

Office of the Chief Coroner
Province of Ontario

December 2019



Geriatric and Long Term Care Review Committee

2018 Annual Report

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Message from the Chair



It is my pleasure to present to you the 2018 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 2018, the GLTCRC reviewed 20 cases, involving 20 deaths and generated 43 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.

Long-Term Care deaths were under particular public scrutiny when Justice Eileen Gillese was appointed commissioner of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System on August 1, 2017. While the recommendations were not released until June 2019, they will have a significant impact on how future deaths in long term care are managed and investigated by both health and justice sectors. The OCC accepted the recommendations and is working on an implementation strategy.

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 (2018)

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. Dov Gandell

Geriatrician

Dr. Heather Gilley

Geriatrician

Dr. Barry Goldlist

Geriatrician

Dr. Rebekah Jacques

Pathologist

Dr. Mark Lachmann

Geriatric Psychiatrist/Coroner

Dr. Andrea Moser

Family Physician

Dr. Joel Ross

Family Physician/Coroner

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 2018, the GLTCRC reviewed 20 cases involving 20 deaths and generated 43 recommendations directed toward the prevention of future deaths. Of the 20 cases reviewed, five resulted in no recommendations.
- Of the 20 deaths that were reviewed in 2018, the breakdown for manners of death were:
 - Natural - 5 (two males and three females)
 - Accident - 9 (two males and seven females)
 - Homicide* - 4 (one male and three females)
 - Undetermined – 2 (one male and one female)
- Of the 20 deaths reviewed, six were male and 14 were female.
- The average age of men whose deaths were reviewed was 83.2 years.
- The average age of women whose deaths were reviewed was 83.6 years.
- The average age of all deaths reviewed in 2018 was 83.6 years.
- In 2018, the most common areas for improvement identified by GLTCRC through their case reviews and resulting recommendations consisted of:
 - Medical and nursing management
 - Communication and documentation
 - Use of drugs in the elderly
 - Acute care and long-term care industry in Ontario, including the Ministry of Health and Long Term Care (MOHLTC)
 - Other (e.g. quality reviews, referrals to other organizations)

***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 and 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 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 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. Redacted versions of reports are publicly available by contacting occ.inquiries@ontario.ca.

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 six months 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 2018 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: 2004-2018

Between 2004 and 2018, the GLTCRC reviewed a total of 320 cases and generated 723 recommendations aimed towards the prevention of future similar deaths. On average, the GLTCRC has reviewed 21.3 cases and generated 48.2 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.

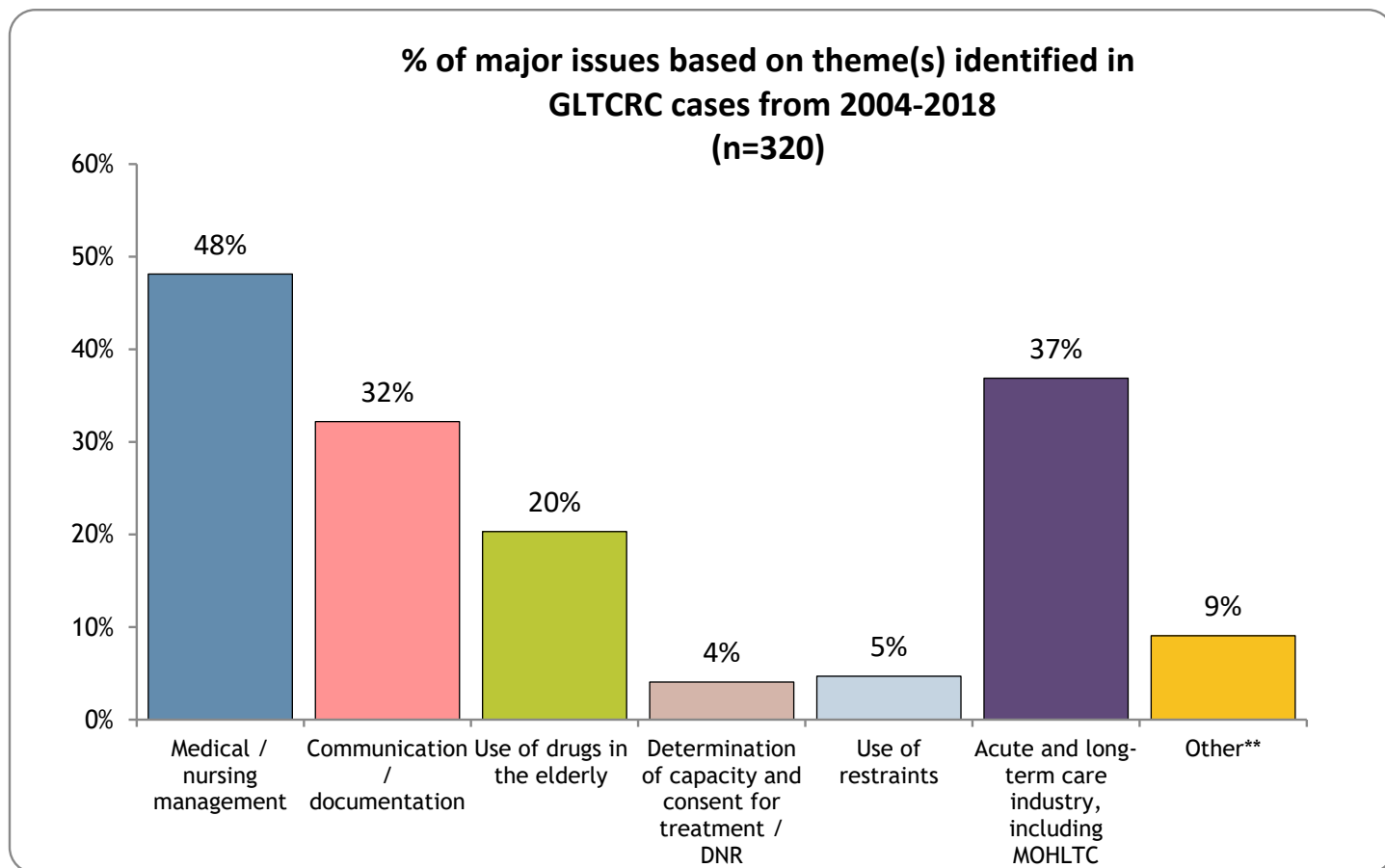
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

