



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

Geriatric and Long Term Care Review Committee

2016 Annual Report

October 2017

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Message from the Chair



It is my pleasure to present to you the 2016 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 2016, the GLTCRC reviewed 23 cases, involving 23 deaths and generated 44 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.

I would like to take this opportunity to thank Ms. Kathy Kerr (Executive Lead) for her 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 occ.inquiries@ontario.ca.

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

Committee Membership (2016)

Dr. Roger Skinner

Regional Supervising Coroner, Committee Chair

Ms. Kathy Kerr

Executive Lead

Ms. Elaine Akers

Pharmacist

Ms. Julie Cavaliere

Registered Dietitian

Dr. Barbara Clive

Geriatrician

Dr. Margaret Found

Family Physician/Coroner

Dr. Sid Feldman

Family Physician

Dr. Heather Gilley

Geriatrician

Dr. Barry Goldlist

Geriatrician

Dr. Mark Lachmann

Geriatric Psychiatrist/Coroner

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 2016, the GLTCRC reviewed 23 cases involving 23 deaths and generated 44 recommendations directed toward the prevention of future deaths. Of the 23 cases reviewed, six resulted in no recommendations.
- Of the 23 deaths that were reviewed in 2016, the breakdown for manners of death were:
 - Natural - 6 (two men and four women)
 - Accident - 12 (five men and seven women)
 - Homicide* - 4 (three men and one woman)
 - Suicide - 1 (one man)
- Of the 23 deaths reviewed, 11 were men and 12 were women.
- The average age of men whose deaths were reviewed was 83.8 years.
- The average age of women whose deaths were reviewed was 84.1 years.
- The average age of all deaths reviewed in 2016 was 83.9 years.
- In 2016, the most common areas for improvement identified by GLTCRC through their case reviews consisted of:
 - Medical and nursing management
 - Determination of capacity and consent for treatment/DNR
 - Acute care and long term care industry in Ontario, including the Ministry of Health and Long Term Care (MOHLTC)
 - Communication and documentation
 - Use of restraints
 - 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 .

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. Effective January 2017, organizations are asked to respond back within six months.

Recommendations made to cases reviewed by the GLTCRC in 2016 are included in Appendix A.

Responses to recommendations are part of the public record and are available by [contacting the OCC](mailto:occ.inquiries@ontario.ca) (occ.inquiries@ontario.ca).

Chapter Two: Statistical Overview: 2004-2016

Between 2004 and 2016, the GLTCRC reviewed a total of 282 cases and generated 639 recommendations aimed towards the prevention of future similar deaths. On average, the GLTCRC has reviewed 21.7 cases and generated 49.2 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
- Determination of capacity and consent for treatment/DNR
- 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.

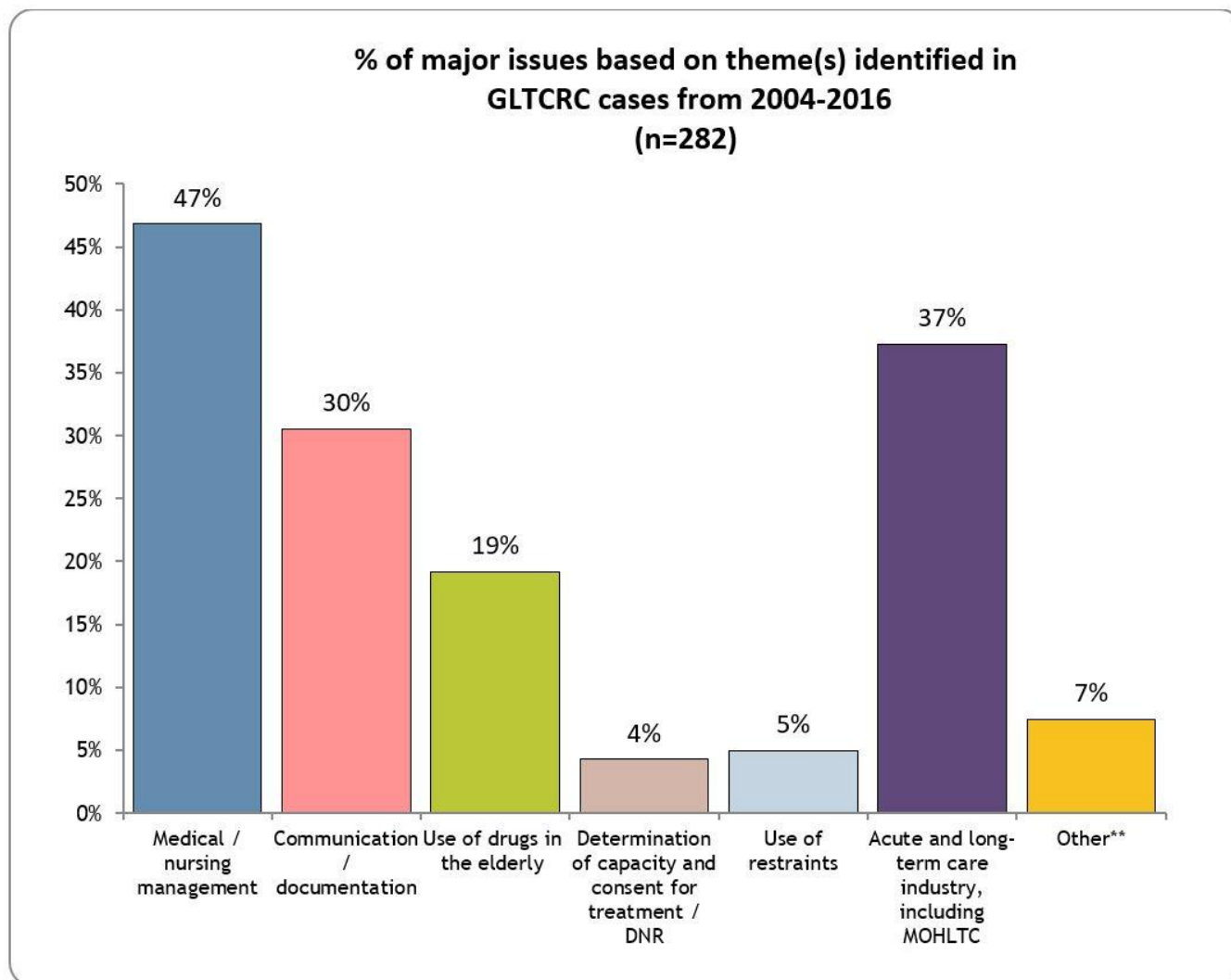
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

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 2004-2016

From 2004 until 2016, the GLTCRC has reviewed a total of 282 cases.

