2019 Report of the Geriatric and Long-Term Care Review Committee

Office of the Chief Coroner of Ontario
December 2020

Table of Contents

Message from the Chair

It is my pleasure to present to you the 2019 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 2019, the GLTCRC reviewed 27 cases, involving 28 deaths and generated 64 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.

The recommendations of the Long-Term Care (LTC) Public Inquiry were released in June 2019. Since then, government, the LTC industry and organizations representing health care providers have been busy developing their responses. I am pleased to be involved with the tasks assigned to the Office of the Chief Coroner, aimed at improving death investigation in LTC and increasing the awareness of vulnerabilities of the elderly, including intentional harm by those providing care. The GLTCRC has applied the lessons learned from the inquiry to their reviews.

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: mailto:mocc.inquiries@ontario.ca.

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

Committee Membership (2019)

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. Barry Goldlist
Geriatrician

Dr. Mark Lachmann
Geriatric Psychiatrist/Coroner

Dr. Andrea Moser
Family Physician

Dr. Joel Ross
Family Physician/Coroner

Ms. Anne Stephens
Clinical Nurse Specialist

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 2019, the GLTCRC reviewed 27 cases involving 28 deaths and generated 64 recommendations directed toward the prevention of future deaths. Of the 27 cases reviewed, five resulted in no recommendations.
- Of the 28 deaths that were reviewed in 2019, the breakdown for manners of death were:
    - Natural - 11 (six males and five females)
    - Accident - 9 (two males and seven females)
    - Homicide* - 6 (four males and two females)
    - Undetermined – 2 (two males and no females)
    - Of the 28 deaths reviewed, 14 were male and 14 were female.
    - The average age of men whose deaths were reviewed was 82.4 years.
    - The average age of women whose deaths were reviewed was 86 years.
    - The average age of all deaths reviewed in 2019 was 84.2 years.
- In 2019, 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 future deaths. 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 substitute member may be asked to participate in the review or 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 future deaths. 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 2019 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: 2004-2019

Between 2004 and 2019, the GLTCRC reviewed a total of 347 cases and generated 787 recommendations aimed towards the prevention of future similar deaths. On average, the GLTCRC has reviewed 21.6 cases and generated 49.1 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.

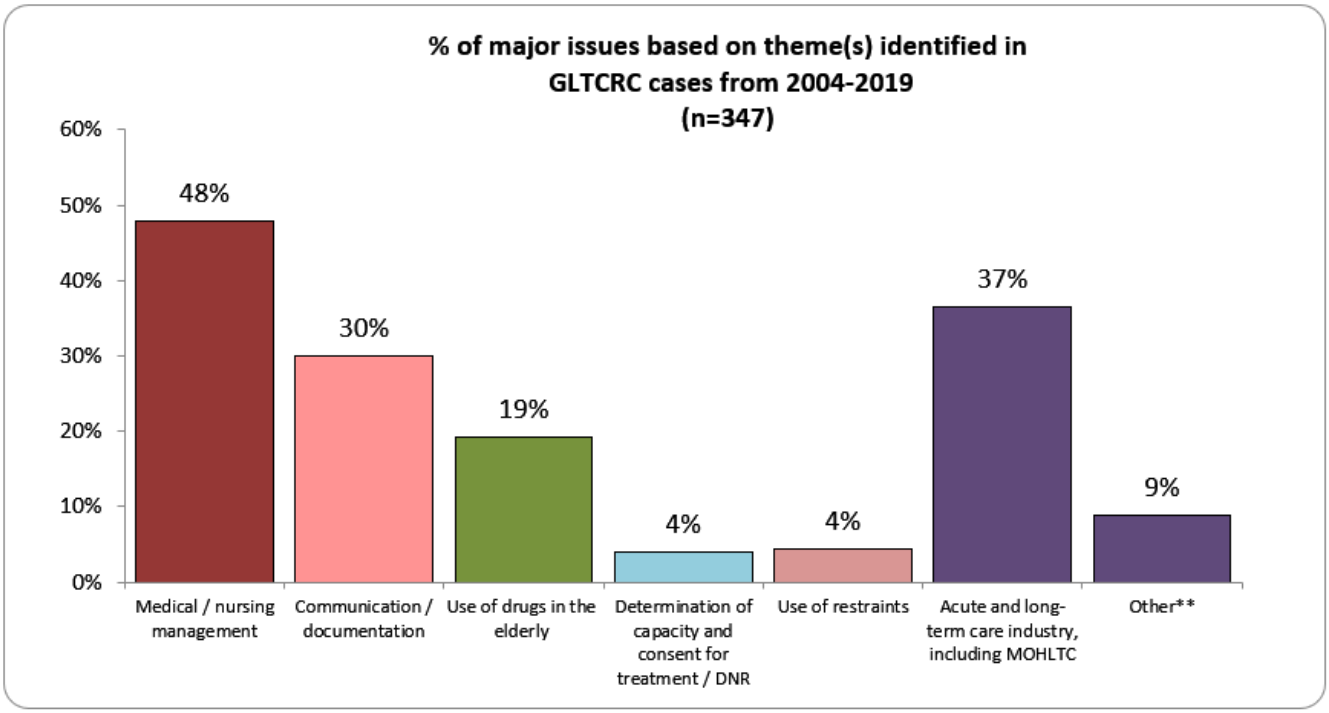
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

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 2004-2019

From 2004 until 2019, the GLTCRC has reviewed a total of 347 cases.

