



**Office of the Chief Coroner
Province of Ontario**

Geriatric and Long Term Care Review Committee

2015 Annual Report

October 2016

Table of Contents

MESSAGE FROM THE CHAIR	I
COMMITTEE MEMBERSHIP (2015)	III
EXECUTIVE SUMMARY	IV
CHAPTER ONE: INTRODUCTION	1
CHAPTER TWO: STATISTICAL OVERVIEW: 2004-2015	4
CHAPTER THREE: CASES REVIEWED IN 2015	9
CHAPTER FOUR: LEARNING FROM GLTCRC REVIEWS	13
APPENDIX A: SUMMARY OF 2015 CASES AND RECOMMENDATIONS	14

Message from the Chair



It is my pleasure to present to you the 2015 Annual Report of the Geriatric and Long term Care Review Committee (GLTCRC).

The GLTCRC was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, gerontology, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.

The Office of the Chief Coroner (OCC), through the GLTCRC, has made it a policy to review all homicides involving residents of long term care or retirement homes. The GLTCRC also reviews cases where systemic issues may be present or where significant concerns have been identified by the family, investigating coroner or Regional Supervising Coroner.

Reviews conducted by the GLTCRC include a comprehensive and thorough review of the circumstances surrounding the death and if appropriate, the development of recommendations aimed towards the prevention of future similar deaths. In 2015, the GLTCRC reviewed 35 cases, involving 35 deaths and generated 54 recommendations.

Reviews and recommendations prepared by the GLTCRC are widely distributed to service providers, long term care providers and other relevant agencies and organizations throughout the province. Our role is to provide information to relevant organizations that will subsequently lead to improvements in processes, policies and initiatives, with the goal of preventing future deaths in similar circumstances.

In 2015, we welcomed three new members to the GLTCRC. Cst. Patricia Fleishmann from the Toronto Police Service provided invaluable insight into the issue of elder abuse. Ms. Julie Cavaliere, a registered dietician working within the long term care industry, has replaced Ms. Margaret Leaver-Power to provide the GLTCRC with expertise relating to dietary issues involving the geriatric population. Also joining the GLTCRC in 2015 is Mr. Todd Ruston representing the Retirement Home Regulatory Authority.

Ms. Sheila Driscoll from the Ministry of Health and Long Term Care retired from the Committee in 2015.

I would like to take this opportunity to thank Ms. Tara McCord (A/Executive Lead) and Ms. Kathy Kerr (Executive Lead) for their assistance with the ongoing administration and management of GLTCRC activities and data.

It is an honour to participate in the work of the GLTCRC and I am grateful for the commitment of its members to the people of Ontario.

Readers who wish to obtain the redacted narrative reports can do so by contacting the OCC at <mailto:occ.inquiries@ontario.ca>.

Roger Skinner, MD, CCFP (EM)
Regional Supervising Coroner and
Chair, Geriatric and Long Term Care Review Committee

Committee Membership (2015)

Dr. Roger Skinner

Regional Supervising Coroner, Committee Chair

Ms. Kathy Kerr

Executive Lead

Ms. Elaine Akers

Pharmacist

Ms. Julie Cavaliere

Registered Dietician

Dr. Barbara Clive

Geriatrician

Ms. Sheila Driscoll

Ministry of Health and Long Term Care

Dr. Margaret Found

Family Physician/Coroner

Dr. Sid Feldman

Family Physician

Cst. Patricia Fleischmann

Toronto Police Service

Dr. Heather Gilley

Geriatrician

Dr. Barry Goldlist

Geriatrician

Dr. Mark Lachmann

Geriatric Psychiatrist/Coroner

Ms. Margaret Leaver-Power

Registered Dietician

Mr. Todd Ruston

Retirement Home Regulatory Authority

Ms. Anne Stephens

Clinical Nurse Specialist

Dr. Ramesh Zacharias

Chronic Pain Management/Coroner

Executive Summary

- The Geriatric and Long Term Care Review Committee (GLTCRC) was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, gerontology, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.
- In 2015, the GLTCRC reviewed 35 cases, involving 35 deaths and generated 54 recommendations directed toward the prevention of future deaths. Of the 35 cases reviewed, 10 resulted in no recommendations.
- Of the 35 deaths that were reviewed in 2015, the breakdown for manners of death were:
 - Natural - 10 (seven men and three women)
 - Accident - 14 (four men and 10 women)
 - Homicide* - 9 (three men and six women)
 - Undetermined - 1 (one woman)
 - Suicide - 1 (one man)
- Of the 35 deaths reviewed, 15 were men and 20 were women.
- The average age of men whose deaths were reviewed was 82.1 years.
- The average age of women whose deaths were reviewed was 85.2 years.
- The average age of all deaths reviewed in 2015 was 84.3 years.
- In 2015, the most common areas for improvement identified by GLTCRC through their case reviews consisted of:
 - Medical and nursing management
 - Communication and documentation
 - Acute care and long term care industry in Ontario, including the Ministry of Health and Long Term Care (MOHLTC)
 - Use of drugs in the elderly

***Note:** For the purposes of a coroner's investigation, the finding of "homicide" does not imply a finding of legal responsibility or culpability.

Chapter One: Introduction

The annual GLTCRC report is intended to provoke thought and stimulate discussion about geriatric and long term care deaths in Ontario. It contains statistical information about cases reviewed and the resulting recommendations from those reviews.

Aims and Objectives

The aims and objectives of the GLTCRC are:

1. To assist coroners in the Province of Ontario with the investigation of deaths involving geriatric and elderly individuals and others receiving services within long term care homes;
2. To provide expert review of the circumstances of the care provided to individuals receiving geriatric and/or long term care in Ontario prior to their death;
3. To produce an annual report that is available to doctors, nurses, healthcare providers, social service agencies, and others, for the purposes of death prevention awareness;
4. To review cases forwarded to them and help identify whether there are any systemic issues, trends, risk factors, problems, gaps, or other shortcomings in the circumstances of each case, in order to facilitate the development of appropriate recommendations to prevent future similar deaths; and,
5. To conduct and promote research where results and a comprehensive understanding may lead to recommendations that will prevent future similar deaths.

Note: The above described objectives and committee activities are subject to limitations imposed by the *Coroners Act* of Ontario section 18(2) and the *Freedom of Information and Protection of Privacy Act*.

The OCC has made it a policy to submit all coroner's investigations involving homicides in long term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present.

Structure and Size

The GLTCRC consists of respected practitioners in the fields of geriatrics, gerontology, pharmacology, family medicine, emergency medicine, psychiatry, nursing and services to seniors. This Committee

membership reflects practical geographical balance and representation from various levels of institutions providing geriatric and long term care.

The Chair of the GLTCRC can either be a Regional Supervising Coroner or Deputy Chief Coroner. Committee support is provided by the Executive Lead, Committee Management, OCC.

Other individuals with specific expertise may be invited to committee meetings as necessary on a case-by-case basis (e.g., investigating coroners, Regional Supervising Coroners, police officers, other specialty practitioners relevant to the facts of the case, etc.).

Membership is reviewed regularly by the Committee Chair and by the Chief Coroner as requested. In 2015, the GLTCRC welcomed new members representing the policing and retirement home sectors.

Methodology

Cases are referred to the GLTCRC by a Regional Supervising Coroner when expert or specialized knowledge is needed to further the coroner's investigation, and/or when there are significant concerns or issues identified by the family, investigating coroner, Regional Supervising Coroner, or other relevant stakeholders. All homicides that occur within a long term care setting are referred to the Committee for review.

A minimum of at least one member of the Committee reviews the information submitted by the Regional Supervising Coroner, and then presents the case to the other Committee members. Following Committee discussion, a final case report is produced that includes a summary of the events, the Committee's collective findings and recommendations intended to prevent deaths in similar circumstances. The report is sent by the Chairperson to the referring Regional Supervising Coroner, who may conduct further death investigation if necessary.

When a case presents a potential or real conflict of interest for a Committee member, a temporary substitute member may be asked to participate in the review. Alternatively, the Committee may review the case in the absence of the member with the conflict of interest.

When a case requires expertise from another discipline, an external expert may be asked to review the case, attend the meeting, and/or participate in the discussion and drafting of recommendations if necessary.