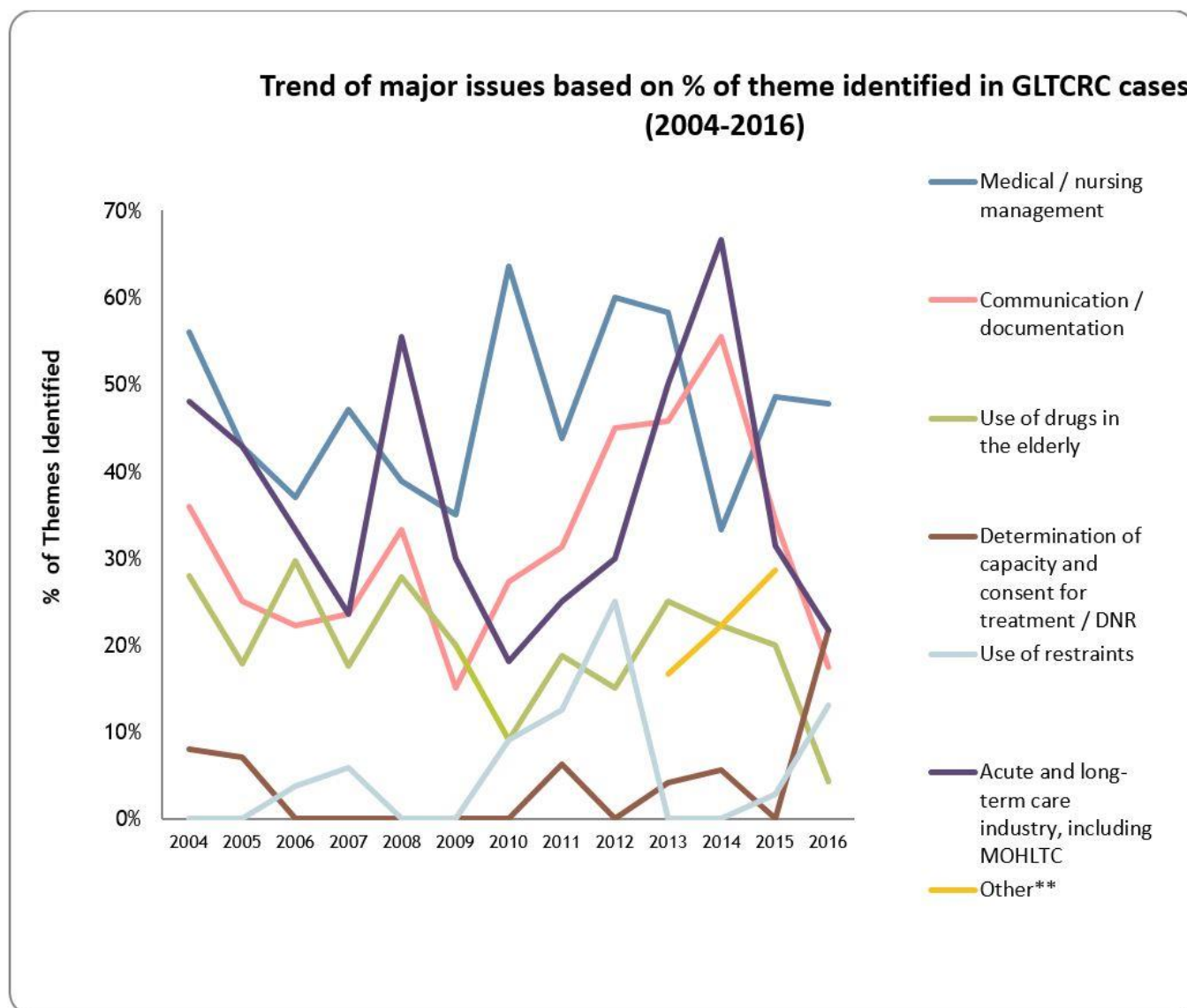
Many cases had more than one theme/issue attributed to the recommendations. A theme was attributed to a case if it applied to one or more of the recommendations made for that case.



****Note:** 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph One demonstrates that in 47% of the cases reviewed by the GLTCRC from 2004-2016, issues relating to medical/nursing management were identified. This is followed by 37% of the cases where issues pertaining to the acute and long term care industry (including MOHLTC) were noted and 30% of the cases where issues of communication/documentation were present. Other key themes included use of drugs in the elderly (19%), use of restraints (5%), determination of consent and capacity/DNR (4%) and other (7%).

Graph Two: Trend of major issues based on % of theme identified in GLTCRC cases (2004-2016)