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

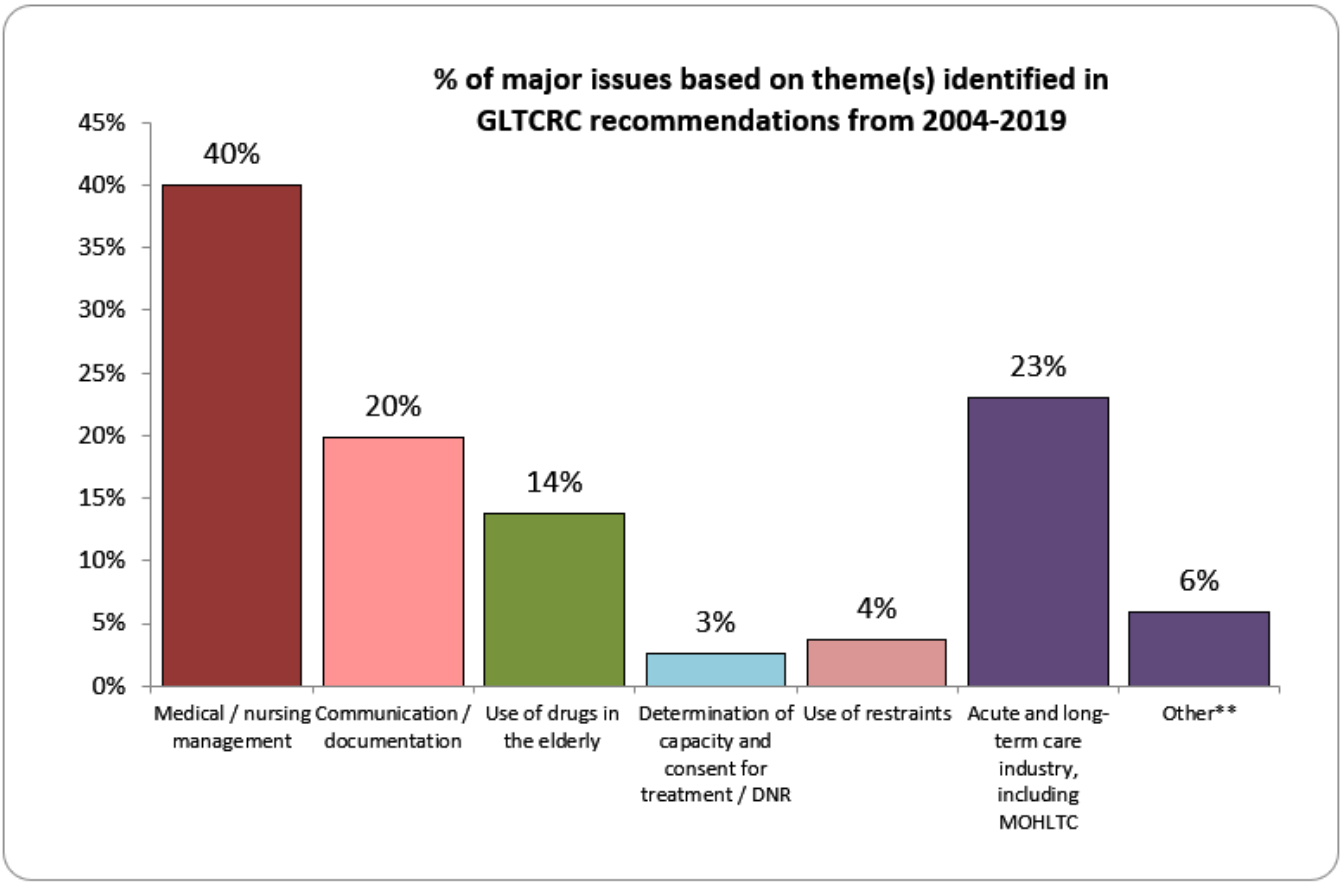


**Note: 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph One demonstrates that in 48% of the cases reviewed by the GLTCRC from 2004-2019, 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 (4%), determination of consent and capacity/DNR (4%) and other (9%).

Graph Two: % of major issues based on theme(s) identified in GLTCRC recommendations (2004-2019)

From 2004 until 2019, the GLTCRC generated 787 recommendations aimed at the prevention of future 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 2004-2019. 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 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 (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 (6%).

Chapter Three: Cases Reviewed in 2019

In 2019, the GLTCRC reviewed a total of 27 cases involving the deaths of 28 elderly individuals (14 females and 14 males), including residents of long-term care and retirement homes. Of the 27 cases, six were mandatory reviews resulting from homicides that occurred in long-term care facilities.