Limitations

The GLTCRC is advisory in nature and makes recommendations through the Chairperson. While the Committee's consensus report is limited by the data provided, efforts are made to obtain all available and relevant information. It is not within the mandate of the Committee to re-open other investigations (e.g., criminal proceedings) that may have already taken place.

Information collected and examined by the GLTCRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to section 15(4) of the *Coroners Act* and subject to confidentiality and privacy limitations imposed by the *Coroners Act* and the *Freedom of Information and Protection of Privacy Act*. Accordingly, individual reports, review meetings, and any other documents or reports produced by the GLTCRC are confidential and may not be released publicly. Each Committee member has entered into and is bound by the terms of a confidentiality agreement that recognizes these interests and limitations.

Members of the Committee do not publicly give opinions about cases they have reviewed. In particular, Committee members will not act as experts at civil trials for cases that the GLTCRC has reviewed. Additionally, members do not participate in discussions or prepare reports of clinical cases where they have (or may have) a conflict of interest, or perceived conflict of interest, whether personal or professional.

It is recognized that the GLTCRC only reviews deaths that meet the criteria for mandatory referral (i.e. homicides in long term care or retirement homes), or discretionary referral (i.e. where systemic issues or implications may be present). Discretionary referrals may be based on concerns or issues identified by the investigating coroner, Regional Supervising Coroner or family.

Statistics generated from GLTCRC reviews, particularly as they relate to themes and trends, may be inherently biased due to the selection criteria for cases referred to the Committee. It is also recognized that there is a certain level of subjectivity when themes are assigned during analysis.

Recommendations

One of the primary goals of the GLTCRC is to make recommendations aimed at preventing deaths in similar circumstances. Recommendations are distributed to relevant organizations and agencies through the Chairperson.

Organizations and agencies are asked to respond to the Executive Lead, Committee Management, OCC on the status of implementation of issued recommendations within one year of receiving them. Similar to recommendations generated through coroner's inquests, GLTCRC recommendations are not legally binding and there is no legal obligation for agencies and organizations to implement or respond to them.

Recommendations made to cases reviewed by the GLTCRC in 2015 are included in Appendix A.

Responses to recommendations are part of the public record and are available by contacting occ.inquiries@ontario.ca

Chapter Two: Statistical Overview: 2004-2015

Between 2004 and 2015, the GLTCRC reviewed a total of 259 cases and generated 595 recommendations aimed towards the prevention of future similar deaths. On average, the GLTCRC has reviewed 21.6 cases and generated 49.6 recommendations per year.

It is recognized that there is an inherent bias as to which cases undergo review (i.e. most cases are discretionary referrals sent to GLTCRC due to the presence of identified concerns and issues). There is also the possibility of researcher bias in attributing certain themes to cases and recommendations. It is also recognized however, that regardless of these potential biases, there are certain recurring themes that have emerged over the years. These themes can be applied at a broader level to cases and more specifically to focused recommendations.

The themes identified include:

- Medical and nursing management
- Communication and documentation
- Use of drugs in the elderly
- Use of restraints
- The acute care and long term care industry in Ontario, including the Ministry of Health and Long Term Care (MOHLTC)
- Other: includes other Ontario ministries, justice and legal systems

The following statistical analysis on themes has been broken down into two distinct sections:

- An analysis of themes based on individual cases reviewed
- An analysis of themes based on individual recommendations made

By breaking the analysis down into cases vs. recommendations, it is possible to observe general trends relating to themes that emerge throughout cases that have been referred and reviewed by the GLTCRC, compared to themes that have emerged from specific recommendations.

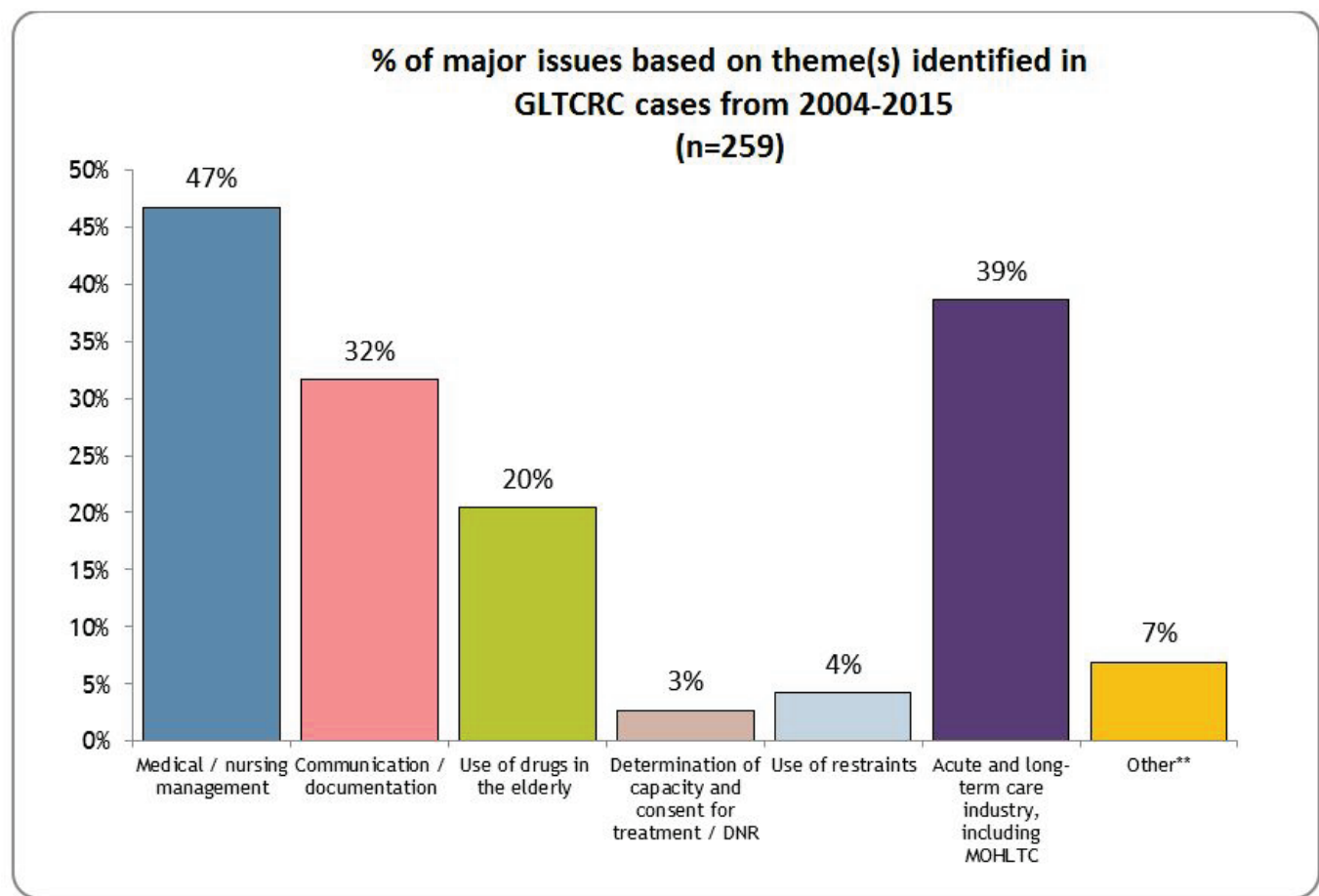
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

Trends based on themes in **recommendations** helps to identify what specific themes/issues have been identified and addressed in recommendations aimed toward the prevention of future similar deaths. A trend in themes of recommendations helps to identify specific areas where the need for change, action or attention has been suggested.

Graph One: % of major issues based on theme identified in GLTCRC cases from 2004-2015

From 2004 until 2015, the GLTCRC has reviewed a total of 259 cases.