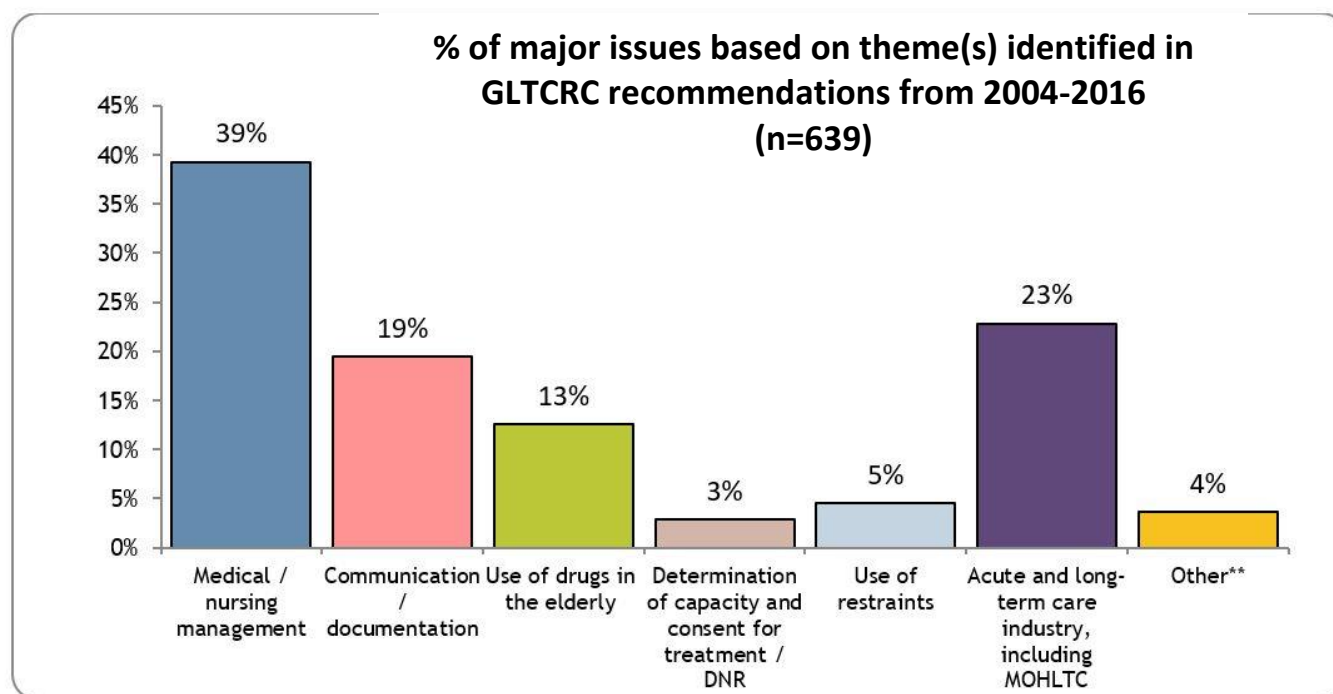


**Note: 'Other' includes recommendations to other ministries or in the legal/justice sector

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. The issue of determination of capacity and consent for treatment and/or DNR was a key issue addressed in five cases in 2016.

Graph Three: % of major issues based on theme(s) identified in GLTCRC recommendations (2004-2016)

From 2004 until 2016, the GLTCRC generated 639 recommendations aimed at the prevention of future similar deaths.

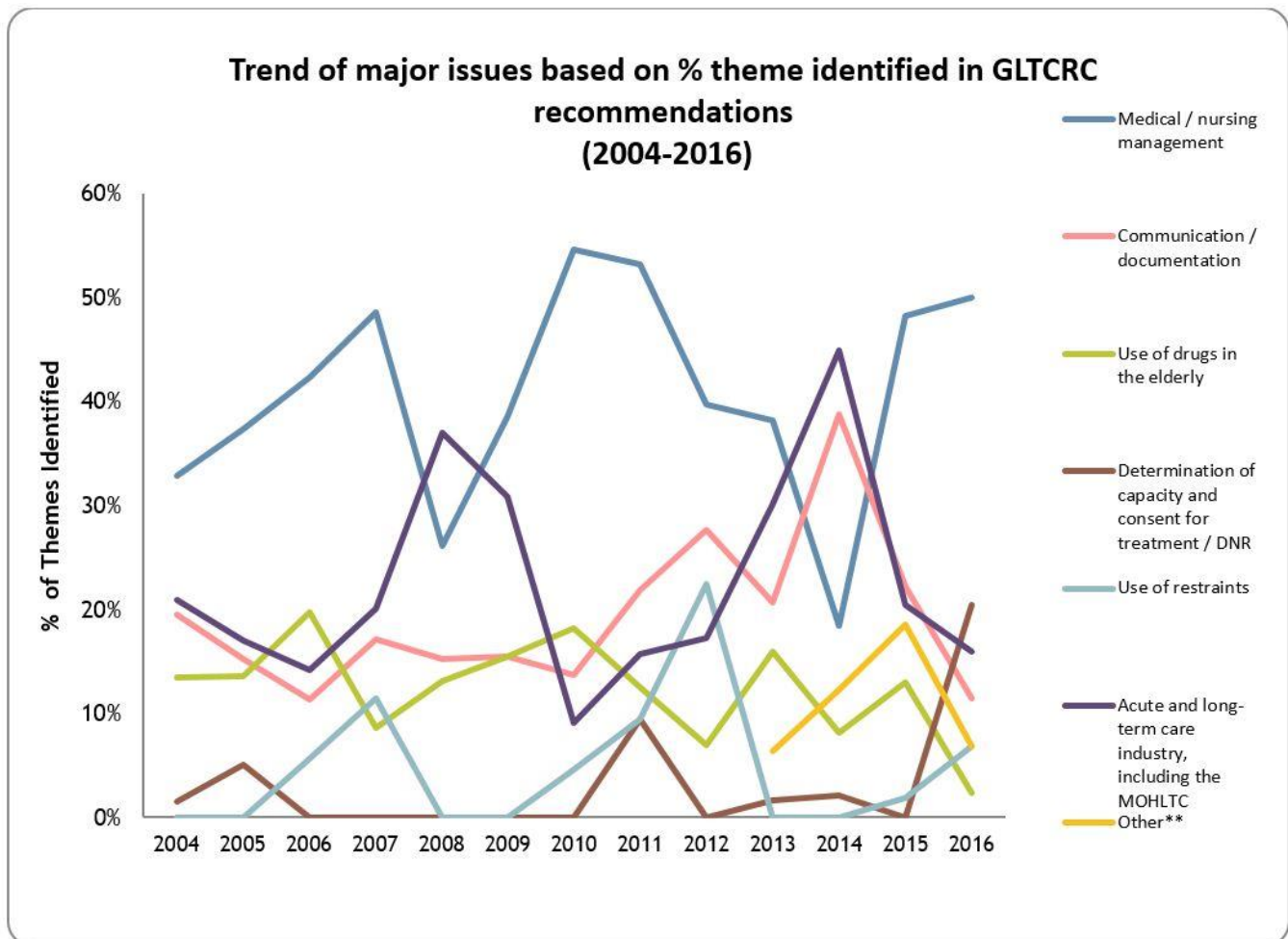


*Note: Many recommendations had more than one theme/issue attributed.

**Note: 'Other' includes 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 2004-2016. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 39% of all recommendations made were related to medical or nursing management while 23% 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 (19%), use of drugs in the elderly (13%), determination of capacity and consent for treatment or DNR (3%), the use of restraints (5%) and other (4%).