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 2004-2018

From 2004 until 2018, the GLTCRC has reviewed a total of 320 cases.

Many cases had more than one theme/issue attributed to the recommendations.

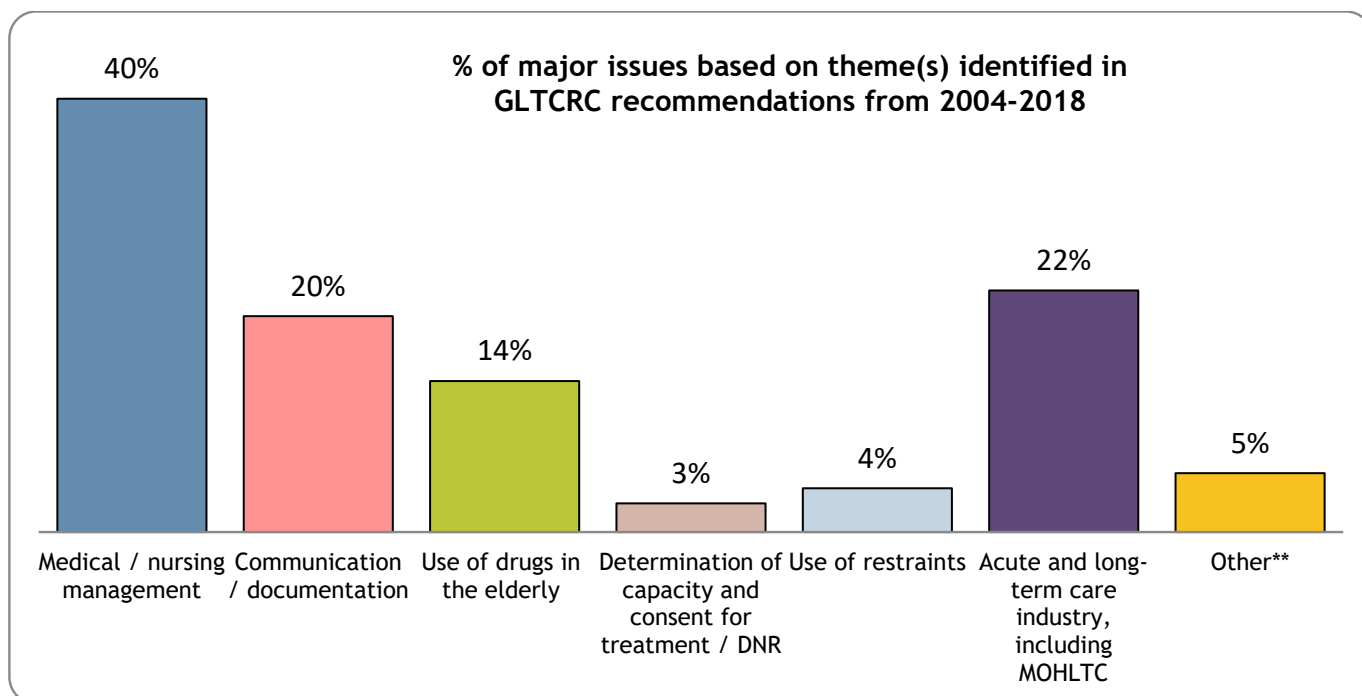


****Note:** 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph One demonstrates that in 48% of the cases reviewed by the GLTCRC from 2004-2018, 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 32% of the cases where issues of communication/documentation were present. Other key themes included use of drugs in the elderly (20%), use of restraints (5%), determination of consent and capacity/DNR (4%) and other (9%).

Graph Two: % of major issues based on theme(s) identified in GLTCRC recommendations (2004-2018)

From 2004 until 2018, the GLTCRC generated 723 recommendations aimed at the prevention of future similar deaths.



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

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

Graph Two demonstrates the percentage of common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004-2018. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 40% of all recommendations made were related to medical or nursing management while 22% 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 (14%), determination of capacity and consent for treatment or DNR (3%), the use of restraints (4%) and other (5%).

Chapter Three: Cases Reviewed in 2018

In 2018, the GLTCRC reviewed a total of 20 cases involving the deaths of 20 elderly individuals (14 females and six males), including residents of long-term care and retirement homes. Of the 20 cases, four were mandatory reviews resulting from homicides that occurred in long term care facilities.

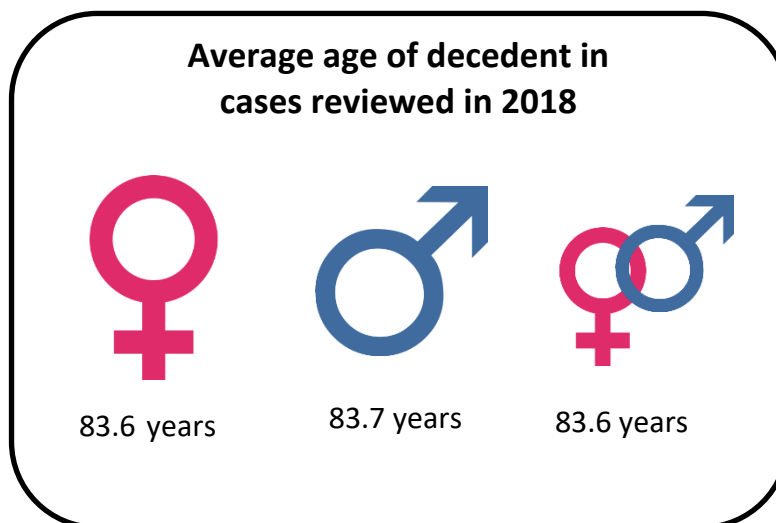
Of the 20 cases reviewed in 2018, one of the deaths occurred in 2013, one in 2015, six in 2016 and 12 in 2017.

[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.]