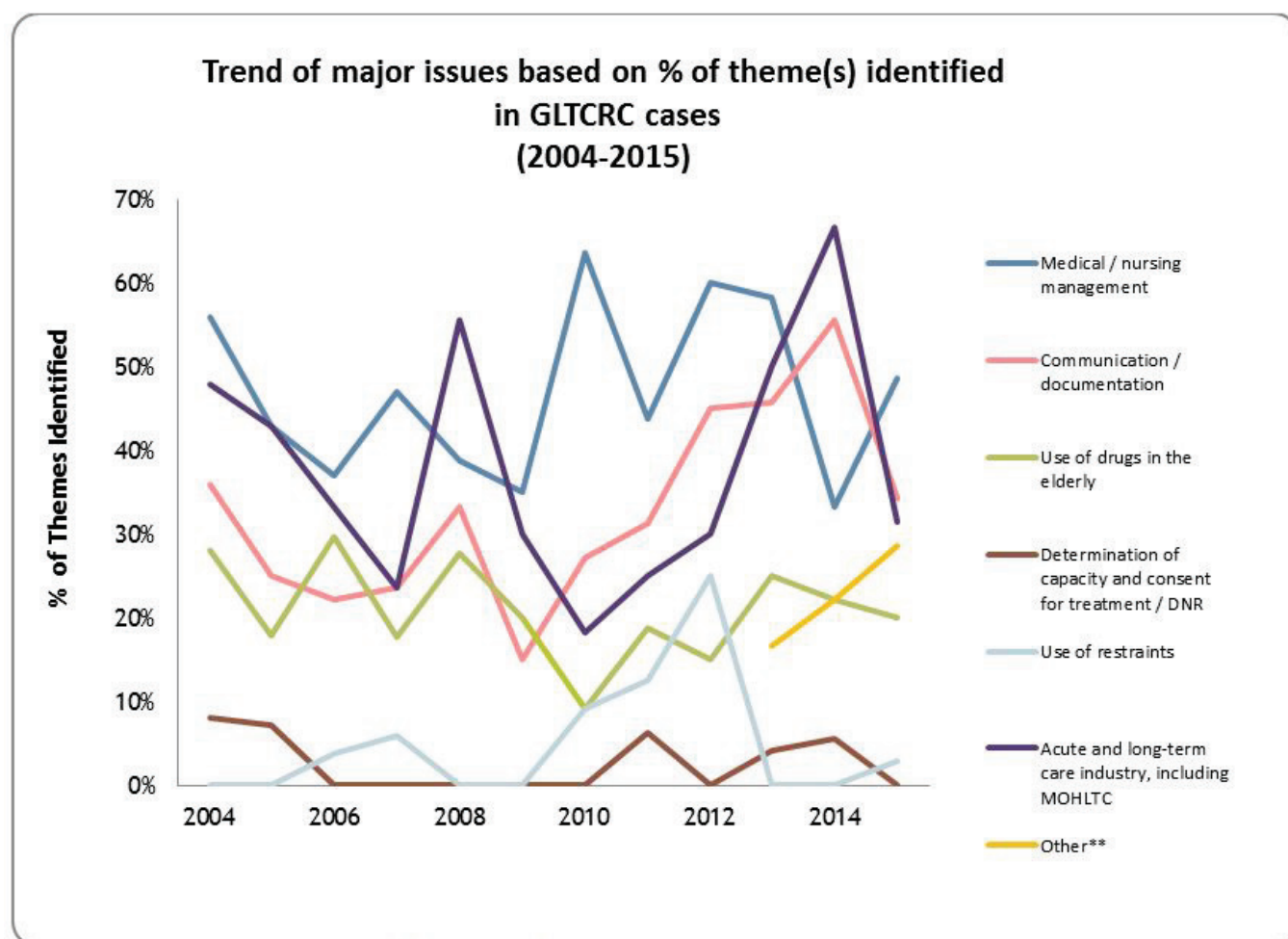
Many cases had more than one theme/issue attributed to the recommendations. A theme was attributed to a case if it applied to one or more of the recommendations made for that case.



**Note: 'Other' is a new category as of 2013 to include recommendations to other ministries or in the legal/justice sector

Graph One demonstrates that in 47% of the cases reviewed by the GLTCRC from 2004-2015, issues relating to medical/nursing management were identified. This is followed by 39% of the cases where issues pertaining to the acute and long term care industry (including MOHLTC) were noted and 32% of the cases where issues of communication/documentation were present. Other key themes included used of drugs in the elderly (20%), use of restraints (4%), determination of consent and capacity/DNR (3%) and other (7%).

Graph Two: Trend of major issues based on % of theme identified in GLTCRC cases (2004-2015)

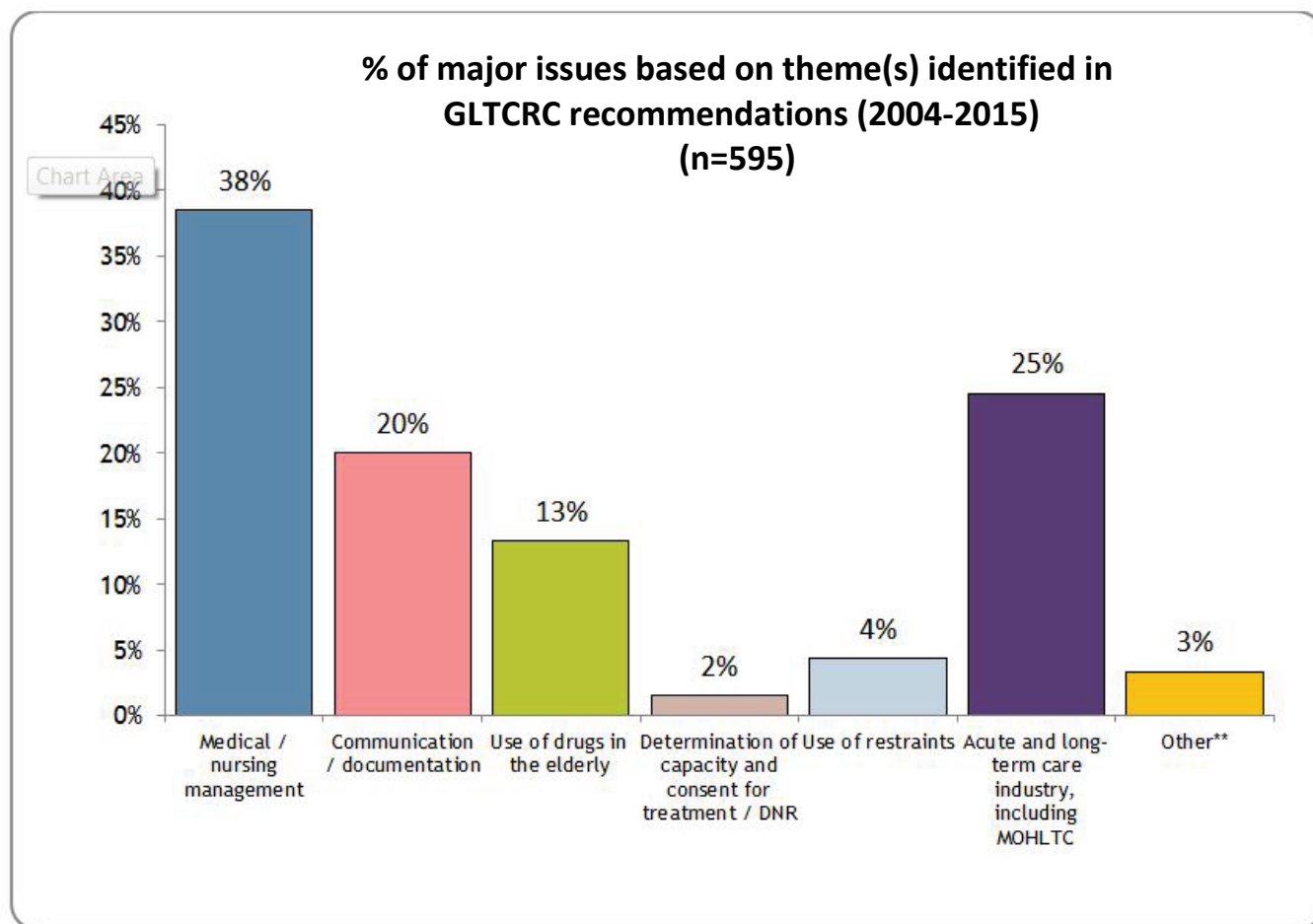


**Note: 'Other' is a new category as of 2013 to include recommendations to other ministries or in the legal/justice sector

Graph Two demonstrates that consistently over the years, the themes of medical/nursing management, communication/documentation and acute care and long term care industry have been prominently identified in cases reviewed by the GLTCRC. Communication/documentation issues were on a steady increase until 2014 and declined in 2015. Use of drugs in the elderly has remained fairly constant. Issues relating to the use of restraints were on the increase until 2012 and have declined since then.