Graph Four: Trend of major issues based on % theme identified in GLTCRC recommendations (2004-2016)



****Note:** 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph Four demonstrates that consistently over the past 13 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 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. In 2016, the determination of capacity and consent was an issue in five of the cases reviewed. Issues relating to communications/documentation were increasing until 2014 and declined in 2015 and 2016.

Chapter Three: Cases Reviewed in 2016

In 2016, the GLTCRC reviewed a total of 23 cases involving the deaths of 23 elderly individuals (12 females and 11 males), including residents of long term care and retirement homes. Of the 23 cases, four were mandatory reviews resulting from homicides that occurred in long term care facilities.

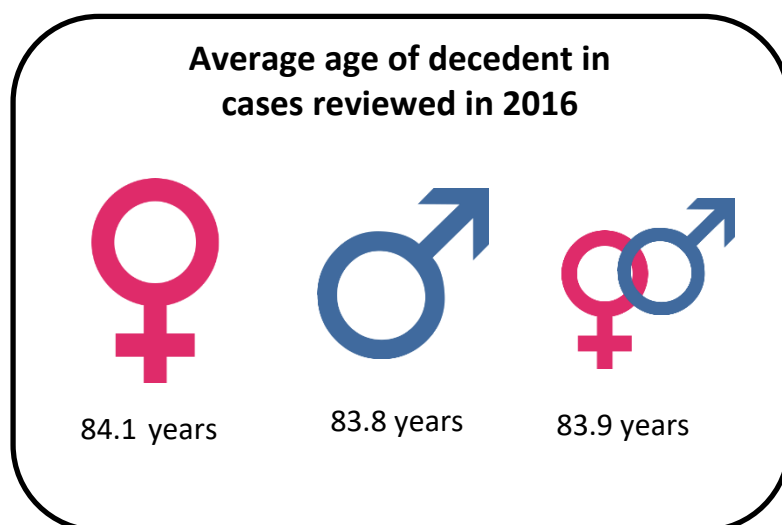
Of the 23 cases reviewed in 2016, five of the deaths occurred in 2013, five in 2014, 10 in 2015 and three in 2016.

[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.]

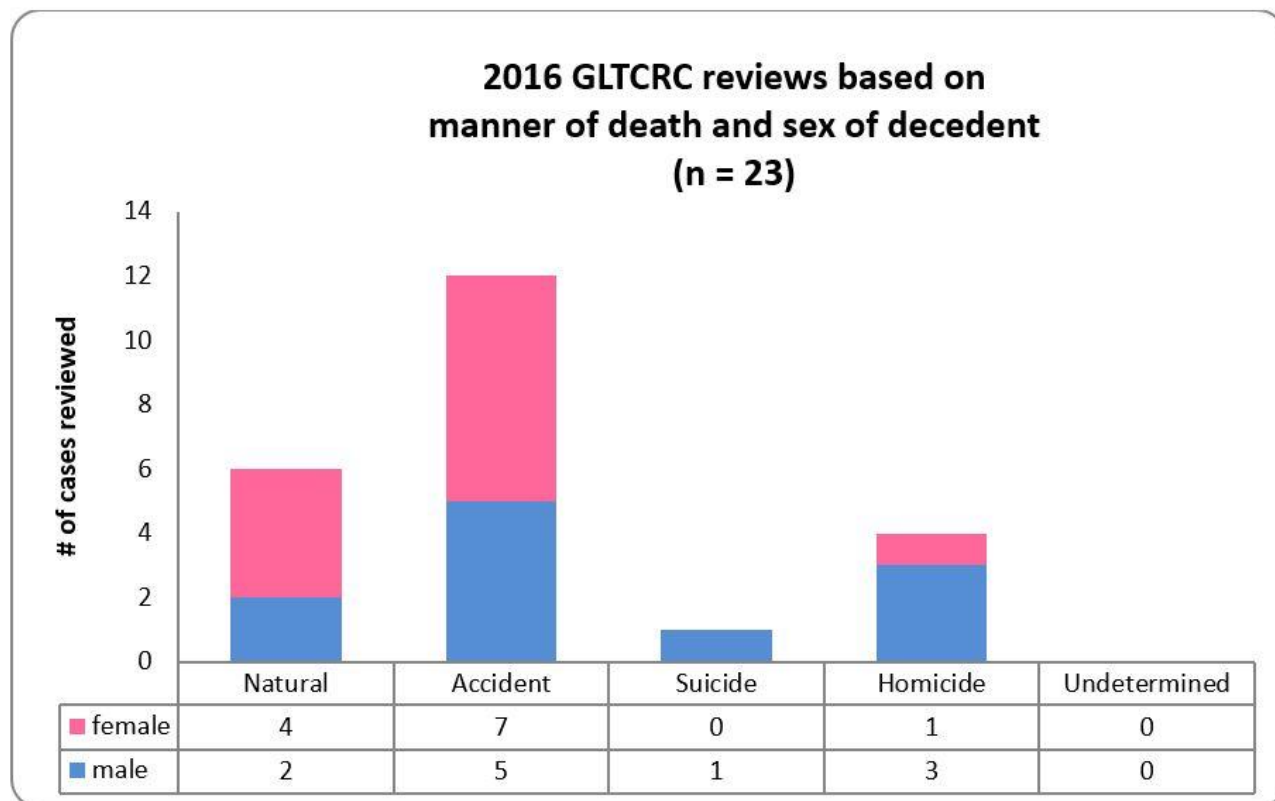
A summary of cases reviewed and recommendations made in 2016 is included in Appendix A.

Full, redacted narrative reports may be obtained by [contacting the OCC](mailto:occ.inquiries@ontario.ca) (occ.inquiries@ontario.ca).

From the cases reviewed in 2016, the average age of female decedents was 84.1 years and male decedents was 83.8 years; combined, the average age of all decedents reviewed in 2016 was 83.9 years.