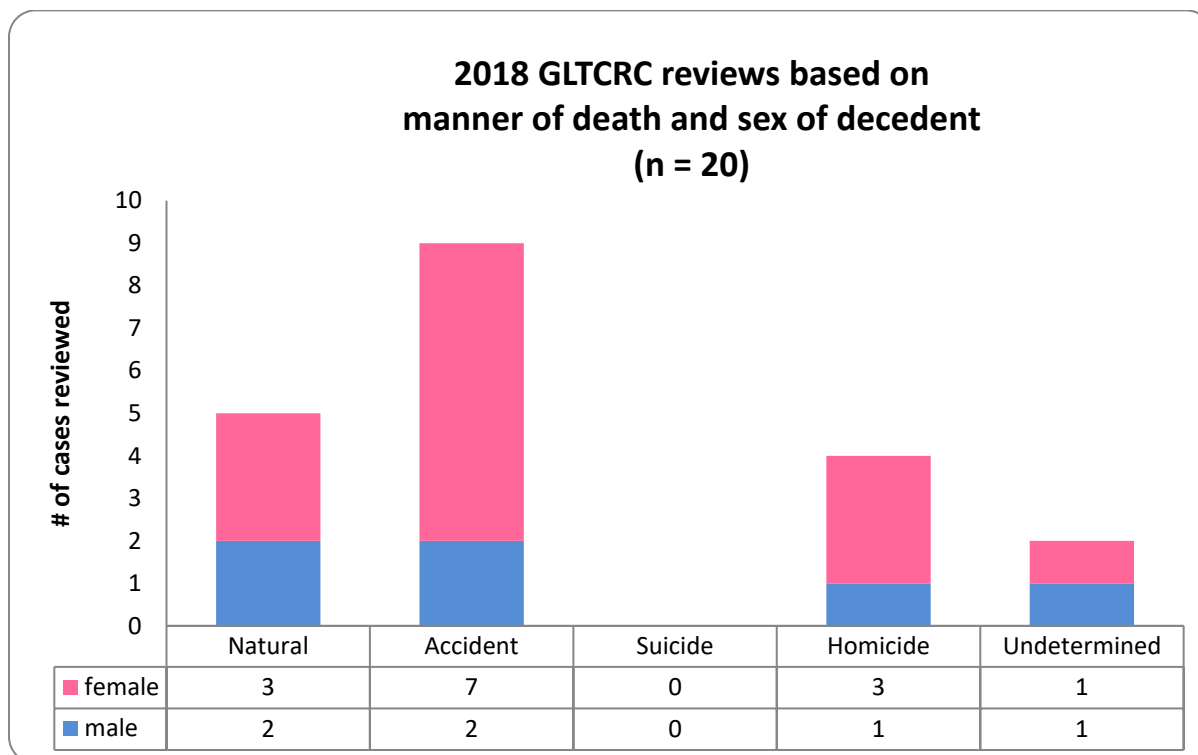
A summary of cases reviewed, and recommendations made in 2018 is included in Appendix A.

Full, redacted reports and responses to recommendations may be obtained by contacting the OCC at occ.inquiries@ontario.ca.

From the cases reviewed in 2018, the average age of all decedents was 83.6 years.



Graph Three: 2018 GLTCRC reviews based on manner of death and sex of decedent



