Health and Long-Term Care licensed long term care home, these frail elderly patients should remain in a setting that is as resource-intensive as a licensed long term care home.
3. Programs in private care or retirement homes in the Province of Ontario providing care to the frail elderly residents awaiting placement in a licensed long term care home should be held to the same standards for care and services as a licensed long term care home. Implicit in this recommendation is the need to ensure the same regulations and inspections with regular public reporting of findings that exists for licensed long term care homes.
4. Private care homes or retirement homes in the Province of Ontario should be subject to regulations, oversight, and regular inspection by a public sector agency in order to ensure that care and safety needs are met. The guiding priority should be the care and safety needs of the frail elderly and not the type of facility in which the placement occurs.

Case 6

Reference 0818-0395

Issue

The transfer of elderly patients to a convalescent care setting.

Background and History

This is the case of an 84 year old man who lived alone in his own apartment. In early March 2008, he was admitted to the general hospital with increasing shortness of breath and orthopnea. The documentation from the general hospital included:

1. A follow-up chest X-ray report from March 6, 2008 which revealed the presence of residual pulmonary edema;
2. A negative gastroscopy report;
3. A physiotherapy report, and
4. Laboratory results indicating a negative MRSA and blood culture.

On March 14, 2008, a Community Care Access Centre (CCAC) referral for convalescent care was made. His medical diagnoses were listed as: Hematochezia, an anterior non-ST Elevation myocardial infarction, pulmonary edema and leg edema.

As well, his past medical history included coronary artery disease with angina, a colonic polypectomy in December 2007, and peripheral vascular disease with a previous femoral bypass.

The CCAC evaluation identified that the man was taking the following medications:

1. Metoprolol Tartrate 25 mg bid;
2. Digoxin 0.25 mg od;
3. Furosemide 40 mg od;
4. Ferrous Sulfate 300 mg bid;
5. Atorvastatin Calcium 40 mg od;
6. Lansoprazole 30 mg od;
7. Docusate Sodium 1 od;
8. Clotrimazole Cream bid;
9. Spironolactone 25 mg od;
10. Oxazepam 30 mg prn and
11. Ipratropium Bromide/Salbutamol Sulfate puffer prn.

On April 3, 2008, the man was admitted to the convalescent centre located in the long term care home at which time his medication list was:

1. Metoprolol Tartrate 25 mg bid;
2. Digoxin 0.125 mg od;
3. Furosemide 40 mg od;
4. Glyceryl Trinitrate Spray prn and
5. Lisinopril 2.5 mg bid.

On admission, the man was noted to be alert and cooperative with no apparent cognitive concerns. He signed an Advance Directive indicating that he wanted aggressive medical care, but did not want cardiopulmonary resuscitation (CPR).

Upon admission, his blood pressure (BP) was 114/48.

There were two nursing notes recorded on April 3, 2008, which did not identify any concerns. The nursing note recorded on April 5, 2008 documented that the TB skin test was negative.

On April 7, 2008, there was a nutrition note and a nursing note recorded. The nursing note reported a BP of 127/45 and a pulse of 74. The registered nurse was advised and ordered that the Metoprolol Tartrate and Lisinopril be held. A follow-up note indicated that the

physician was in and the Metoprolol Tartrate was discontinued. At this time, the patient's BP was 116/41 and his pulse was 64. These vital signs were not significantly different from his morning vital signs. There was no documentation to suggest the presence of hypotension or bradycardia.

Prior to the discontinuation of the Metoprolol Tartrate on April 7, 2008, the morning vital sign record showed that the patient's pulse was generally in the high 60's. After Metoprolol Tartrate was discontinued, the pulse became more rapid, often being above 100.

The first nursing note after April 7, 2008 was recorded at 0820 hours, just after the vital signs were recorded. The note indicated the patient was complaining of increasing shortness of breath over the last two days and was observed to be visibly short of breath walking to the dining room. On examination, there was a slight decrease in air entry to the right lung and fine crackles in the left lower lobe. In addition, there was no documentation indicating that a physician was informed of the patient's deteriorating clinical status. The next nursing note recorded at 2330 hours was dated April 10, 2008, but was likely April 11, 2008 indicating that the patient was resting quietly in bed.

On April 11, 2008, the morning vital signs revealed a BP of 154/60, a temperature of 36C and a pulse of 104. The patient's BP had been in the 120 systolic range prior to the discontinuation of the Metoprolol Tartrate.

At 0215 hours on April 12, 2008, nursing staff were summoned to the patient's bedside where it was noted that he was in severe distress. Nursing staff documented that he had a productive cough, was wheezing, and had crackles in his chest. His vital signs were: Blood Pressure - 159/75, Pulse - 138, and Oxygen Saturation - 84% (this had been 94-96% up until the morning of April 11, 2008).

The patient asked to be transferred to the hospital. By the time the ambulance arrived, he had suffered a cardiopulmonary arrest and no CPR was performed as per his Advance Directive. The patient subsequently died.

A post mortem was not performed.