Graph Five: 2016 GLTCRC reviews based on manner of death and sex of decedent



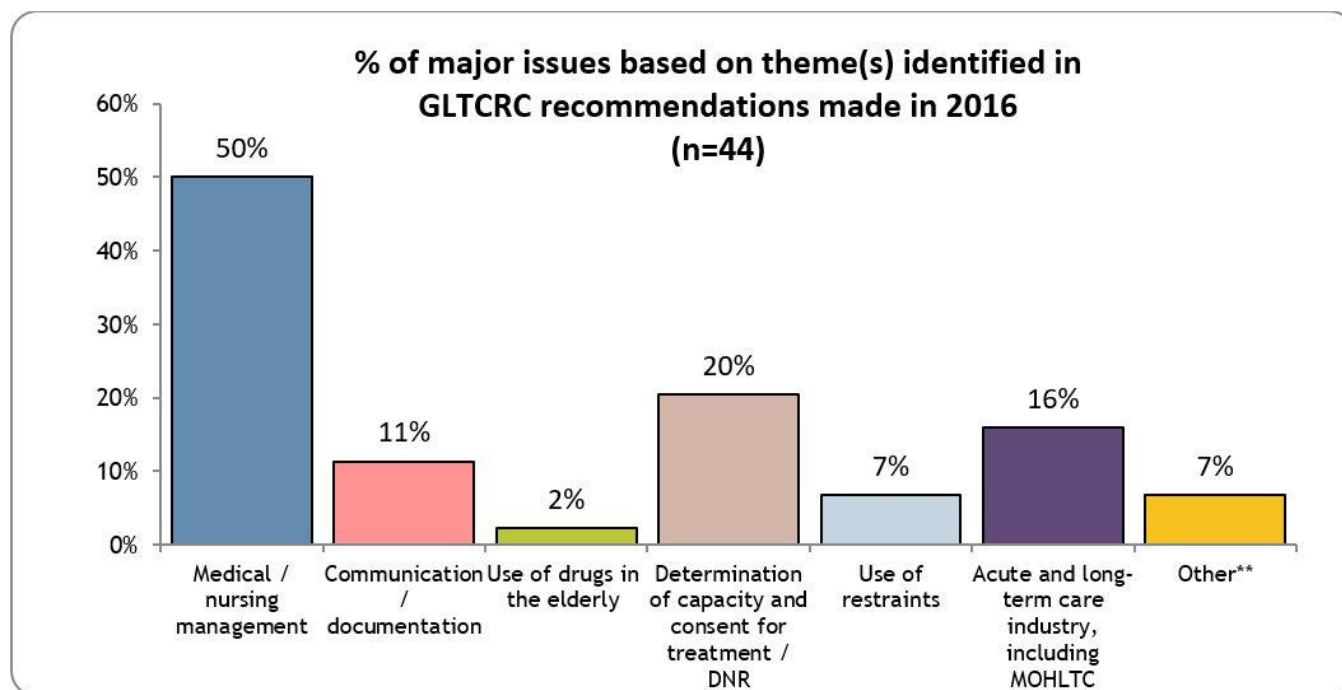
Graph Five demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 23 cases reviewed, 12 were accidents (seven females and five males), four were homicides (one female and three males), six were natural (four females and two males) and one was suicide (one male).

In 2016, the GLTCRC generated a total of 44 recommendations aimed at preventing future similar deaths. There were six cases that did not result in any recommendations. Although the GLTCRC may not have generated recommendations in these cases, the analysis of the circumstances and subsequent discussion contributed significantly to the larger coroner's investigation of the deaths.

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. Commencing in January 2017, organizations will be asked to respond within six months of receiving the recommendations. Organizations that have responded to recommendations from reviews conducted in 2016 are noted in the chart in Appendix A.

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 2016



****Note:** 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph Six demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2016. The most commonly identified themes/issues were related to medical or nursing management (50%), determination of capacity and consent for treatment/DNR (20%), the acute and long term care industry (16%), communication and documentation (11%), “other” (including recommendations to the OCC and Regional Supervising Coroners) (7%), use of restraints (7%) and the use of drugs in the elderly (2%).

It is recognized that the issues identified and any resulting trends, are based on the cases that are referred for review. Other than the reviews of homicides within LTCHs which are mandatory (based on the policy of the Office of the Chief Coroner), all other cases are referred for review based on a discretionary, and therefor subjective, decision to do so. It is acknowledged that the discretionary nature of some referrals may result in trends based on issues or concerns that have been identified as areas requiring further attention and analysis.

Overall summary of cases reviewed and recommendations made by the GLTCRC in 2016:

- In 2016, there were 23 cases reviewed and 44 recommendations made.
- Of the 23 cases reviewed in 2016, five of the deaths occurred in 2013, five in 2014, 10 in 2015 and three in 2016.
- Medical/nursing management issues were identified in 50% of the recommendations made.
- Determination of capacity and consent for treatment / DNR was identified in 20% of the recommendations made.
- Communication and documentation issues were identified in 11% of the recommendations made.
- MOHLTC and/or LTC industry issues were identified in 16% of the recommendations made.
- 'Other' (including direction to the OCCO, Regional Supervising Coroner, etc.) was identified in 7% of the recommendations made.
- Use of restraints was identified in 7% of the recommendations made.
- Use of drugs in the elderly was identified in 2% of the recommendations made.
- Some of the recommendations touched on more than one issue.
- There were six cases that did not have any recommendations.
- Of the 23 cases reviewed, 12 involved female decedents and 11 male decedents.
- The average age of female decedents in cases reviewed in 2016 was 84.1 years.
- The average age of male decedents in cases reviewed in 2016 was 83.8 years.
- The average age of all decedents (i.e. male and female combined) in cases reviewed in 2016 was 83.9 years.
- Of the cases reviewed in 2016, the manner of death for each of the 23 cases was broken down into: natural (6), accident (12), suicide (1) and homicide (4).

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.

One issue that seems to be increasingly present in cases referred to the GLTCRC is that of consent and capacity. It is clear that organizational practices often do not reflect the law in regard to the use of advance directives, do not resuscitate orders and powers of attorney for personal care. The committee has identified a need for broad industry education in order to ensure the rights of elderly individuals and residents of long term care facilities. Healthcare providers in particular must be aware of their responsibilities and authorities and of the resources available to them when questions and conflict relating to consent and capacity arise. The committee provides guidance and recommendations in this regard in cases such as 2016-10, 2016-16 and 2016-19 of this year's report.

Although physical abuse and neglect causing death is not often seen in the cases reviewed by the GLTCRC, elder abuse in its many forms is often a peripheral or contributory issue. This is true not only in facilities, but also in the community, where the elderly cannot access resources or are in the care of those who cannot or will not access the resources on their behalf. It falls to the community as a whole to accept responsibility for vulnerable seniors, much as we have for vulnerable children.