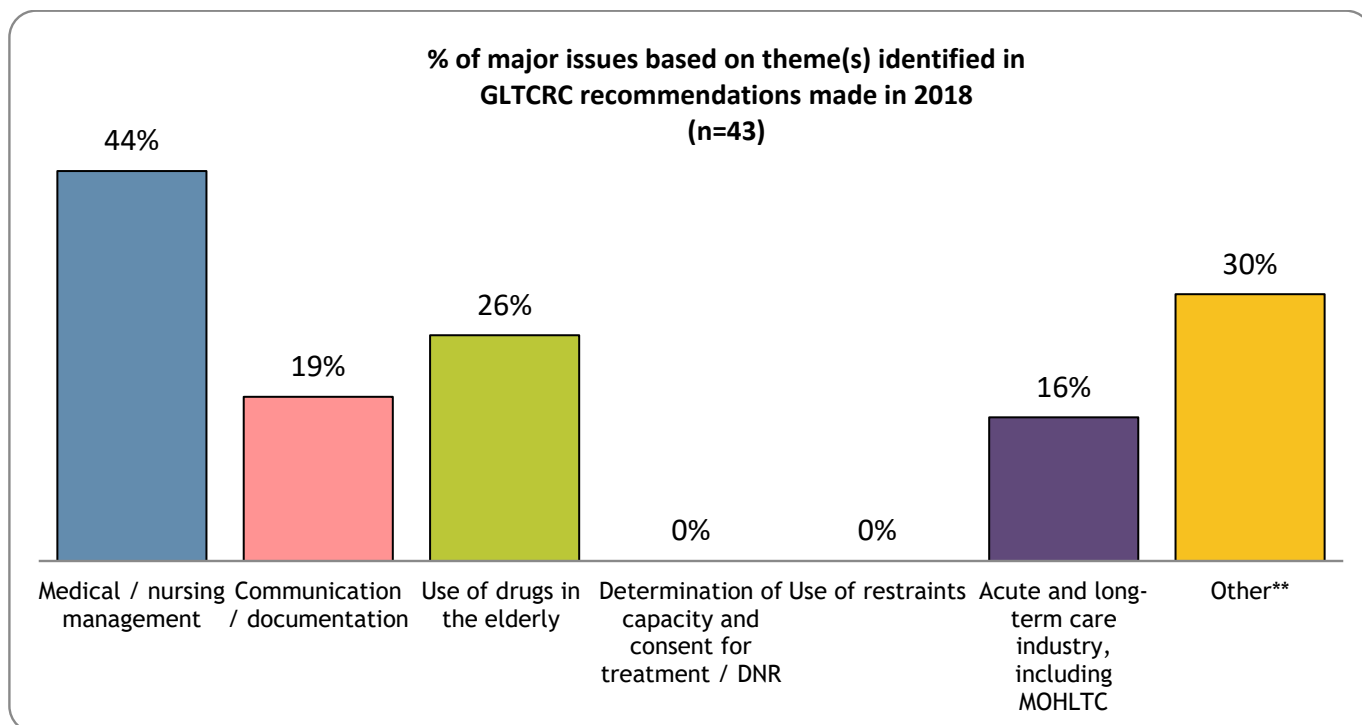
Graph Three demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 20 cases reviewed, five were natural (three females and two males), nine were accidents (seven females and two males), four were homicides (three females and one male), two were undetermined (one female and one male) and there were no suicide cases reviewed.