Graph Three: % of major issues based on theme(s) identified in GLTCRC recommendations (2004-2015)

From 2004 until 2015, the GLTCRC generated 595 recommendations aimed at the prevention of future similar deaths.

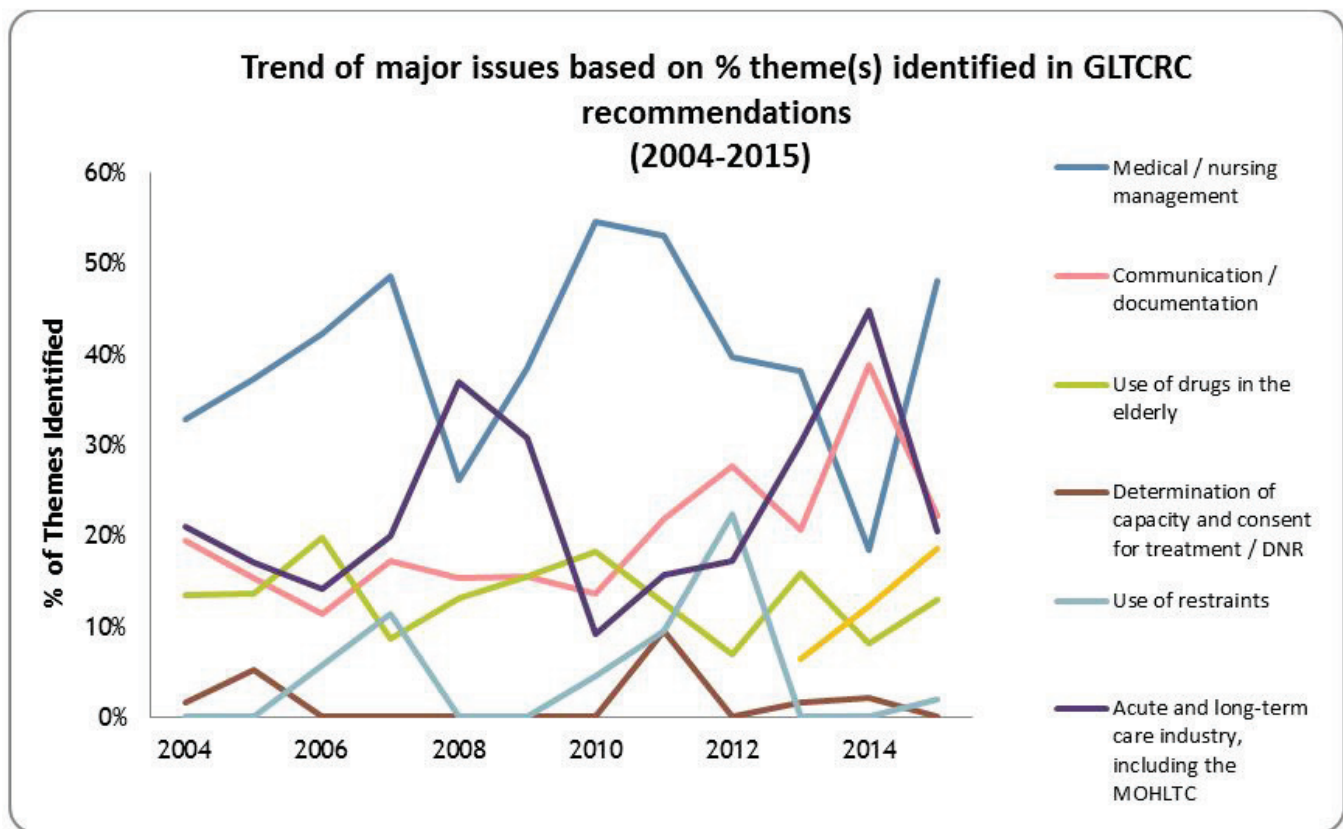


*Note: Many recommendations had more than one theme/issue attributed.

**Note: 'Other' is a new category as of 2013 to include recommendations to other ministries or in the legal/justice sector

Graph Three demonstrates the percentage of common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004-2015. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 38% of all recommendations made were related to medical or nursing management while 25% of the recommendations touched on the acute and long term care industry, including the MOHLTC. The other themes/issues that were present, but that were less frequently assigned to the recommendations, were related to communication/documentation (20%), use of drugs in the elderly (13%), determination of capacity and consent for treatment or DNR (2%), the use of restraints (4%) and other (3%).

Graph Four: Trend of major issues based on % theme identified in GLTCRC recommendations (2004-2015)



Graph Four demonstrates that consistently over the past ten years, the majority of recommendations made by the GLTCRC addressed issues pertaining to medical and nursing management, communication and documentation and the acute and long term care industry, including MOHLTC. The other themes/issues that were identified, but less frequently, were related to use of drugs in the elderly, determination of capacity and consent for treatment or DNR, the use of restraints and other.

This graph demonstrates that medical/nursing management issues appeared to be decreasing between 2010 and 2014, but are now on the rise. Issues surrounding the use of drugs in the elderly, the use of restraints and the determination of consent and capacity have fluctuated over the years. Issues relating to communications/documentation were increasing until 2014 and declined in 2015.

Chapter Three: Cases Reviewed in 2015

In 2015, the GLTCRC reviewed a total of 35 cases involving the deaths of 35 elderly individuals (20 females and 15 males), including residents of long term care and retirement homes. Of the 35 cases, nine were mandatory reviews resulting from homicides that occurred in long term care facilities.

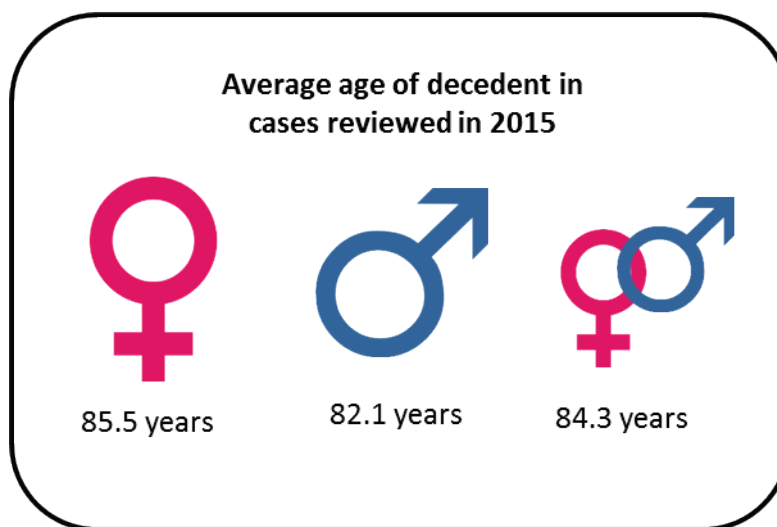
Of the 35 cases reviewed in 2015, 16 of the deaths occurred in 2013, 17 of the deaths occurred in 2014 and two deaths occurred in 2015.

[Note: The OCC has made it a policy to submit all coroner's investigations involving homicides in long term care or retirement homes in the province to the GLTCRC for further review. Other cases involving the deaths of elderly individuals (regardless of whether they are in a long term care or retirement setting), may be referred to the GLTCRC for review if systemic issues or implications may be present, or if concerns were identified by the family, investigating coroner or Regional Supervising Coroner.]