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.

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 2016 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](mailto:occ.inquiries@ontario.ca) (occ.inquiries@ontario.ca)]

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Responses Received (as of July 2017)	Theme
2016-01	2	This was a mandatory referral to the Geriatric and Long Term Care Review Committee (GLTCRC) as the manner of death was determined to be homicide. The 87-year-old decedent died of hypertensive heart disease, in the presence of blunt force injury to the face and head. The injuries were sustained after the decedent was assaulted by another resident (Resident B) in the long term care home (LTCH) where they both resided.	1. Physicians are reminded that active planning and an understanding of how to manage psychosis in a particular patient is required. This may include anti-psychotic medication and active non-pharmacologic support (e.g. frequent checks, location of room close to nursing station, explicit safety assessment) and the content of the psychosis should be considered (i.e. simple visual hallucinations are different than command auditory hallucinations to do harm to self or others). Physicians are reminded that a change in the dose of antipsychotic medication is recognized as a period of potential increased risk and may require increased monitoring. 2. The MOHLTC should consider increasing staffing level requirements in long term care settings given the high prevalence of dementia patients with psychosis in long term care settings.		Medical/ Nursing Management, Use of Drugs in the elderly Acute and LTC industry
2016-02	1	This case involved the death of a 94-year-old woman who died from complications of injuries sustained when she was struck by a motorized	1. Regarding the use of power mobility devices in seniors' congregate living environments, the RHRA and Senior's Secretariat should explore the development of	Retirement Home Regulatory Authority	Acute and LTC industry

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Responses Received (as of July 2017)	Theme
		scooter being driven by another resident of the senior's residence where they both lived. Concerns were raised regarding the lack of policy on the use of motorized scooters in the residence.	a framework (similar to that used in many LTCHs) for driver testing and signed accountability agreements to ensure safe and competent operation of the device prior to allowing use of a power mobility device indoors in a retirement home.	Ministry of Seniors Affairs	
2016-03	3	This case was reviewed by the Geriatric and Long Term Care Review Committee (GLTCRC) after concerns were raised when the 92-year-old decedent died after being entrapped in a bed rail at the retirement home (RH) where he resided.	1. Health Canada should mandate that portable bed rails be secured and comply with Health Canada Standards for bed rails and prevention of bed entrapment. 2. The College of Occupational Therapists and any healthcare professionals prescribing bed rails are reminded of the potential hazards of bed rails and the need for a full evaluation of the indication for the rail and the risks and benefits to the particular client. 3. The Regional Supervising Coroner should ensure that this death has been reported to Health Canada using the Bed-related Entrapment and Fall Report Form.	Retirement Home Regulatory Authority College of Physicians and Surgeons of Ontario	Acute and LTC industry Acute and LTC industry Other
2016-04	1	The decedent was a 91-year-old woman who died as the result of a pelvic fracture sustained in an unwitnessed fall from her bed in the Long Term Care Home (LTCH) where she resided. The decedent's family expressed concerns about the level of staffing in the LTCH on the night of the fall.	1. Geriatric healthcare providers are reminded that there is little evidence to suggest that restraint use reduces the risk of injury and that there is some evidence that restraints may actually increase the risk of death, falls, serious injury, pressure sores and hospital length of stay.	Colleges of Nurses of Ontario	Use of restraints
2016-05	1	This case involved the death of a 92-year-old man who died from neck compression after slipping down in his wheelchair and being entrapped by the seat belt.	1. Acute care hospitals should review alternatives to wheel chair seat belts especially in persons with delirium.	Hospital Ontario Hospital Association	Use of restraints

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Responses Received (as of July 2017)	Theme
		The Geriatric and Long Term Care Review Committee (GLTCRC) was asked to review to circumstances surrounding the death in order to determine if recommendations could be made towards the prevention of future similar deaths.			
2016-06	0	This was a mandatory referral to the Geriatric and Long Term Care Review Committee (GLTCRC) as the manner of death was determined to be homicide. The 80-year-old male decedent died from complications of a hip fracture that he sustained after being pushed by another resident in the long term care home (LTCH) where they both resided.			
2016-07	2	This was a mandatory referral to the Geriatric and Long Term Care Review Committee (GLTCRC) as the manner of death was determined to be homicide. The 84-year-old decedent died after an altercation with another resident (Resident B) while in the long term care home (LTCH) where they both resided.	1. In a congregate living setting, such as a LTCH, physically responsive behaviours can have fatal consequences. Health care professionals in these settings should utilize all available resources to assist in assessment and management of these behaviours. If the behaviours continue despite use of existing resources, efforts should be made to access additional resources, including consulting physicians who specialize in management of responsive behaviours (e.g. geriatric psychiatrists, geriatricians, etc.). 2. Healthcare professionals are reminded that stabilization/immobilization of the neck and head after a fall may be critical to preventing spinal cord	Ministry of Health and Long Term Care	Medical/Nursing Management Medical/Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Responses Received (as of July 2017)	Theme
			injury. Falls in the elderly can lead to unrecognized neck injury, including unstable spinal fractures. An elder who has fallen should not be moved until a physical and neurologic assessment has been completed. This is especially true when there has been obvious injury to the neck and head.		
2016-08	3	This case was referred to the Geriatric and Long Term Care Review Committee (GLTCRC) as concerns were raised after the 71-year-old decedent, who was on a “puree” diet at the long term care home (LTCH) where she resided, died after eating a sandwich in the Emergency Department (ED) of a hospital while awaiting transfer back to the LTCH.	1. A standardized diet terminology should be implemented across healthcare sectors. The work of the International Dysphagia Diet Standardisation Initiative (IDDSI) should be considered by governing and regulatory bodies. 2. All health care and other staff of long term care homes, retirement residences and acute care hospitals that order or administer meals should undergo continued training and education on the standardized diet terminology once the IDDSI is implemented. 3. It is recommended that healthcare facilities, long term care homes and retirement homes, establish a process to verify patient/client name (by way of name bracelet or other method) prior to providing a meal to the patient/client in order to ensure the proper therapeutic meal is delivered to the appropriate person.	Retirement Home Regulatory Authority College of Audiologists and Speech-Language Pathologists of Ontario Dietitians of Canada Health Canada Colleges of Nurses of Ontario College of Dietitians of Ontario	Medical/ Nursing Management Acute and LTC industry Communication/ Documentation, Acute and LTC industry
2016-09	3	This case was referred to the Geriatric and Long Term Care Review Committee (GLTCRC) as concerns were raised about the medical care provided to the 72-year-old	1. Geriatric healthcare providers are reminded that when medically unstable patients are transferred into a new facility, the attending physician should conduct an	Colleges of Nurses of Ontario	Medical/ Nursing Management