In 2018, the GLTCRC generated a total of 43 recommendations aimed at preventing future similar deaths. There were five 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 six months. 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 Four: % of major issues based on theme(s) identified in GLTCRC recommendations made in 2018



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

Graph Four demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2018. The most commonly identified themes/issues were related to medical or nursing management (44%), the acute and long term care industry (16%), communication and documentation (19%), use of drugs in the elderly (26%), “other” (including recommendations to the police and Regional Supervising Coroners) (30%). There were no recommendations made in 2018 pertaining to consent for treatment/DNR or use of restraints.

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 2018:

- In 2018, there were 20 cases reviewed and 43 recommendations made.
- Of the 20 cases reviewed in 2018, one of the deaths occurred in 2013, one in 2015, six in 2016 and 12 in 2017.
- Medical/nursing management issues were identified in 44% of the recommendations made.
- Communication and documentation issues were identified in 19% of the recommendations made.
- MOHLTC and/or LTC industry issues were identified in 16% of the recommendations made.
- 'Other' (including recommendations to police services and Regional Supervising Coroners, etc.) was identified in 30% of the recommendations made.
- Use of drugs in the elderly was identified in 26% of the recommendations made.
- None of the recommendations touched on the use of restraints in the elderly or determination of consent and capacity / DNR.
- Some of the recommendations touched on more than one issue.
- There were five cases that did not have any recommendations.
- Of the 20 cases reviewed, 14 involved female decedents and six male decedents.
- The average age of all decedents (i.e. male and female combined) in cases reviewed in 2018 was 83.6 years.
- Of the cases reviewed in 2018, the manner of death for each of the 20 cases was broken down into: natural (5), accident (9), homicide (4) and undetermined (2). There were no cases of suicide reviewed in 2018.

Chapter Four: Learning from GLTCRC Reviews

Recurrent themes from the GLTCRC include violence in long-term care (LTC), elder abuse, medical management including medication use, restraints, consent and capacity and the management of dementia and psychiatric illness.

The elderly as a population present challenges in the management of complex medical and psychiatric conditions; they are best served by a multidisciplinary team of providers with specialized skills. This starts at the level of training and finishes with oversight and effective quality review.

The long-term care industry is one of the most regulated in our society. The committee often finds that what is needed is not more regulation, but rather adequate resourcing to meet the prescribed standards.

Violence in LTC has received much attention within the sector and from the public. Strategies have been developed and resources deployed, yet the problem persists. The GLTCRC recognizes the need for government, regulators, industry and care providers to continue to collaborate on a comprehensive approach to address this issue. Management of aggressive behaviour should be a primary consideration as government pursues facility renewal and expansion.

Regarding consent and capacity, organizational practices often do not reflect the law as it applies to the use of advance directives, “do not resuscitate” (DNR) 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 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 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 2018 Cases and Recommendations