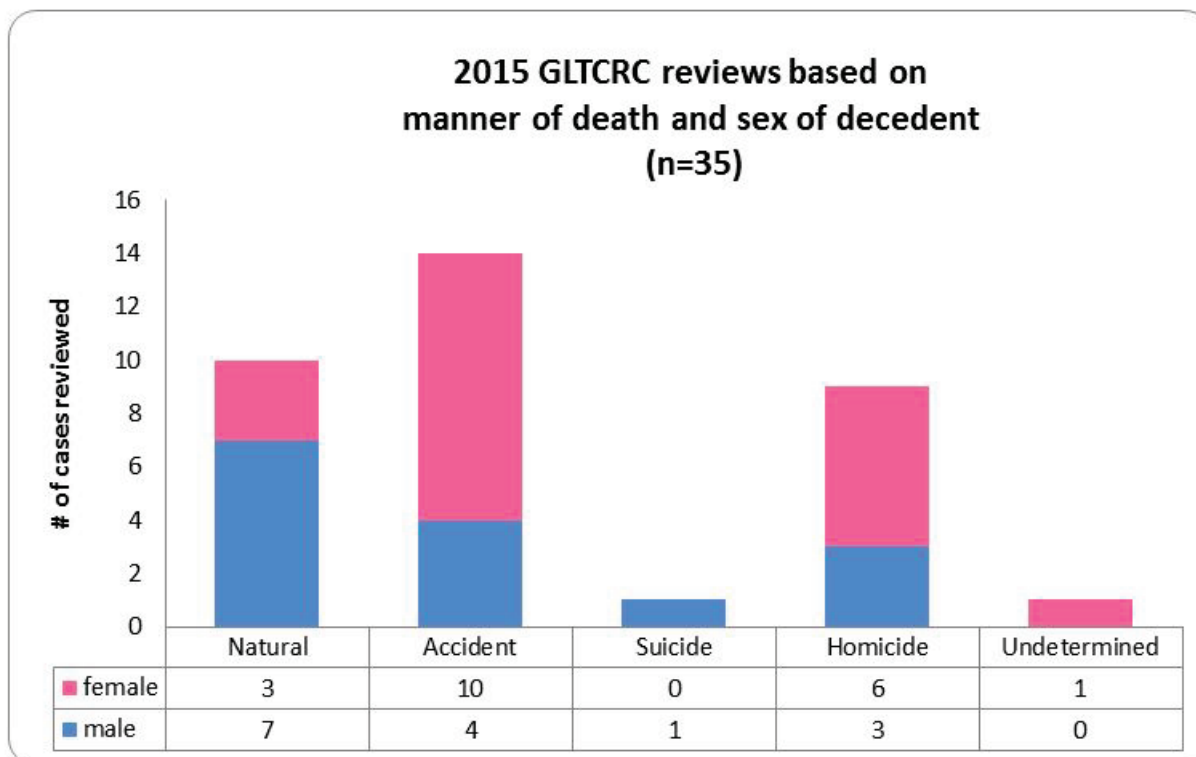
A summary of cases reviewed and recommendations made in 2015 is included in Appendix A.

Full, redacted narrative reports may be obtained by contacting the OCC at occ.inquiries@ontario.ca.

From the cases reviewed in 2015, the average age of female decedents was 85.5 years and male decedents was 82.1 years; combined, the average age of all decedents reviewed in 2015 was 84.3 years.



Graph Five: 2015 GLTCRC reviews based on manner of death and sex of decedent



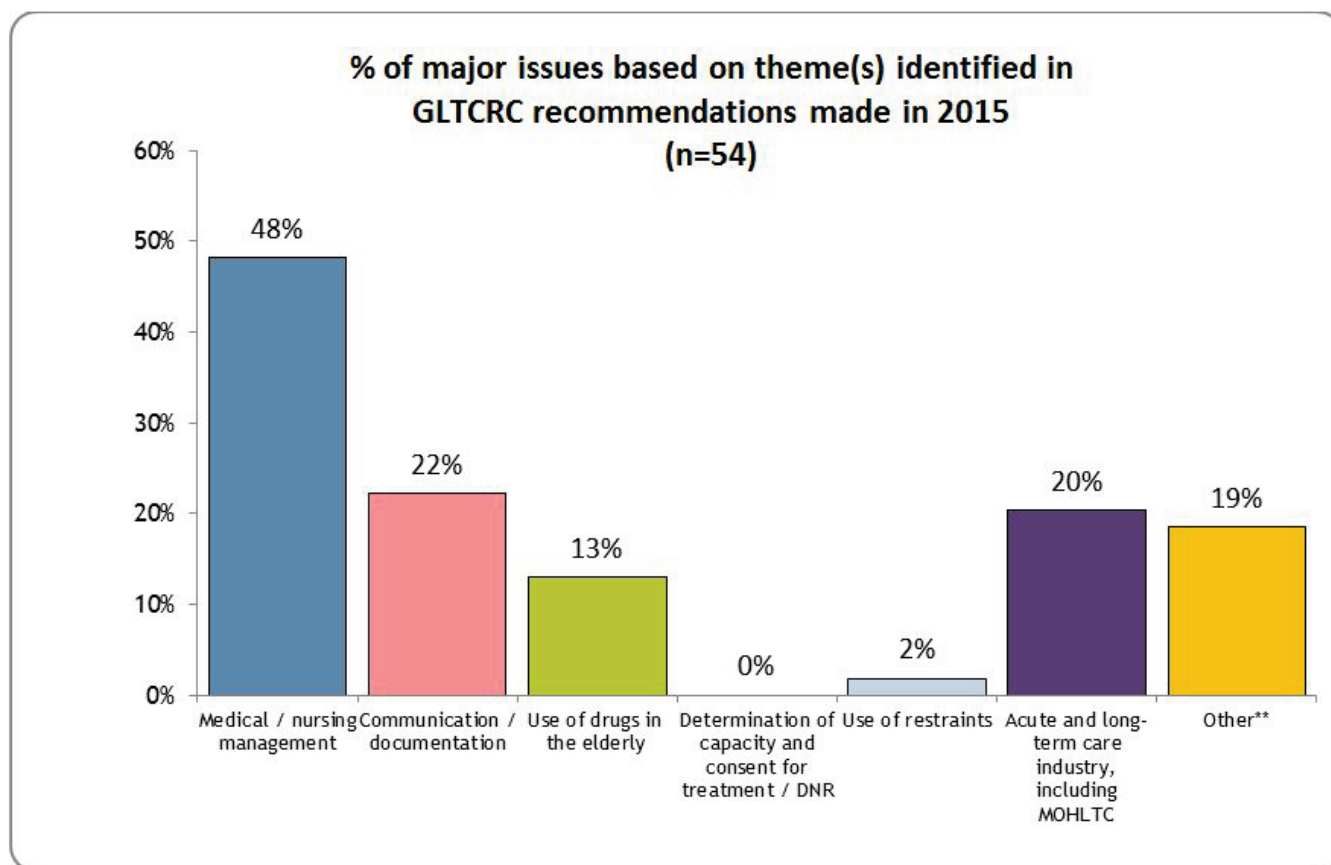
Graph Five demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 35 cases reviewed, 14 were accidents (10 females and four males), nine were homicides (six females and three males), 10 were natural (three females and seven males), one was suicide (male) and one was undetermined (female).

In 2015, the GLTCRC generated a total of 54 recommendations aimed at preventing future similar deaths. There were 10 cases that did not result in any recommendations. Although the GLTCRC may not have generated recommendations in these 10 cases, the analysis of the circumstances and subsequent discussion contributed significantly to the larger coroner's investigation of the death.

Recommendations made by the GLTCRC were distributed to relevant individuals, facilities, ministries, agencies, special interest groups, health care professionals (and their licensing bodies) and coroners. Agencies and organizations in a position to implement recommendations were asked to respond to the OCC within one year. These organizations were encouraged to self-evaluate the implementation status of recommendations assigned to them.

Recommendations were also shared with chief coroners and medical examiners in other Canadian jurisdictions and are available to others upon request.

Graph Six: % of major issues based on theme(s) identified in GLTCRC recommendations made in 2015



Graph Six demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2015. The most commonly identified themes/issues were related to medical or nursing management (48%), communication and documentation (22%), the acute and long term care industry (20%), “other” (including recommendations to the OCC and Regional Supervising Coroners) (19%), the use of drugs in the elderly (13%) and use of restraints (2%). There were no recommendations related to determination of capacity and consent for treatment/DNR in 2015.

It is interesting to note that ordering of percentages of themes identified in recommendations in 2015 is generally consistent with the overall ordering for all recommendations made from 2004-2015 (see Graph Three).