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		decedent who resided in a long term care home (LTCH).	assessment of the patient's condition soon after admission. 2. Geriatric healthcare providers are reminded that when a patient presents with diarrhea and poor oral intake, adequate rehydration strategies should be put in place within 48-72 hours of insufficient oral intake for body weight. 3. Geriatric healthcare providers are reminded that pain assessment, especially in the cognitively impaired, needs to be recognized, assessed, treated and monitored. Proper education of nursing staff and physicians working in long term care facilities on appropriate assessment tools for cognitively impaired should be stressed.		Medical/ Nursing Management Medical/ Nursing Management
2016-10	4	This case involved the death of an 83-year-old woman who died in an acute care hospital five days after admission from the retirement home where she resided. The decedent's family expressed concerns regarding the care she received in hospital prior to her death, including nursing care and a perceived lack of clarity and discussion regarding the overall plan of care, particularly as it pertained to critical care interventions.	1. Physicians and nurses should be proactive in discussing wishes for care and treatment in a seriously ill senior; it is important to document all conversations contemporaneously in the health record. Advance care and treatment planning is a dynamic process and wishes and goals may change, especially in a situation of rapidly changing health status. 2. Healthcare professionals are reminded that "Do Not Resuscitate" (DNR) does not mean do not treat. The specific meaning of a DNR order should be clearly discussed with the patient, family and/or Substitute Decision Maker within the context of overall care and treatment planning at the end of life, and in situations of rapidly changing health status. 3. Retirement Homes and Long Term Care Homes are reminded that the only person who can sign advance	Retirement Home Regulatory Authority Colleges of Nurses of Ontario College of Physicians and Surgeons of Ontario	Medical/Nursing Management, Communication/ Documentation Determination of capacity and consent for treatment / DNR

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			documentation of wishes for future care is the resident themselves. In the case of a resident who is incapable of expressing these wishes, a Substitute Decision Maker cannot sign an advance expression of wishes for care. 4. Physicians are reminded that the “DNR Confirmation Form” only directs the practice of paramedics and firefighters outside of hospital, and is meant as a “confirmation” that a duly executed physician order for DNR exists in the community plan of care and treatment for a patient. A potential DNR order in hospital needs to be discussed with the patient or their Substitute Decision Maker at the time of admission to hospital, and with any change in the health status or wishes of a patient, and these discussions documented appropriately.		Determination of capacity and consent for treatment / DNR Determination of capacity and consent for treatment / DNR
2016-11	0	The Geriatric and Long Term Review Committee (GLTCRC) was asked to review the death of this 90-year-old woman after concerns were expressed by the decedent’s family and the investigating coroner regarding the nature and impact of injuries sustained by the decedent.	N/A		
2016-12	3	This case was referred to the Geriatric and Long Term Care Review Committee (GLTCRC) after concerns were raised by the decedent’s family regarding the care provided in the retirement home where the decedent resided.	1. Healthcare providers are reminded that transitions for complex patients often require formal communications such as a meeting of all providers (e.g. acute hospital, family, retirement home, CCAC, etc) to ensure a safe discharge from the acute hospital back to the referring institution, agency or individual. 2. Healthcare providers, including CCAC case managers, are reminded of their duty to fully understand the care needs of a client who is	Retirement Home Regulatory Authority Colleges of Nurses of Ontario	Communication / Documentation Determination of capacity and consent for treatment / DNR

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			incapable when recommending a care facility. 3. Healthcare providers, including CCAC case managers, are reminded of their responsibility to fully understand the nature of care and supervision provided in a facility they recommend for discharge.		Medical / Nursing Management
2016-13	0	This case involved the death of an 87-year-old woman who sustained injuries after falling at the Long Term Care Home (LTCH) where she resided. Concerns were raised relating to the circumstances of the fall and subsequent admission and discharge from the acute care hospital where she was treated for her injuries.	N/A		
2016-14	4	This case was referred to the Geriatric and Long Term Review Committee because of concerns raised by the investigating coroner. The decedent, a 60-year-old resident of a long term care home (LTCH), died after the non-invasive ventilator that he was using was inadvertently disconnected.	1. Healthcare staff are discouraged from disconnecting or resetting the alarm on non-invasive ventilators without a proper analysis of the circumstances surrounding activation of the alarm. 2. Facilities providing care to residents or patients that are fully dependent on non-invasive ventilators should develop protocols and procedures detailing the frequency of checks, assessment and documentation of functioning alarms and guidelines on the physical placement of devices with due consideration of functionality and interaction with other devices (e.g. adjustable beds) and access to an uninterrupted power source. 3. The College of Respiratory Therapists, College of Physicians and Surgeons, College of Nurses of Ontario and Ontario Hospital Association are encouraged to publish the facts of this case as a "Lessons Learned Case Review."	Ontario Hospital Association	Medical / Nursing Management Medical / Nursing Management Medical / Nursing Management

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			4. Health Canada should explore the nature and use of alarms in BiPAP devices.		Other
2016-15	0	The GLTCRC was asked to review the circumstances surrounding the death of this 77-year-old woman from a pulmonary thromboembolism following discharge from hospital. The focus of this review was the community care provided to the woman after discharge.	N/A		
2016-16	2	This case involved the death of a 63-year-old man with dementia, who died from trauma after being struck by a vehicle outside of the supervised community residence where he had recently been admitted following discharge from an acute care hospital. Concerns were identified relating the level of supervision provided to the decedent.	1. Healthcare providers and CCAC case managers are reminded of the following: • their duty to fully understand the care needs of their client/patient when developing discharge plans • their responsibility to fully understand the nature of care, supervision and security provided at the facilities recommended for discharge • their responsibilities and provincial regulations relating to substitute decision makers 2. The acute care hospital and supervised community residence involved should conduct a lessons learned review focusing on the referral and recommendation process with particular regard to the specific care needs of the patient/client.		Medical / Nursing Management, Determination of capacity and consent for treatment / DNR Medical / Nursing Management
2016-17	2	This case involved the death of an 88-year-old man who died from asphyxia secondary to obstruction of nares and wedging of the face in a “Halo safety ring” that was attached to the bed in the retirement home (RH) where he resided.	1. The Regional Supervising Coroner should ensure that this death has been reported to Health Canada using the Bed-related Entrapment and Fall Report Form. 2. Healthcare providers are reminded of the following recommendations previously made by the GLTCRC relating to the use of bedrails: (2012-18-4) Healthcare providers are reminded that bed rails pose a significant safety risk to patients/residents, especially split	Retirement Home Regulatory Authority	Other Use of restraints