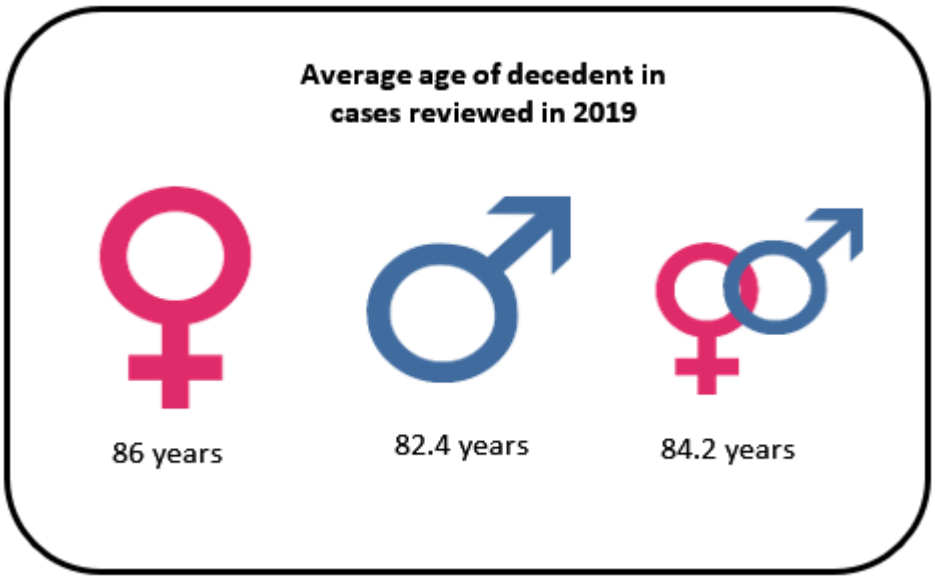
Of the cases reviewed in 2019, three of the deaths occurred in 2015, two in 2016, eight in 2017 and 15 in 2018.

[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.]

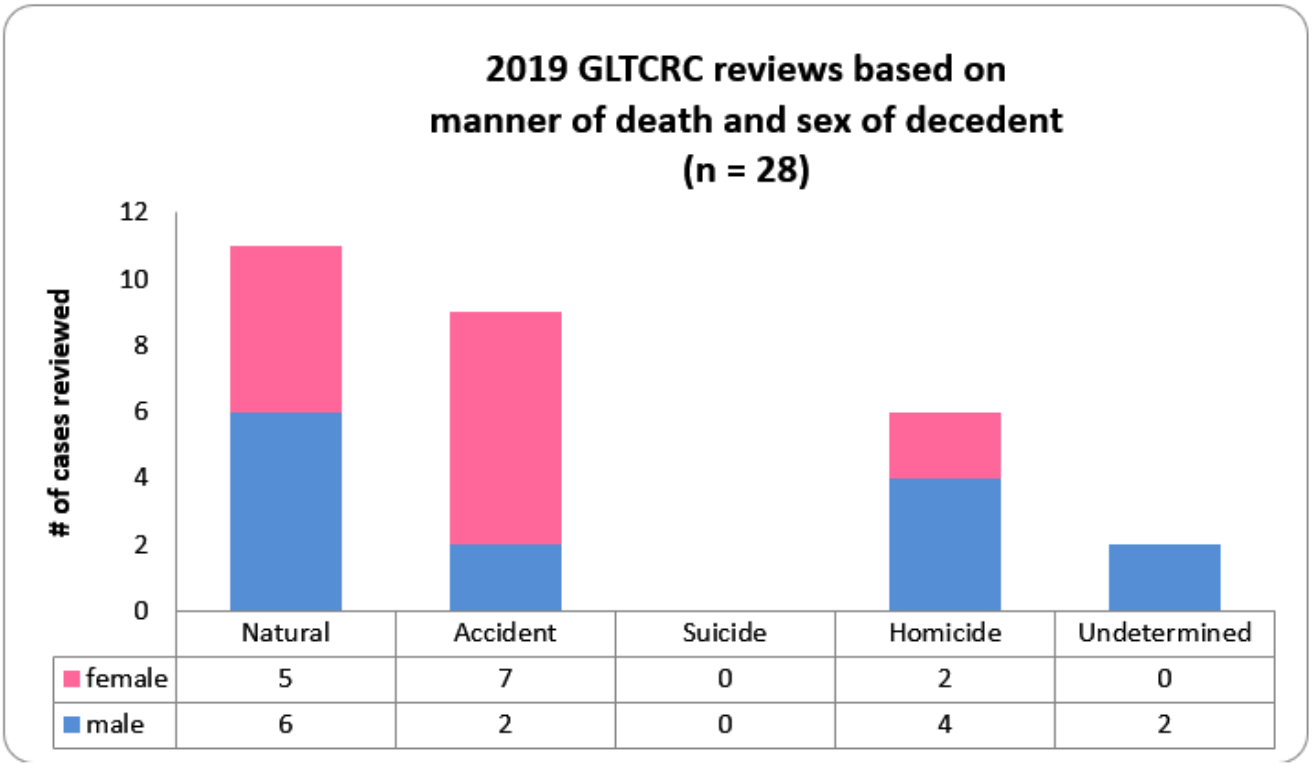
A summary of cases reviewed, and recommendations made in 2019 is included in Appendix A.