Overall summary of cases reviewed and recommendations made by the GLTCRC in 2015:

- In 2015, there were 35 cases reviewed and 54 recommendations made.
- Of the 35 cases reviewed in 2015, 16 of the deaths occurred in 2013, 17 of the deaths occurred in 2014 and two deaths occurred in 2015.
- Medical/nursing management issues were identified in 48% of the recommendations made.
- Communication and documentation issues were identified in 22% of the recommendations made.
- Use of drugs in the elderly was identified in 13% of the recommendations made.
- Determination of capacity and consent for treatment / DNR was not identified as an issue in any of the recommendations.
- MOHLTC and/or LTC industry issues were identified in 20% of the recommendations made.
- 'Other' (including direction to the OCCO, Regional Supervising Coroner, etc.) was identified in 19% of the recommendations made.
- Some of the recommendations touched on more than one issue.
- There were 10 cases that did not have any recommendations.
- Of the 35 cases reviewed, 20 involved female decedents and 15 male decedents.
- The average age of female decedents in cases reviewed in 2015 was 85.5 years.
- The average age of male decedents in cases reviewed in 2015 was 82.1 years.
- The average age of all decedents (i.e. male and female combined) in cases reviewed in 2015 was 84.3 years.
- Of the cases reviewed in 2015, the manner of death for each of the 35 cases was broken down into: natural (10), accident (14), suicide (1), homicide (9) and undetermined (1).

Chapter Four: Learning from GLTCRC Reviews

A primary and recurrent theme of the GLTCRC reports is that, when it comes to medical care, the elderly are a special group. The interplay of multiple medical and social issues requires the effort of a team of professionals to ensure the provision of competent and compassionate care. The recognition by policy makers of the special needs of the elderly is of critical and urgent importance as the population of Ontario ages.

No issue exemplifies the complexity of geriatric care as well as the management of the Behavioural and Psychological Symptoms of Dementia (BPSD). This is a pervasive factor in the safety of the elderly as it relates to falls, the use of restraints and to assaults. More than half of the long term care home residents in Ontario have a diagnosis of dementia and almost half exhibit aggressive behaviours. The education of care providers in the effective management of BPSD and the appropriate allocation of resources have been identified as priorities by the GLTCRC.

The GLTCRC reviews all deaths in long term care that are certified as homicides. These deaths represent the tip of the iceberg in regard to resident-on-resident violence. As evidenced in its recommendations, the committee has recognized the complexity and urgency of this issue and has called on government, regulators, industry and care providers to collaborate to develop a comprehensive approach to address violence in long term care. Residents and their families, as well as the staff at long term care homes, expect and deserve a safe environment. Recipients of the related recommendations have indicated their recognition of the problem and the committee looks forward to their responses.

The GLTCRC recognizes the increased complexity and acuity of long term care residents. Long term care homes and retirement facilities are home to adults of all ages with a variety of chronic medical and mental illnesses. Long term care homes are challenged to provide living environments that meet the needs of such a broad spectrum of individuals.

The GLTCRC appreciates the many Ontarians involved in the provision of care to the elderly. These individuals have taken on the responsibility for this valuable, and at times vulnerable, segment of our population, and they do so with considerable skill and dedication. It is hoped that the work of this committee will be of assistance to them and to the families of those whose deaths have been reviewed.

APPENDIX A: Summary of 2015 Cases and Recommendations

[Note: Organizations receiving recommendations are asked to respond to the OCC within one year of receipt. This is to provide enough time to assess the recommendation and decide on how best to proceed. Some organizations and agencies may have already responded to recommendations in this report prior to the report being published. Copies of responses may be obtained by contacting the OCC at occ.inquiries@ontario.ca]

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
2015-01	0	The Regional Supervising Coroner requested a review of this death due to family concerns that the decedent was given oral medications by a nurse when he was drowsy and nauseated, leading to choking and precipitating the events leading to his death.	None	N/A
2015-02	0	This case was referred to the GLTCRC for review of the management of an elderly, delirious patient in a community hospital.	None	N/A
2015-03	0	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 85-year-old decedent (Resident A) died after being pushed by an 86-year-old resident (Resident B) while in the LTCH where they both lived.	None	N/A
2015-04	0	The Regional Supervising Coroner referred this case for review because family members had concerns about the care provided and about the decision to institute palliative care.	None	N/A
2015-05	5	During a review of cremation certificates, the coroner contacted the family and “concerns were expressed over the quality of the medical and institutional care”. The family wished to proceed with the cremation, but requested a coroner’s investigation. The case was sent to the GTCRC for	Care providers are reminded that a diagnosis of dementia does not mean that individuals with a lifelong history of serious mental illness (ie. bipolar disorder, schizophrenia, depression) are no longer at risk of exacerbations of their mental illness. Behaviour change can be a sign of serious psychiatric illness, and should not	Medical / Nursing Management

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		consideration of the quality of the medical and institutional care.	be discounted as simply attributable to the “behavioural and psychological symptoms of dementia”. Mania is not an illness state which can be safely managed in a long term care setting by primary care practitioners. Individuals with mania require urgent psychiatric assessment and further specialized care. • Physicians should be reminded that admission history and physicals for long term care residents need to be done in a timely fashion. Residents in long term care who become behaviourally unstable require an urgent assessment by the responsible physician to diagnose the medical or psychiatric cause for the unstable behavior. • The MOHLTC/ Community Care Access Centres (CCAC) should review the practice of admitting unstable patients (from a medical or behavioural point of view) to a long term care home on a crisis basis. (If CCAC care is withdrawn from a patient or family due to violence, the response of the health care system should not be to abandon the patient and family. Unstable behaviours in dementia patients are situations when the health care system needs to engage with the patient and family to understand what is going on. In these situations the CCAC should facilitate urgent transfer to the emergency room for a comprehensive assessment.) • Support to the primary care and long term care sectors caring for the dementia patient with a serious mental illness, should be increased. Individuals with pre-existing serious mental illness are a challenge for primary care clinicians used to working with dementia patients.	• Medical / Nursing Management • Medical / Nursing Management • Acute and long term care industry, including MOHLTC • Acute and long term care industry, including MOHLTC • Acute and long

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			A provincial strategy and implementation plan to improve access to specialized senior's mental health should be developed. It is too difficult to access crisis mental health support for seniors. There are a minority of seniors who require urgent access to specialized geriatric psychiatry in-patient beds. The current level of geriatric psychiatry in-patient beds is insufficient to meet the demand.	term care industry, including MOHLTC
2015-06	0	The 86-year-old decedent who lived on his own in an apartment in the community with minimal support, was found at home by friends after approximately three days of lying on the floor. The ambulance was called and he was transported to hospital, dying two days later. The Regional Supervising Coroner referred this death for review due to concerns about the decedent's ability to care for himself and to make competent decisions to refuse medical care.	None	N/A
2015-07	5	The 84-year-old decedent, who resided in a behavioral support unit in a LTCH, was punched in the head by a co-resident causing her to fall and fracture her hip. She died two months later of complications related to immobility and dehydration. This was a mandatory referral to the GLTCRC as the manner of death was homicide.	- Dementia patients who are on a waiting list for admission to a psychiatric unit due to concerns about aggressive behaviors should be placed on one to one observation with an appropriately trained staff member until the dementia patient is admitted. The cost of this one to one care should be borne by the Ministry of Health and Long Term Care. - Provincial standards for specialized behavior units in long term care for dementia should be clearly articulated with appropriate levels of 24 hour staffing. These standards should contain guidelines describing situations when the care needs of individuals in these settings exceed the	- Medical / Nursing Management - Acute and long term care industry, including the MOHLTC