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			side rails. The benefit of bed rails is almost always outweighed by the potential for harm and therefore, alternatives to the use of bed rails should always be sought (and documented). The use of side rails may constitute a restraint and therefore all the usual standard policies for restraints, including physician's orders, must be followed. (2012-4-1) Long-term care providers are reminded that positional asphyxia is a real risk with any type of restraint. All acute care and long-term care facilities, both licensed and unlicensed, should have a detailed policy regarding the use of restraints (chemical and physical, including bed side rails). All staff caring for patients should review these policies (i.e. inservices) on a regular basis. New staff should be oriented to these policies prior to commencing patient contact. These policies should include detailed instruction on the various types of restraints, their application, and ways to maximize safety. These policies should be consistent with the Long Term Care Homes and Retirement Homes acts.		
2016-18	3	This case involved the death of a 77-year-old woman who died as a result of bilateral subdural hematomas. The woman had been receiving warfarin therapy for stroke prophylaxis. Concerns were identified related to the monitoring of INR at the Long Term Care Home (LCTH) where the woman resided.	1. The attending physicians, registered staff and pharmacist for this long term care home should review the Anticoagulant Therapy Protocol and be aware of the need for regular and as needed monitoring of the INR, especially when there is a change in health status. 2. All long term care homes should revise their standardized admission order sets to include automatic monitoring of INR on a prescribed basis and reassessment with medication changes, changes in dietary intake or health status. Further modifications could include monitoring of medications requiring	Colleges of Nurses of Ontario	Medical / Nursing Management Medical / Nursing Management

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			dosage adjustments for toxicity or therapeutic range. 3. Healthcare providers in long term care homes are reminded of the following previous recommendations made by the GLTCRC pertaining to identification, assessment and management of changes in health status of residents: 2012-16-3, 2014-6-2, 2014-7-3, 2015-29-1.		Medical / Nursing Management, Communication / Documentation
2016-19	4	This case was referred to the Geriatric and Long Term Care Review Committee (GLTRC) because concerns were raised by the family regarding the care provided to the 88-year-old decedent who died of multiple organ failure following a prolonged vegetative state.	1. All members of the healthcare team should have a clear understanding of the Health Care and Consent Act in Ontario, particularly if they work in long term care and intensive care environments. 2. Healthcare providers are reminded that residents of long term care facilities in Ontario should receive their primary medical care on-site. 3. Where conflict exists between substitute decision maker(s) and the treating medical team, the conflict should not interfere with patient-centered decision making. If such conflict does interfere with patient care, then formal processes, such as the Consent and Capacity Board, should be utilized to establish clarity in the direction of care. Health care providers are reminded that conflict cannot simply be ignored in the hope that issues will simply resolve with time. 4. The Consent and Capacity Board (CCB) should conduct a comprehensive public education campaign to inform members of healthcare teams and institutions on the Health Care and Consent Act and the role and responsibilities of the CCB.		Determination of capacity and consent for treatment / DNR Acute and LTC industry Determination of capacity and consent for treatment / DNR Determination of capacity and consent for treatment / DNR
2016-20	2	This case involved a 95-year-old woman who died from complications of a fractured left hip after a fall in the retirement home (RH) where	1. Care providers are reminded that comprehensive care planning for each new resident should occur according to the regulations set out in the Ontario Retirement Homes		Medical / Nursing Management

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		she resided. Concerns were identified relating to the management of falls and fall risk mitigation policies and plans within the RH.	Act. This care planning should include a plan for falls prevention if there is a history of falls, or the resident is identified at high risk for a fall. 2. Diagnosis and treatment of osteoporosis is an important part of preventing serious injuries, and should be undertaken in elders who sustain a fall. Persons who have sustained a fragility fracture should particularly be targeted for treatment of osteoporosis.		Medical / Nursing Management
2016-21	0	This case was referred to the Geriatric and Long Term Care Review Committee (GLTCRC) as concerns were identified by the family regarding the use of psychotropic medications and/or laxatives in the long term care home (LTCH) where the decedent resided.	N/A		
2016-22	0	This was a mandatory referral to the Geriatric and Long Term Care Review Committee (GLTCRC) as the manner of death was determined to be homicide. The 91-year-old decedent died after an altercation with another resident while in the long term care home (LTCH) where they both resided.	N/A		
2016-23	4	This case was referred to the Geriatric and Long Term Care Review Committee (GLTCRC) after concerns relating to the circumstances of the death were identified by the Regional Supervising Coroner. The decedent was a 95-year-old man who resided in a long term care home (LTCH). He died of plastic bag asphyxia after complaining of severe uncontrolled pain related to a compression	1. Healthcare providers are reminded that anticholinergic medications should not be prescribed to the elderly in the treatment of nausea. 2. Healthcare providers are reminded that treatment plans should be developed and administered in consultation with other members of the team. Any changes to a plan should be communicated and discussed with other team members. 3. All physicians and healthcare staff working in long term care facilities		Medical / Nursing Management Medical / Nursing Management, Communication/ Documentation

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		fracture of the spine. He had no mental health diagnoses and no cognitive impairment.	should receive appropriate training and education on the principles of recognition of pain in the elderly as well as the complications associated with poorly managed pain. Inadequate treatment of pain will often result in sleep abnormalities and signs and symptoms of depression. 4. All staff and healthcare professionals should be reminded that elderly patients are to be considered capable of making treatment decisions unless proven otherwise as referenced in the Healthcare Consent Act. A substitute decision maker should only be involved when it has been determined that an individual is incapable of making decisions.		Medical / Nursing Management Determination of capacity and consent for treatment / DNR

Questions and comments regarding this report may be directed to:

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