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

From the cases reviewed in 2019, the average age of all decedents was 84.2 years.



Graph Three: 2019 GLTCRC reviews based on manner of death and sex of decedent



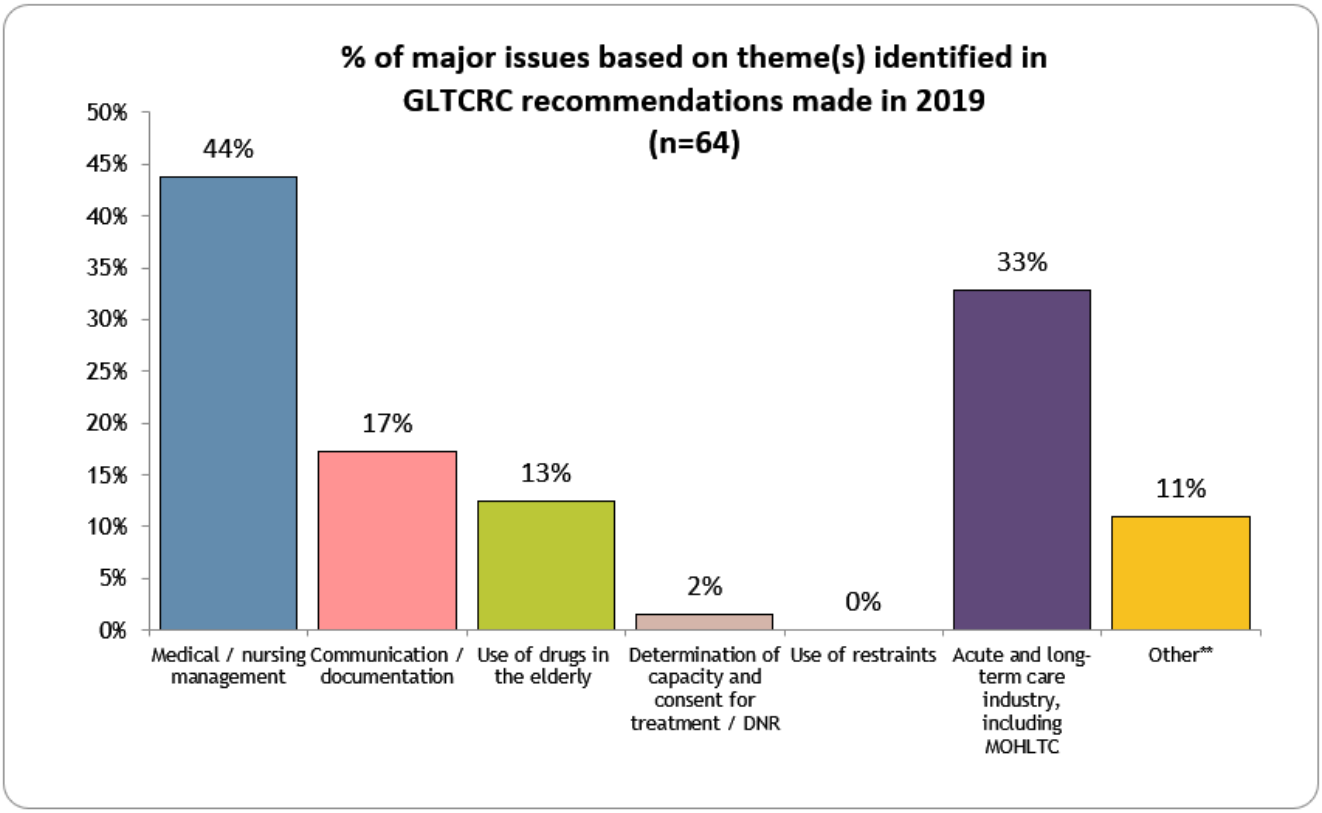
Graph Three demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 28 cases reviewed, 11 were natural (five females and six males), nine were accidents (seven females and two males), six were homicides (two females and four males), two were undetermined (two males) and there were no suicide cases reviewed.

In 2019, the GLTCRC generated a total of 64 recommendations aimed at preventing future 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 are 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 are asked to respond to the OCC within six months. These organizations are encouraged to self-evaluate the implementation status of recommendations assigned to them.