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			capacity of care in the long term care home so that there is no delay in transferring residents to higher levels of care. • The capacity of the geriatric psychiatry units in hospital settings province wide should be expanded to allow for urgent same day admission to a specialized psychiatric unit where required. • The ministries should urgently appoint a task force of experts from health care and justice perspectives to develop a strategy and specific protocols to address violence in dementia care. More specifically, the MOHLTC and the Attorney General should focus on how dementia patients with high care needs in terms of aggressive behaviors are able to access specialized geriatric psychiatry support in a forensic mental health setting. • Over the last several years, the GLTCRC has reviewed a number of resident-to-resident violent interactions in long term care settings which have resulted in the death of one of the residents. The committee calls upon the Chief Coroner to urgently bring the issue of homicide in long term care homes to the attention of the MOHLTC and the Attorney General.	• Acute and long term care industry, including the MOHLTC • Acute and long term care industry, including the MOHLTC • Other
2015-08	3	The GLTCRC was asked to review this case by the Regional Supervising Coroner due to concerns raised about the documentation and assessment of geriatric complaints in the primary care setting, the assessment of frail seniors in pre-operative assessment clinics and the assessment of pain and generalized deterioration in the elderly.	• Hospital surgical quality improvement committees should assess the process by which seniors are assessed preoperatively. Consideration should be given to adoption of an algorithm that flags seniors with frailty, significant functional decline or multiple chronic conditions/medications for a more thorough review by clinicians with expertise in care of the elderly. • Hospital surgical quality improvement committees should	• Medical / nursing management • Medical / nursing management

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			review medication reconciliation processes to ensure accurate communication of medications to receiving facilities when patients are discharged, especially in high risk situations such as post-operative anticoagulation following joint arthroplasty. Physicians should be reminded of the importance of timely, accurate and thorough documentation. Health records should document the process and rationale for decision making.	- Communication / documentation - Communication / documentation
2015-09	2	The GLTCRC was asked to review and comment on the circumstances surrounding the death of this 87-year-old woman that occurred as a result of a fall from a variable height bed.	- All facilities using variable height electronic beds should be reminded that where patients/residents are not capable of safely setting the bed height, the “lock” feature should be engaged once the bed is positioned in order to disable the patient/resident pendant height adjustment feature. - Health Canada should be notified of this incident pertaining to the unintentional activation of a hand pendant in a variable height bed leading to a death due to a fall from the highest position.	- Medical / nursing management - Other
2015-10	1	The GLTCRC was asked to review the death of this 76-year-old woman who was a LTCH resident. The family and coroner raised concerns related to the development of a sacral ulcer, malnourishment, dehydration and the lack of blood sugar monitoring.	Health care providers are reminded that communication with family is crucial. A family care conference should be arranged soon after the admission to clarify the prognosis and goals of care for a patient.	Communication / documentation
2015-11	3	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 91-year-old decedent died after being pulled from her wheelchair by another resident (Resident B) while in the LTCH where they both resided.	- Documentation of physician care and treatment in patients with responsive behaviours is essential. Ongoing responsive behaviours require the same approach as any problem in medicine, including documentation of the history and symptoms, examination findings, treatments and responses to treatment. - Health professionals working in	- Communication / documentation - Medical / nursing

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			long term care homes should be reminded that moving to, or within the long term care home transiently increases the risks associated with responsive behaviours in residents with dementia. Times of transition should be managed with increased support and monitoring of the resident and increased support for the staff caring for the resident, until the resident is settled into their new home days or weeks later. The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in long term care homes. The panel membership should include, but not be limited to, the MOHLTC, the long term care home associations (OANHSS, OLTC), experts in dementia care and mental health in the elderly, representatives of consumer advocates (e.g. the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, representatives of the criminal justice system, elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in the care of physically violent persons with dementia. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	management Acute and long term care industry, including the MOHLTC
2015-12	2	The GLTCRC was asked to review and comment on the circumstances surrounding the death of this 84-year-old man due to concerns identified by his spouse regarding the medical care provided during	- Police and health care providers should be educated about their responsibilities and options when dealing with a vulnerable adult who appears to be the victim of neglect or abuse. - Police services should be	- Other - Other

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		the terminal hospital admission.	encouraged to include seniors' services as a planning priority. Training in elder abuse should be promoted and consideration should be given to including an elder abuse resource officer in each police service.	
2015-13	0	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 91-year-old decedent (Resident A) died after being pushed by another resident (Resident B) while in the retirement residence where they both lived.	None	N/A
2015-14	0	This was a discretionary referral to the GLTCRC involving a 92-year-old woman with dementia who fell outside in the winter while at home where she lived alone. The GLTCRC was asked to review the circumstances surrounding this death to determine if the woman's death could have been prevented.	None	N/A
2015-15	1	This case was referred to the GLTCRC as concerns were identified by the family relating to standards of care in the convalescent section of the LTCH where the decedent resided.	Staff and physicians in long term care homes should have an organized approach to recognition, assessment and management of depression and recognition, assessment and management of suicide risk.	Medical / nursing management
2015-16	3	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 96-year-old decedent died of medical complications of a fractured left hand which she sustained when she was assaulted by another resident (Resident B) in the LTCH where they both resided.	The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in long term care homes and other institutions that care for elderly patients with behavioural issues. The panel membership should include, but not be limited to, the MOHLTC, the LTCH associations (e.g. OANHSS, OLTC), representatives of the retirement home industry, experts in dementia care and mental health in the elderly, representatives of	Acute and long term care industry, including the Ministry of Health and Long term Care

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, representatives of the criminal justice system, elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened. • The Office of the Chief Coroner should consider compiling a consolidated assessment of all cases involving resident-to-resident violence reviewed by the Geriatric and Long Term Care Review Committee. • The Office of the Chief Coroner should consider conducting an inquest into death(s) involving resident-to-resident violence in Ontario long term care homes.	• Other • Other
2015-17	0	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 85-year-old decedent (Resident A) died after being pushed by another resident (Resident B) at the LTCH where they both resided.	None	N/A
2015-18	1	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 90-year-old decedent (Resident A) died after being pushed by another resident (Resident B) while in the retirement home where they both resided.	• Retirement homes in Ontario should ensure comprehensive team based care with appropriate documentation in the health record when providing specialized care to residents with dementia.	• Communication / documentation
2015-19	1	This case was referred to the GLTCRC as concerns were identified by the Regional Supervising Coroner relating to	• As the federal government, together with relevant provincial stakeholders, continues to develop the National Strategy on Aging,	• Medical / nursing management

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		the care provided to the elderly, vulnerable decedent by caregivers who were also vulnerable.	attention should be given to identifying and assisting elderly at-risk individuals who reside at home and within the community.	
2015-20	3	This case was referred to the GLTCRC as concerns were identified by the investigating coroner about the quality of care the decedent received at home prior to her death.	• CCACs across the province should actively provide outreach to ethno-cultural communities in a language and culturally appropriate media and manner that specifically identifies services that are available through local CCACs to enable care at home. • The MOHLTC should engage with partners in ethno-cultural communities to provide education about dementia and care services available using language and culturally appropriate media. • The College of Physicians and Surgeons should support family physicians in providing information to patients and families about dementia and encouraging early referral to supports such as the First Link program through the Alzheimer's Society, the CCAC, local adult day programs and local community social support agencies.	• Communication / documentation • Communication / documentation • Communication / documentation
2015-21	1	This case was referred to the GLTCRC as the decedent's family expressed concerns over the use of psychotropic medications and whether the medications contributed to the death.	• In-patient psychiatric units are reminded that careful assessment, management, and documentation of patient falls are essential components of care, especially in the elderly.	• Medical / nursing management • Communication / documentation
2015-22	2	This case involves the death of a 97-year-old woman who died after being given medication intended for another resident at the LTCH where she resided. The coroner identified concerns relating to medication distribution and administration.	• The long term care home where this incident occurred should consider conducting a root cause analysis of the medication error. This analysis should include a pharmacist with experience in long term care and should focus on whether the policies and procedures at the LTCH are optimal. Consideration should be given to utilizing expertise from an organization such as the Institute for Safe Medication Practices (ISMP-Canada) to conduct this	• Medical / nursing management • Use of drugs in the elderly