It was noted that the blood work, ordered on April 4, 2008, was not drawn until April 10, 2008 - 6 days later - and the results were not available to the health care professionals caring for him. The complete blood count showed a significant macrocytic anemia and the Digoxin level was 2.1. Although the Digoxin level was within the therapeutic range, the level of 2.1 may not have been appropriate for an 84 year old man.¹ In addition, it was noted that electrolytes were ordered, but never done.

Discussion

This is the case of an 84 year old man who was admitted to a regional general hospital in early March 2008 with pulmonary edema and a myocardial infarction. He was assessed by the CCAC on March 14, 2008 for transfer to a convalescent care bed located in a long term

care home where he was admitted on April 3, 2008. The March 14, 2008 CCAC evaluation listed 11 different medications which, for reasons that are unclear, were reduced to 5 medications at the time of admission to convalescent care. In addition, the dosage of Digoxin was reduced from 0.25 mg to 0.125 mg daily. There was a lack of any documentation explaining the rationale for these changes. The reduction of medications, including the reduction of the dosage of Digoxin, may have made the patient's clinical status less stable.

There was a lack of documentation regarding the patient's cardiac rhythm around the time of his transfer.

The issue of transferring frail, elderly patients from acute care hospital beds to convalescent care is a huge systemic issue in the Province of Ontario and is becoming increasingly problematic. The rationale for convalescent care appears to be the need to free up acute care hospital beds. The concept of convalescent care is excellent, but only if the convalescent care beds are appropriately resourced with adequate nursing and medical personnel and oversight. If convalescent care beds are not adequately resourced, the health and safety of frail, elderly patients will be in jeopardy as was the case for this patient.

A number of questions were raised throughout the review of the circumstances surrounding this man's death. These questions include:

1. Why was so little documentation available from the acute care general hospital, especially given that the convalescent care unit was part of the same organization?
2. Why was the beta blocker abruptly discontinued without any documented symptoms or even a significant change in the patient's vital signs?
3. Was the attending physician unaware of the benefits of beta blocker therapy in elderly patients post myocardial infarction with severe congestive heart failure? ²
4. Was the attending physician knowledgeable about the dangers of abrupt beta blocker withdrawal? ³
5. Why did it take six days for blood work to be drawn?
6. Why were electrolytes not drawn as the combination of Digoxin and Furosemide can result in severe toxicity if the potassium level is low?
7. On April 11, 2008, did the nursing health care professionals recognize that progressive shortness of breath required an urgent medical assessment?
8. Did the attending physician ever see and examine the patient? If the patient was seen, why was there no documentation?
9. Did the licensed long term care home and the Ministry of Health and Long-Term Care realize that the care and safety needs of frail, elderly patients are less predictable

in the convalescent care setting as opposed to the licensed long term care home setting? Given that frequent changes in a frail, elderly patient's clinical status can occur during periods of transition, the need for laboratory support and physician availability are increased in the convalescent care setting.

Recommendations:

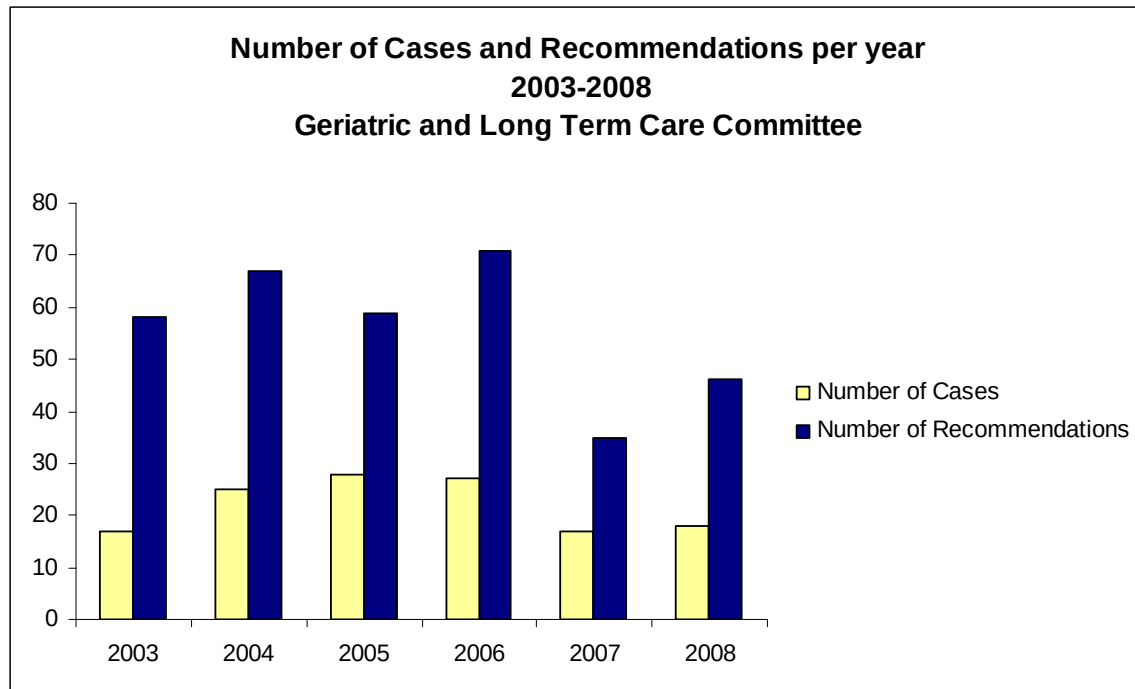
1. All acute care general hospitals in the Province of Ontario should be reminded of the importance of providing a comprehensive information documentation package when frail elderly patients are transferred to another care facility.
2. The Ministry of Health and Long-Term Care, in consultation with appropriate stakeholders in the long term care industry, should establish standards for medical, nursing, and laboratory services for convalescent care units located in licensed long term care homes in the Province of Ontario.
3. Health care professionals should be reminded that the abrupt discontinuation of beta blockers should be done with extreme caution.
4. The Ministry of Health and Long-Term Care should recognize and ensure that convalescent care facilities are adequately resourced to provide for the care and safety needs of the frail elderly.