Recommendations are 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 2019



****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 2019. The most commonly identified themes/issues were related to medical or nursing management (44%), the acute and long-term care industry (33%), communication and documentation (17%), use of drugs in the elderly (13%), "other" (including recommendations to the police and Regional Supervising Coroners) (11%). There were no recommendations made in 2019 pertaining to 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 2019:

- In 2019, there were 27 cases involving 28 deaths reviewed by the GLTCRC. There were 64 recommendations made.
    - Of the cases reviewed in 2019, three of the deaths occurred in 2015, two in 2016, eight in 2017 and 15 in 2018.
    - Medical/nursing management issues were identified in 44% of the recommendations made.
    - Communication and documentation issues were identified in 17% of the recommendations made.
    - MOHLTC and/or LTC industry issues were identified in 33% of the recommendations made.
    - 'Other' (including recommendations to police services and Regional Supervising Coroners, etc.) was identified in 11% of the recommendations made.
    - Use of drugs in the elderly was identified in 13% 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 27 cases (involving 28 deaths) reviewed, 14 involved female deceased persons and 14 male deceased persons.
    - The average age of all decedents (i.e. male and female combined) in cases reviewed in 2019 was 84.2 years.
    - Of the cases reviewed in 2019, the manner of death for each of the 28 deceased persons was: natural (11), accident (9), homicide (6) and undetermined (2). There were no cases of suicide reviewed in 2019.

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. This chronic lack of resources was laid bare during the Covid 19 pandemic this year. The government's staffing review and the independent commission reviewing LTC have recommended increases in resources. It is the hope of this committee that these recommendations are heeded.

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 2019 Cases and Recommendations

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
GLTCRC 2019-01	3	This case involved the death of an 86-year-old woman who died from gastro-intestinal hemorrhage, due to dabigatran therapy and coagulopathy. Concerns were raised by the family and the investigating coroner relating to medications prescribed to the decedent.	1. This case should be used as an educational tool to inform physicians and pharmacists about possible adverse reactions from the co-administration of verapamil and dabigatran. 2. Physicians are reminded that community pharmacists are an important part of the health care team. Alerts from the pharmacist related to high risk medications should be carefully considered. 3. 3. Physicians are reminded that close follow up and reassessment of patients for side effects is necessary when initiating high risk medications.	Use of Drugs in the Elderly Communication/ Documentation Use of Drugs in the Elderly Use of Drugs in the Elderly
GLTCRC 2019-02	3	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 (Resident A) while in the long-term care home (LTCH) where they both resided.	1. All critical incidents leading to serious injury and death occurring in long-term care should be investigated in a timely fashion. 2. If a resident is recognized to have behavioural care needs beyond which can be accommodated with usual care in a long-term care setting, and the resident is waiting for further assessment and care in a specialized environment, then supports	Acute and long-term care industry, including MOHLTC Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			should be put in place in long term care to safely care for the resident while waiting to access another level of care. 3. Behavioral Support Ontario resources should be made available to all long-term care homes across Ontario to a degree that enables safe care of residents with dementia.	Acute and long-term care industry, including MOHLTC
GLTCRC 2019-03	2	This case involved the death of an 87-year-old woman 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.	1. The "normalization" of violence should be considered when developing the Ontario Provincial Dementia Strategy by the MOHLTC. 2. Consideration should be given to increasing high-needs funding for long-term care facilities.	Acute and long-term care industry, including MOHLTC Acute and long-term care industry, including MOHLTC
GLTCRC 2019-04		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. This case involved the death of an 88-year-old man who sustained a broken hip after being pushed by another resident (Resident A) of the long-term care home (LTCH) where they both resided.	1. The MOHLTC should consider, as a component of the configuration of a system-wide approach to responsive behaviours/ behavioural and psychological symptoms of dementia (BPSD), the establishment of an increased number of non-transitional long-term care home behaviour support units for carefully selected individuals with severe and prolonged behavioural symptoms, adequately resourced and staffed, with individuals	Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			trained to manage BPSD, throughout the province. 2. There should be a continued increase in resources to support training and education of long-term care home staff and physicians in the management of responsive behaviours/ behavioural and psychological symptoms of dementia (BPSD), as well as to support increased staffing levels in long-term care homes, not through high-intensity needs funding (which is responsive), but through increased general staffing (which is proactive). 3. When working with patients with complex presentations involving male sexual aggression or disinhibition, geriatric psychiatrists are reminded to consider anti-androgen therapy (e.g. cyproterone acetate or progesterone products), rather than adding more trials of psychiatric medications with sedative side effects.	Medical / Nursing Management Acute and long-term care industry, including MOHLTC Medical / Nursing Management
GLTCRC 2019-05	4	This case involved an 89-year-old woman who died of aspiration pneumonia in association with blunt impact injuries of the head and shoulders after falling from a mechanical	1. Long-term care staff are reminded that documentation should be completed as soon as possible after a safety incident in order to avoid recall bias.	Communication/ Documentation