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
2018-01	3	The Geriatric and Long-Term Care Review Committee (GLTCRC) was asked to review the circumstances surrounding the death of this 87-year-old woman who died shortly after two visits to the local acute care emergency department (ED) following falls at the retirement home (RH) that she resided in. The decedent's family was concerned about the quality of care provided in the ED after the first visit, and a perceived unsafe environment at the RH with an unlocked stairwell door.	1. The hospital should undertake a quality of care review of this case. The main issue for discussion should be the recognition, assessment and treatment of delirium. 2. Discussions and panels on violence in long-term care facilities should consider how to screen individuals with dementia and increased risk of violent behaviour in order to identify appropriate levels of care and safety. 3. Physicians are reminded of the importance of completing a thorough and timely admission assessment of all new residents. The assessment must occur according the Long-Term Care regulations, within seven days of a new resident being admitted to the home. As part of the admission assessment, the physician should review and examine all documentation related to the medical history and ongoing medical problems and treatments of the new resident, including the records from the previous primary care physician, and records from hospitals and other care programs.	Medical / Nursing Management Medical / Nursing Management Medical / Nursing Management
2018-02	3	This case involved the death of a 72-year-old woman who died after being stabbed by her 82-year-old husband. The husband (perpetrator) lived in a long-term care home (LTCH), but was visiting family outside of the facility when the homicide took place. The perpetrator had dementia and a history of paranoid delusions. The perpetrator was deemed unfit to stand trial.	1. Individuals admitted to long-term care with dementia and psychosis should be assessed by specialist geriatric mental health teams and followed up on a regular basis. 2. Discussions and panels on violence in long term care facilities should consider how to screen individuals with dementia and increased risk of violent behaviour in	Medical / Nursing Management Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			order to identify appropriate levels of care and safety. 3. Long-term care and retirement residences are encouraged to document full and complete histories of residents upon admission to the facility.	Communication/ Documentation
2018-03	8	This case involved the death of an 83-year-old woman who died of severe hypothyroidism approximately three months after admission to a Long-Term Care Home (LTCH). Her long-term thyroid replacement medication had been erroneously omitted from her medications when she was admitted to the LTCH, and she did not receive any thyroid replacement medication for the duration of her residency.	1. This medication incident should be reported to the Canadian Medication Incident Reporting and Prevention System (http://www.cmirps-scdpim.ca/) and the Institute for Safe Medication Practices (https://www.ismp.org/). 2. Physicians are reminded of the importance of completing a thorough and timely admission assessment of all new residents. The assessment must occur according the Long-Term Care regulations, within seven days of a new resident being admitted to the home. As part of the admission assessment, the physician should review and examine all documentation related to the medical history and ongoing medical problems and treatments of the new resident, including the records from the previous primary care physician, and records from hospitals and other care programs. 3. Consulting pharmacists are reminded that the pharmacy review for a new LTCH resident should occur in a timely manner according to the LTC regulations. This initial consultation should include a review of pre-admission medications. 4. Pharmacists working in Long-Term Care should be granted access to the "Ontario Drug Benefit Program Drug Profile Viewer" in order to optimize the accuracy and value of their consultation. 5. A requirement for a process of standardized and formal medication reconciliation, with dedicated staff, at times of admission and return (from	Use of Drugs in the Elderly Medical / Nursing Management Communication/ Documentation Medical / Nursing Management Use of Drugs in the Elderly Use of Drugs in the Elderly Acute and long-term care industry, including MOHLTC Use of Drugs in the Elderly