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			- analysis. - Drug prescribing in long term care homes should focus not only on the indications for the medications, but also on the side effects and their impact on quality of life.	Use of drugs in the elderly
2015-23	0	This case was referred to the GLTCRC due to concerns from family regarding the quality of care provided at the LTCH where the decedent resided.	None	N/A
2015-24	2	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 82-year-old decedent died after being pushed to the floor by another resident while in the LTCH where they both resided.	- When a LTCH is caring for a resident with dementia and responsive behaviours, it is critical that the LTCH utilize all available resources, both inside and outside the home, to reduce risk of harm to other residents. This should include active pharmacologic and non-pharmacologic management, and referral to available expert practitioners or teams outside the LTCH. If there are systemic barriers to getting outside expert help, these should be documented and addressed. - In cases where a resident's dementia is complicated by responsive behaviours, use of neuroleptic medications can be appropriate. Physicians caring for this population should be familiar with the generally cited literature and best practice guidelines regarding prescribing and monitoring the use of neuroleptic medications for responsive behaviours (for example, http://www.effectivepractice.org/index.cfm?pagePath=RESOURCES/PROJECTS/Academic_Detailing_Service/Discussion_Guide&id=72544).	- Medical / nursing management - Medical / nursing management - Use of drugs in the elderly
2015-25	0	This case involved the death of a 68-year-old woman who died after falling at home on a weekend while awaiting admission to a LTCH. This case was referred to the GLTCRC as	None	N/A

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		concerns were identified by the decedent's family regarding the timeliness of the admission process.		
2015-26	4	This case was referred to the GLTCRC as concerns were identified regarding the lack of continuity of care received when the decedent went to a LTCH, then to hospital, then back to the LTCH.	• Frail, elderly seniors who are admitted to a long term care home should have early assessment and a review of their medications. This is especially true for high risk individuals who have diagnoses such as liver or kidney failure and are on diuretics and narcotics. • Healthcare providers are reminded that long-acting pain medications should not be crushed. If the patient is unable to swallow, consideration should be given to using a patch. As per guidelines, when switching to different opioids, the initial starting dose should be 50% of the morphine equivalent dose of the current opioid. • Physicians should complete an in-person assessment when making significant changes in dosing of opioids. Increases should be limited to 10% above the previous day's dose. • The long term care home involved should review the circumstances of this case with particular attention to improved communication and pain assessments by the nursing staff and improved communication between the attending physicians and the nursing staff, especially when prescribing opioids.	• Medical / nursing management • <i>Use of drugs in the elderly</i> • Use of drugs in the elderly • Use of drugs in the elderly • Communication / documentation • Medical / nursing management
2015-27	5	This case was referred to the GLTCRC as concerns were identified relating to the management and reporting of falls at the retirement residence where the decedent lived.	• Physicians providing care to the frail elderly should be familiar with the most recent evidence regarding treatment of common, chronic conditions in frail elders, including hypertension and diabetes. The evidence suggests that treatment targets should be different than in younger adults. • Physicians who care for elderly adults should be reminded that	• Medical / nursing management • Medical / nursing management

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
			falls carry high morbidity and mortality in this population, and can often be prevented. Physicians must recognize their important role in trying to prevent further falls. When an older adult falls, physicians should perform a comprehensive assessment of risk factors for further falls, address those risk factors that are modifiable (particularly medications), and document the assessment and plan. - Retirement Homes are reminded that S. 22(2) of the Retirement Homes Act (2010), states that when a resident falls, the Home is to ensure that, “corrective action is taken as necessary to prevent future harm to residents.” When an older adult falls, the professional staff of the Home should, along with the physician, perform a comprehensive assessment of risk factors for further falls, address those risk factors that are modifiable (particularly medications), and document the assessment, plan of care and safety going forward. - The CPSO should consider publishing the details of this GLTCRC report and recommendations in an upcoming issue of the “Dialogue” magazine in order to improve physician awareness of the issues raised. - The Regional Supervising Coroner should forward the Committee’s report and recommendations to the attending physician in this case, and to the retirement home (both the company that owns the home, and the specific home in this case) with a request that they review the report and respond with any resulting changes or recommendations.	- Medical / nursing management - Acute and long term care industry, including the Ministry of Health and Long term Care - Other - Other
2015-28	1	The GLTCRC was asked to review the circumstances	The Complex Continuing Care unit of the hospital should carry out a	- Medical / nursing management - Use of restraints

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		surrounding the death of the 93-year-old decedent after concerns were raised by the family pertaining to the standard of care received in a hospital complex care unit while awaiting admission to a LTCH.	quality review of this case with focus on: a) the indications and use of physical restraints to ensure their Restraint Policy and Procedure is in compliance with provincial Restraint Minimization Legislation; b) the indications and use of neuroleptic agents in the elderly; c) the assessment and management of pain in patients with dementia; d) a review of their Fall Prevention Policy and Procedure which is a required organizational practice under Accreditation Canada.	• Use of drugs in the elderly
2015-29	1	This case was referred to the GLTCRC as the Regional Supervising Coroner requested assistance in determining the cause and manner of death. The decedent died of complications of fractures to his pelvis and shoulder, with no apparent evidence of a traumatic cause.	• Any significant change in health status (e.g. decreased mobility) should necessitate a complete and thorough reassessment including appropriate testing and examinations (e.g. X-rays).	• Medical / nursing management
2015-30	1	This case was referred to the GLTCRC after concerns were raised regarding the use of unregulated care providers (UCPs) within LTCHs.	• Policies and procedures, including a clearly defined scope of care, should be developed regarding the use of unregulated care providers in long term care settings. Policies should delineate and clearly document the roles, responsibilities and reporting relationships of care providers.	• Medical / nursing management • Acute and long term care industry, including the Ministry of Health and Long term Care
2015-31	1	This case was referred to the GLTCRC for consideration of possible systemic concerns regarding elder care in long term care home settings arising out of a death due to an accidental fall from a mechanical lift.	• Long term care homes are reminded of the importance in following manufacturer recommendations on the safe usage of mechanical lifts and slings and that adequate training and maintenance programs are established and followed.	• Medical / nursing management
2015-32	1	This case was referred to the GLTCRC as the death resulted after the 88-year-old decedent became entrapped in a bedrail at the LTCH where she resided.	• Health Canada should conduct further research into: - the design of bedrails in order to prevent bed entrapment - more effective bed alarm systems	• Other
2015-33	1	The GLTCRC was asked to	• Health care professionals working	• Communication /

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		review and comment on the circumstances surrounding the death of this 95-year-old woman due to concerns identified by the family regarding early discharge and lack of rehabilitative services provided to the decedent following a hip fracture.	in long term care homes are reminded of the importance of keeping complete, comprehensive, and accurate progress notes regarding treatment decisions and assessments.	documentation
2015-34	3	This was a mandatory referral to the GLTCRC as the manner of death was determined to be homicide. The 81-year-old decedent died after being pushed by another resident (Resident B) while in the LTCH where they both resided.	- Healthcare Providers and Geriatric Mental Health Outreach Teams (GMHOT) are encouraged to consider early referral for residents of Long Term Care Homes to Behaviour Support Ontario (BSO) if the resident has both a dementia and a major mental illness, and behavior concerns exist. - Healthcare providers are reminded that individuals with major mental illness live in long term care facilities and that behaviours of concern which arise may be related not to a dementia, but to the major mental illness. If a behavior of concern (e.g. aggression, deteriorating mental status, etc.) arises in the context of a poorly controlled mental illness, then urgent psychiatric consultation is recommended. - Mental health providers are reminded that long term care homes are not in-patient geriatric psychiatry facilities and do not have the resources to care for acutely psychiatrically ill patients/residents.	- Medical / nursing management - Medical / nursing management - Medical / nursing management
2015-35	1	This case involved the death of an 88-year-old man who died in hospital after being transferred from the home where he lived with his wife and son. The GLTCRC was asked to review the circumstances surrounding this death as concerns were raised about the safety of the fragile elderly living at home, in the care of similarly frail	In cases of suspected elder abuse or neglect, it is critical that the elderly person be interviewed independently of the potential abuser, in a safe environment where the confidentiality of the interview can be assured. It is vital that the conditions for the interview be optimized for the elderly person, including the use of trained translators where the	- Communication / documentation - Other

GLTCRC File Number	# of Recs	Summary of Case	Recommendation(s)	Theme
		persons.	elderly person does not speak fluent English. Abused elderly persons are vulnerable, and unlikely to disclose abuse when interviewed in the presence of the potential abuser or with the potential abuser acting as a translator.	

Questions and comments regarding this report may be directed to:

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