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		lift used to move her in the long-term care home (LTCH) where she resided. There were differing reports as to how the injury occurred.	2. Recommended safety procedures and individual patient care plans should be adhered to. 3. Outdated and/or unsafe transfer and bathing equipment should be reviewed at regular intervals and replaced accordingly. 4. Multidisciplinary quality improvement rounds should occur to review injuries (explained and unexplained) and to promote a culture of safety within the institution.	Medical / Nursing Management Communication/ Documentation Medical / Nursing Management Medical / Nursing Management Acute and long-term care industry, including MOHLTC
GLTCRC 2019-06	0	This case involved an 82-year-old woman who died from complications of a right intertrochanteric hip fracture after falling in the retirement home (RH) where she resided. The decedent resided in the RH as part of a municipal domiciliary hostels program. The decedent's family had concerns relating to the care provided within the RH.	N/A	N/A
GLTCRC 2019-07	1	This case involved the death of an 88-year-old man with dementia and wandering behaviour following an interaction with another resident in the long-term care home where they both resided.	1. The MOLTC should assess the appropriateness of having four-person rooms for residents (particularly with cognitive impairments) in long-term care homes.	Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
GLTCRC 2019-08	2	The Geriatric and Long-Term Care Review Committee (GLTCRC) was asked to review the death of this 89-year-old woman who died of complications of injuries sustained in a fall at the long-term care home (LTCH) where she lived. Concerns relating to her care were identified by the family and coroner.	1. The Ministry of Health should consider regulating personal support workers (PSWs) in order to establish a consistent and standardized level of service for care providers in the PSW role. 2. Long-term Care Homes are encouraged to create a working environment that engages staff to identify and address concerns and errors in an open and honest manner.	Acute and long-term care industry, including MOHLTC Medical / Nursing Management
GLTCRC 2019-09	0	This case involved the death of a 93-year-old male who lived in a long-term care home (LTCH). Concerns were identified after the man was found deceased in a bed that was flat when he usually slept with the head of his bed elevated. Concerns were raised that the position of the bed may have impacted his death.	N/A	N/A
GLTCRC 2019-10	3	The decedent was a 58-year-old blind, mute man with cerebral palsy who resided in a long-term care home (LTCH). He died as a result of sepsis from peritonitis from perforation of the gastrointestinal tract. Concerns were identified relating to the care the decedent received in the LTCH.	1. Care providers in long-term care homes are reminded that responsive behaviours need a thoughtful approach addressing causative and relieving factors in an organized manner. "Responsive behaviours" is a diagnosis of exclusion once other causes have been ruled out. Individuals with intellectual delay and dementia are particularly	Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			vulnerable to having physical causes of behaviours overlooked. 2. On discharge from hospital, findings and treatment recommendations must be clearly communicated to the family and care team at the long-term care home. All recommendations should be discussed with the patient/resident and or substitute decision maker and reviewed with the long-term care team to guide a plan of care based on new findings in hospital. 3. Short term behaviour management teams and units cannot fully meet the needs of those with chronic behaviours. Long-term facilities should be available and appropriately resourced for the ongoing care of those with challenging behaviours.	Communication/ Documentation Acute and long-term care industry, including MOHLTC
GLTCRC 2019-11	4	These cases involved the homicide of a 76-year-old woman by her 82-year-old husband with Alzheimer's dementia. The husband died shortly after the incident from a urinary tract infection. Concerns were raised about the care provided to the male decedent relating to his dementia.	1. When an individual has been apprehended by the police under the Mental Health Act, a short, written summary of the reasons for apprehension should be provided to the receiving hospital, both as a record of events and as evidence that the patient was apprehended under the Act.	Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			2. A pattern of escalating aggressive behaviour in the presence of psychosis where there is an underlying major neurocognitive impairment is a known risk factor for physical violence, impulsive decisions and possibly suicide and/or homicide. Hospital admission to establish clear diagnosis and establish an effective treatment plan may be required prior to safe re-integration into the community. 3. For specific high-risk transitions between hospital and home, it is essential that clear communication and treatment plans be established and maintained. 4. Rapid, easy access to respite beds for community crisis should be accessible within 24 – 48 hours for dementia patients/families in crisis.	Medical / Nursing Management Communication/ Documentation Acute and long-term care industry, including MOHLTC
GLTCRC 2019-12	0	This case involved a 92-year-old woman who died after a fall in the long-term care home where she lived. The decedent's family raised concerns relating to monitoring and transfer to hospital.	N/A	N/A
GLTCRC 2019-13	1	This case involved the death of an 84-year-old man (Resident A) after	1. Long-term care homes should have a process for tracking and flagging violent behavior	Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		being pushed by an 82-year-old woman (Resident B) with a history of responsive behaviours, who lived in the same long-term care home (LTCH). This was a mandatory referral to the GLTCRC as the manner of death was homicide.	of residents. This process should trigger a mandatory multidisciplinary team review that should, in turn, encourage the involvement of expert support services.	Communication/ Documentation Acute and long-term care industry, including MOHLTC
GLTCRC 2019-14	0	The decedent was a 91-year-old man who died from septic shock due to aspiration pneumonia and osteomyelitis. The decedent was using a back brace for the treatment of an unstable vertebral fracture. Concerns were raised that the back brace may have contributed to the man's death.	N/A	N/A
GLTCRC 2019-15	4	The decedent was a 95-year-old woman with a history of osteoporosis and atherosclerotic heart disease who died from acute bilateral bronchopneumonia complicated by bilateral oblique distal femoral fractures. The etiology of the fractures is not known. Concerns were raised by the decedent's family regarding care at the long-term care home (LTCH) where she resided and the subsequent police investigation into her death.	1. Mobile x-ray services should be readily available to all long-term care homes in the province, including access on weekends. 2. Long-term care clinicians and staff are reminded of the risks of fracture with minimal traction force in people with osteoporosis, including those with non-weight bearing status. 3. Clinicians should utilize the Fracture Risk Scale (FRS) generated from MDS-RAI assessments to identify those	Acute and long-term care industry, including MOHLTC Medical / Nursing Management Medical / Nursing Management Other