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			hospital) to Long-Term Care should be added to the Long-Term Care Home regulations. 6. This licensee should review its policy and procedures dealing with medication reconciliation to ensure they represent best practices and current standards in health care. In particular, the health professionals admitting a resident must have dedicated time set aside from other duties to perform the task of medication reconciliation. 7. The Regional Supervising Coroner should consider meeting with the clinical leadership of the Long-Term Care Home in this case, including the attending physician and medical director, for a discussion of the facts of this case and the committee's recommendations. 8. The OLTCC should consider an educational session on medication reconciliation at their annual educational conference.	Acute and long-term care industry, including MOHLTC Medical / Nursing Management Use of Drugs in the Elderly Other Use of Drugs in the Elderly
2018-04	3	This case involved the death of an 85-year-old woman who died while a resident of a long term care home (LTCH). The manner of death was undetermined and the cause of death was not definitive. Concerns were raised about the facility's response to the resident's death (i.e. where she died and where she was moved to) and the medication prescribed (specifically regarding the dose of sertraline and the drug's potential for adverse events).	1. Patients with dementia should be carefully assessed for precipitating conditions and inter-current medical illnesses (e.g. delirium), before treatment is started. 2. Management of responsive behavioural disturbances in dementia is difficult and requires a multi-faceted, coordinated and inter-professional plan that includes more than just psychotropic medications. When drugs are used, the risks and benefits must be carefully reviewed, monitored and communicated with all involved. 3. Expert psychogeriatric help should be obtained in difficult cases. If a community does not have such expertise, the local LHIN should be lobbied to provide funding to develop such a consulting service. Behavioural Support Ontario	Medical / Nursing Management Medical / Nursing Management Use of Drugs in the Elderly Medical / Nursing Management Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			(BSO) and the Ontario Telemedicine Network, are valuable resources.	
2018-05	1	This case involved the death of a 95-year-old woman who died after falling at a Long-Term Care Home (LTCH) where she was visiting a friend. The fall was not witnessed and may have resulted from a pushing incident involving other residents at the facility. Concerns were raised by the decedent's family as the incident was not initially reported to the MOHLTC or to the police.	1. Long-Term Care Homes are reminded that if an assault, or possible assault has occurred on the premises, police should be immediately notified.	Communication/ Documentation
2018-06	3	This case involved the death of an 83-year-old woman who died after complications of injuries sustained in a fall that occurred while she was a resident in a retirement home (RH).	1. The hospital and retirement home involved should conduct reviews of their protocols and assessments for: a) post-falls in the elderly and b) narcotic bowel management 2. Emergency Department physicians and nurses are reminded that examination of elderly post-fall patients should include an assessment of functional change in status. 3. Practitioners prescribing and administering narcotics to the elderly should follow standard practice guidelines for the recognition and management of narcotic-induced side effects, including constipation. Constipation should be an anticipated side effect of narcotic use in elderly, and should be managed proactively, not reactively.	Medical / Nursing Management Medical / Nursing Management Use of Drugs in the Elderly
2018-07	3	This case involved the death of an 84-year-old woman who was a resident of a long-term care home (LTCH). The woman died after an altercation with a personal support worker (PSW) that worked in the home.	1. The long-term care home involved should engage the local psychogeriatric resource consultant (PRC) to review the circumstances of this case from an educational perspective, with all staff providing direct care in the home, to reduce the likelihood of future similar events.	Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			2. The MOHLTC should consider revisions to regulations associated with the Long-Term Care Homes Act, specifically to section 2007, c. 8, s. 76(7), to provide more specific direction to LTCHs regarding the nature, duration and activities required to fulfil the objective of appropriate management of behavioural and psychological symptoms (BPSD)/responsive behaviours in LTCHs. Advice for this content could be sought from, and could be developed by, experts in this field (e.g. the Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRIs). 3. Consideration should be given to providing LTCHs with additional funding to backfill staff positions during training events that will encourage and promote the meaningful and effective incorporation of knowledge into practice.	Acute and long-term care industry, including MOHLTC Acute and long-term care industry, including MOHLTC
2018-08	0	This case involved the death of an 84-year-old woman who died post-operatively after an elective total abdominal hysterectomy and bilateral salpingo-oophorectomy. Concerns were raised about the recognition of hyponatremia by the healthcare team involved.	No recommendations.	
2018-09	1	This case involved the death of a 95-year-old female who died from pulmonary emboli following a hip fracture. Concerns were raised by the decedent's Power of Attorney (POA) regarding the quality of care at the long-term care home (LTCH) where the decedent resided and about the use of restraints.	1. The acute care hospital involved in this case should carry out a quality of care review regarding post-operative venous thromboembolism management.	Other
2018-10	2	This case involved the death of a 75-year-old woman from complications of	1. Physicians and nurse practitioners are reminded of the Canadian Opioid Guidelines when prescribing opioids to	Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		hydromorphone use. Concerns were raised regarding the use of opioids with elderly patients.	elderly patients, particularly when other drugs such as benzodiazepines are also being used. 2. The College of Physicians and Surgeons are encouraged to publish the details of this review in the publication Dialogue to provide further education on the use of opioids with elderly patients.	Use of Drugs in the Elderly Use of Drugs in the Elderly Other
2018-11	0	The decedent was a 68-year-old man with a history of a major neurocognitive disorder who died of sepsis due to Fournier's gangrene. Concerns were identified relating to a lack of communication and coordinated care, including discharge planning, between service providers.	No recommendations.	
2018-12	5	This case involved the death of a 79-year-old woman with dementia who was living in a long-term care home (LTCH) until she was moved out of the facility to live with her daughter in the community. Concerns were identified regarding possible abuse or neglect of a palliative patient with end-stage dementia.	1. Acute care hospitals should consider an ethics consultation (or psychiatric consultation) when elder neglect and/or elder mistreatment is suspected before finalizing a discharge for a vulnerable person who is incapable of making treatment and/or shelter decisions. 2. Police services should receive formal dementia education, including the management of cases involving possible elder mistreatment and/or neglect. 3. LHIN Home and Community Care services should consider referral to a LHIN-funded Palliative Care Nurse Practitioner (PCNP) for in-home nurse practitioner services for any client with end-stage dementia who is housebound and does not have access to primary care. 4. Hospital A should conduct a review of discharge policies, particularly as they relate to follow-up resources (like a family physician and the personal support worker services), the status of environmental and social conditions that the patient is to be	Medical / Nursing Management Other Medical / Nursing Management Acute and long-term care industry, including MOHLTC Other