References

1. van Feldhuisen DJ. Low-dose Digoxin in patients with Heart Failure: less Toxic and at Least as Effective? *Journal of the American College of Cardiology*. 2002; 39 (6): 954-956.
2. The Task Force on Beta-Blockers of the European Society of Cardiology. Expert Consensus Document on B-adrenergic Receptor Blockers. *European Heart Journal*. 2004; 25 (15): 1341-1362.

Analysis of Recommendations: 2003 - 2008

	2003	2004	2005	2006	2007	2008
Total Number of Cases Reviewed	17	25	28	27	17	18
Total Number of Recommendations	58	67	59	71	35	46
# of Cases and Recommendations Based on Area of Concern <i>(Note: Cases may have more than one area of concern identified)</i>						
Medical / Nursing Management						
Number of cases with area of concern:	7	14	12	10	8	7
% of total cases:	41%	56%	43%	37%	47%	41%
Number of recommendations:	14	22	22	30	17	14
% of total recommendations:	24%	33%	37%	42%	48%	30%
Communication / Documentation						
Number of cases with area of concern:	9	9	7	6	4	6
% of total cases:	53%	36%	25%	22%	24%	33%
Number of recommendations:	8	13	9	8	6	7
% of total recommendations:	14%	19%	15%	11%	17%	15%
Use of Drugs in the Elderly						
Number of cases with area of concern:	4	7	5	8	3	5
% of total cases:	24%	28%	18%	30%	18%	28%
Number of recommendations:	8	9	8	14	3	6
% of total recommendations:	14%	13%	14%	20%	9%	13%
Admission, Discharge and Transfer Procedures						
Number of cases with area of concern:	4	3	3	3	1	2
% of total cases:	24%	12%	11%	11%	6%	11%
Number of recommendations:	8	3	4	4	2	2
% of total recommendations:	14%	4%	7%	6%	6%	4%
Determination of Capacity and Consent for Treatment / DNR						
Number of cases with area of concern:	3	2	2	0	0	0
% of total cases:	18%	8%	7%			
Number of recommendations:	3	1	3			
% of total recommendations:	5%	2%	5%			
Use of Restraints						
Number of cases with area of concern:	4	0	0	1	0	0
% of total cases:	24%	n/a	n/a	4%		
Number of recommendations:	6	0	0	4		
% of total recommendations:	10%	n/a	n/a	6%		
Emergency Room Management						
Number of cases with area of concern:	1					
% of total cases:	6%					
Number of recommendations:	6					
% of total recommendations:	10%	n/a	n/a	n/a	n/a	n/a
Acute and Long Term Care Industry, including the Ministry of Health and Long-Term Care						
Number of cases with area of concern:	2	12	7	9	4	1
% of total cases:	12%	48%	25%	33%	24%	6%
Number of recommendations:	4	14	10	10	7	17
% of total recommendations:	7%	21%	17%	14%	20%	38%



Summary

While the “Medical/Nursing Management” and “Communication/Documentation” sections continue to account for the greatest number of recommendations in 2008, there has also been an increase in the number of cases and recommendations directed towards the acute care and long term care industry and the Ministry of Health and Long Term Care. The significance of this increase could not be determined.

Within each of the areas of concern, there are recommendations that tend to be repeatedly made on an annual basis. The presence of repeated recommendations may be indicative of systemic risk to public safety for the elderly citizens of Ontario.

General Comments

The Geriatric and Long Term Care Review Committee is thankful for continuing to have the privilege of serving the Office of the Chief Coroner and the citizens of Ontario over the past year. We trust that these recommendations will be of value in ensuring that elderly residents of acute care and long term care institutions and “care” homes in Ontario receive the best possible care in the future.

Acknowledgements

The Geriatric and Long Term Care Review Committee would like to acknowledge the efforts of Mrs. Cathy Traynor and Ms. Carolyn McLellan for their dedicated and invaluable service in the preparation of the individual reports and the Nineteenth Annual Report.

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