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			residents at high risk for fracture. 4. Medical researchers should recognize an opportunity for research on low trauma fractures and fractures with no apparent injury or minimal trauma.	
GLTCRC 2019-16	6	This case involved the death of a 79-year-old woman who was admitted with responsive behaviours to a local hospital from a long-term care home (LTCH). She was treated with multiple psychiatric medications and subsequently died from aspiration with the contributing factor of severe vascular and mixed dementia. Issues regarding toxicity of multiple psychiatric medications, medication reconciliation, treatment of responsive behaviours and patient confidentiality were identified.	1. Healthcare providers are encouraged to develop and utilize a controlled access system for "as needed" (i.e. PRN) medications. This may include having the medication only available as ordered or requiring sign off by more than one healthcare provider when PRN doses are administered. 2. Electrocardiograms (ECGs) should be completed for all patients admitted to hospital on QT prolonging medications and there should be increased knowledge and communication between clinicians and pharmacists about QT prolonging medications and the in-creased risk of arrhythmias. Pharmacists should consider reviewing prolonged QT algorithms for patients. 3. Consideration should be given for the use of a stepwise or rational approach to prescription and dosing	Medical / Nursing Management Medical / Nursing Management Medical / Nursing Management Other

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			medications in behavioural and psychological symptoms of dementia (BPSD) . 4. The hospital involved should conduct a document audit relating to the care provided to the decedent. 5. Hospitals should consider: • psychiatric or specialized behaviour ward admission for geriatric patients with behavioural issues; • increased funding for education to nurses outside geriatric psychiatry (e.g. PEICES education for non-psychiatric wards); • increased funding for sitters/attendants for patients with responsive behaviours; • dedicated geriatric psychiatric behavioural units (such as tertiary care beds) to lessen behavioural admissions to medical wards. 6. Healthcare providers are reminded of the mandatory requirement for patient confidentiality as per the Personal Health Information	Acute and long-term care industry, including MOHLTC Communication/Documentation Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			Protection Act PHIPA (2004), particularly in relation to the use of personal communication devices and the use of social media.	
GLTCRC 2019-17	2	This case was referred to the Geriatric and Long-Term Care Review Committee (GLTCRC) after concerns were raised about the hospital discharge process and capacity of the 83-year-old decedent to return to independent living in the community despite concerns raised by his family.	1. The hospital involved should consider the involvement of a Hospital Ethicist in discussions with families regarding issues of capacity and consent. 2. Discharge referral information (i.e. to the LHIN) should be checked for accuracy regarding correct contact information, consents and the direction of a capable client where a request to not have family involved has been made. Attention to this detail will help to mitigate delays in service provision and avoid breaches of privacy.	Determination of capacity and consent for treatment / DNR Communication/Documentation
GLTCRC 2019-18	4	This case involved the death of an 82-year-old man who died as a result of injury sustained after falling from an electronic power recliner. The man's cognitive abilities had been declining and it is believed that he may have inadvertently pressed an incorrect button on the chair's control device.	1. Staff and families should be reminded that when there is a change in the cognitive status of a resident who uses an electronic assistive device, and independent use of that device may no longer be safe, the controls should be removed or locked to make the device inoperable to the individual. 2. The circumstances surrounding this death and the involvement of an	Medical / Nursing Management Other