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			discharged to and any concerns or issues that may have been previously identified (e.g. paramedic incident report). 5. The paramedic service involved should review protocols for following up on concerns identified in incident reports prepared by responding EMS staff.	Other
2018-13	1	This case involved the death of an 85-year-old man after an unwitnessed fall that might have resulted from being pushed by another resident on the Special Behaviour Unit of the rehabilitation hospital where they both lived.	1. The hospital involved is reminded that assaults, or incidents that may have resulted from assaultive behaviour between or involving patients, residents, visitors or staff, should be reported to police.	Other
2018-14	0	This case involved the death of an 86-year-old man who died after being pushed by another resident in the long-term care home (LTCH) where they both resided. This was a mandatory referral to the Geriatric and Long-Term Care Review Committee (GLTCRC) as the manner of death was homicide.	No recommendations.	
2018-15	0	This case involved the death of a 93-year-old male resident of a long-term care home (LTCH) who died after suffering a second hip fracture four months after his first hip fracture. Following the initial fall, the LTCH utilized seatbelts in the decedent's wheelchair. The decedent's family was concerned about the level of supervision in the LTCH.	No recommendations.	
2018-16	2	This case involved the death of a 78-year-old woman who died after becoming entrapped in the bed that she used at the long-term care	1. In facilities where bed and chair alarm systems are used for patient/resident safety, staff must be trained in the proper use of the alarm systems and appropriate maintenance and repair.	Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		home (LTCH) where she resided.	2. Facilities where beds with rails are used are reminded that beds, rails and mattresses work together as a system to prevent bed entrapment. A process and/or policy should be in place for annual assessment of safety standards of these systems and reassessment when any part of the system (like a mattress) is changed or altered. Each individual patient or resident should be assessed in their need for a rail.	Medical / Nursing Management
2018-17	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 90-year-old decedent died at a post-acute hospital (PAH) six days after an incident involving another patient (Patient A).	No recommendations.	
2018-18	2	The decedent was an 82-year-old man who lived in a retirement home (RH). The man died while sleeping and his body was not discovered by staff until several days later. Concerns were raised about care agreements/plans, including the frequency and thoroughness of checks on residents.	1. The retirement home involved should clearly define what a “safety check” is, how it will be conducted, when it will be done (including frequency) and who will conduct it. This information should be clearly documented in agreements made with residents and articulated with family and/or other care providers. 2. Retirement homes are reminded to have clearly documented agreements of care for each resident that are monitored and updated regularly.	Communication/ Documentation Other Communication/ Documentation Other
2018-19	2	The Geriatric and Long-Term Care Review Committee (GLTCRC) was asked to review the circumstances surrounding the death of this 88-year-old male who died from complications of a hip fracture sustained after a fall in the retirement home (RH) where he lived. The fall and subsequent response by staff was captured on video surveillance.	1. It is recommended that when there is a sudden increase in an individual’s fall rates, the retirement home involved should consider seeking a medical evaluation to rule out physical causes in addition to environmental and behavioral modifications. 2. It is recommended that the retirement home involved consider staff education related to falls and dementia. Falls remain common in older people, with higher prevalence and injury rates in those who are cognitively impaired.	Medical / Nursing Management Other

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
2018-20	4	This case involved the death of an 80-year-old woman who died from complications of a hip fracture sustained after a fall while transitioning from a four-wheeled “rollator” personal mobility device to a stair lifter in the retirement home where she resided. Concerns were raised about the structural integrity of the mobility device involved.	1. The manufacturer of the NeXus mobility device should improve their website and other publicly accessible materials to include information on: safety, proper care and inspection of the device (e.g. avoiding UV damage) and replacement of parts etc. A history of recalls should be noted and what individuals should do in the event their devices has been recalled, or appears to be faulty. 2. The manufacturer of the NeXus mobility device is encouraged to initiate outreach programs to proactively encourage periodic safety checks through authorized dealers and retailers of the NeXus walker, as well as healthcare professionals involved in the care of individuals using this walker. 3. The RHRA should encourage all retirement homes to periodically check medical devices, including mobility aids, for structural and/or mechanical problems. Retirement homes are encouraged to monitor the Health Canada and manufacturer websites and other publicly available material, for recalls and/or alert notices. 4. Retirement homes are reminded and encouraged to report problems with any medical device to the appropriate bodies including Health Canada and the company whose product may be involved.	Communication/ Documentation Other Communication/ Documentation Other Other Communication/ Documentation

Questions and comments regarding this report may be directed to:

Geriatric and Long-Term Care Review Committee

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