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			electronic/power lift recliner should be reported to Health Canada. 3. The classification of electronic/power lift recliners, particularly when used as an assistive device, should be reviewed by Health Canada. 4. Health Canada should encourage manufacturers of electronic/power lift recliner chairs to modify the control pendant or install a mechanism to prevent inadvertent activation of the chair. A locking mechanism should be available on all electronic/power lift recliners.	Other Other
GLTCRC 2019-19	3	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 92-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. The long-term care home involved should conduct a review of the circumstances leading up to the death of this decedent including how the home responds to incidents of violence and subsequent notification of police. 2. The long-term care home should consider including all members of the care team (e.g. attending physician/RNEC (extended class), and outside behavioural support specialists/consultants, etc.)	Other Medical / Nursing Management Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			in the evaluation of residents with responsive behaviours. 3. The long-term care home should consider developing a protocol for residents expressing violent behaviours that includes a timely comprehensive medical assessment.	
GLTCRC 2019-20	2	This case involved the death of a 98-year old woman who died from necrotizing squamous cell carcinoma bacteremia. Concerns were raised by the decedent's family regarding the quality of care relating to wound management.	1. Long-term care homes should ensure that private caregivers are not providing direct care to residents. 2. Long-term care homes (LTCHs) should ensure that wound and skin care is provided by regulated staff and not unregulated care providers who are not employees of the LTCH.	Medical / Nursing Management Medical / Nursing Management
GLTCRC 2019-21	4	This case involved the death of a 77-year-old man from complications of advanced dementia. Concerns were raised by the family and investigating coroner regarding behaviour management and level of care for those with dementia, particularly in a retirement home setting.	1. Healthcare providers are reminded of a low threshold for consultation and admission for frail elderly patients with frequent visits to acute care hospital emergency departments. If they are to be discharged, a comprehensive care plan should be developed in consultation with the care team. 2. Acute care providers should be reminded of the difference in levels of care between	Medical / Nursing Management Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			retirement homes and long-term care homes. 3. Acute care providers should be aware of the BEERS list of potentially inappropriate medications in older adults. 4. It is recommended that a review of indications and dangers of anticholinergic agents in the frail elderly with attention to anticholinergic burden scoring, be considered. In particular, the medication Benztropine should be used sparingly if ever in the elderly. If Benztropine is used, it should be in younger patients, for clinically significant medication-related movement disorders, and the indication for use should be documented.	Use of Drugs in the Elderly Use of Drugs in the Elderly
GLTCRC 2019-22	0	This case was referred to the Geriatric and Long-Term Care Review Committee (GLTCRC) after concerns were raised about possible elder abuse towards the 82-year-old male decedent.	N/A	N/A
GLTCRC 2019-23	1	This case involved the death of a 63-year-old man following an altercation with another individual who resided at the same retirement residence providing supportive care to adults	1. All facilities providing care to persons with dementia should have access to Behaviour Support Ontario (BSO) teams and geriatric psychiatry support.	Acute and long-term care industry, including MOHLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		with special needs. The manner of death was undetermined. The case was referred to the Geriatric and Long-Term Care Review Committee (GLTCRC) for review of the circumstances leading up to the death.		
GLTCRC 2019-24	3	This case involved the death of a 79-year-old woman with dementia who resided in a secure unit of a long-term care home (LTCH). The woman fell to her death after opening and climbing out the window of her third-floor room. The Geriatric and Long-Term Care Review Committee (GLTCRC) was asked to review the circumstances leading up to the woman's death.	1. All long-term care homes in the province should have easy and timely access to Behavior Support Ontario (BSO) teams and geriatric psychiatry support to assist in the care of residents with complex behavioural challenges as part of their dementia. 2. It is recommended that all long-term care homes in the province conduct an audit of their window and door compliance and perform yearly safety and compliance checks. 3. All physicians working in long-term care homes are reminded that a serotonin syndrome can emerge in seniors with dementia as they age, even if they have tolerated a given dose of psychiatric medication at a younger age. The risk of developing a serotonin syndrome increases with the number of serotonergic medications prescribed.	Acute and long-term care industry, including MOHLTC 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
GLTCRC 2019-25	3	This case involves the death of a 90-year-old woman from complications of a fractured humerus due to a fall from a bed in a long-term care home (LTCH). Concerns were raised about quality of care and use of safety devices	1. Increasing frequency of falls or near falls should trigger a medical assessment including a careful review of all medications that could contribute to increased falls risk and laboratory investigations to look for a cause of increased restlessness and falls. 2. Admission to a long-term care home is an opportunity to do a thorough medication review and de-prescribe where possible. 3. Emergency preparations for power failures should include a functioning telephone to contact emergency medical services. All staff should be aware of the address of the facility and this should be posted throughout the facility.	Medical / Nursing Management Use of Drugs in the Elderly Medical / Nursing Management Use of Drugs in the Elderly Acute and long-term care industry, including MOHLTC
GLTCRC 2019-26	2	This case involved the death of a 98-year-old woman who died from complications of dementia while a resident of a long-term care home (LTCH). This case was referred to the Geriatric and Long-Term Care Review Committee (GLTCRC) after concerns were identified relating to the care provided, particularly regarding the management of the	1. Care providers are reminded of the importance of a multi-disciplinary assessment of change in health status. 2. Care providers are reminded of the importance of maintaining adequate nutrition throughout changes in health status and environment.	Medical / Nursing Management Medical / Nursing Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		decedent's dietary needs.		
GLTCRC 2019-27	4	The decedent was a 64-year-old woman who was bed-bound, deaf and blind with schizophrenia and diabetes. Concerns were raised after an apparent delay in accessing emergency care for the woman.	1. When there is a change in the health status of a resident of a long-term care facility, nurses and physicians are reminded that a comprehensive assessment is required to diagnosis and treat whatever the underlying medical problem may be. These comprehensive assessments are to be documented using a standardized format such as the SOAP template. 2. When there is an acute change in health status that is unexplained, and in which the resident has opted for active investigation and treatment, then a rapid comprehensive assessment must occur or emergency services ("911") should be activated promptly. 3. The use of a standardized nursing–physician communication tool (e.g. SBAR) is recommended to be used in long-term care settings. 4. The College of Physicians and Surgeons Ontario are encouraged to prepare an article for publication in Dialogue that touches on the details of this case and focuses on communication and	Medical / Nursing Management Communication/ Documentation Medical / Nursing Management Communication/ Documentation Communication/ Documentation

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			documentation between physicians, nurses and other members of the healthcare team.	

Questions and comments regarding this report may be directed to:

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