# Geriatric and Long-Term Care Review Committee 2020 Annual Report

Office of the Chief Coroner of Ontario
May 2023

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# Message from the Chair

The following is the 2020 Annual Report of the Geriatric and Long-Term Care Review Committee (GLTCRC). The delay in this report is due to the COVID-19 pandemic.

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 deaths. In 2020, the GLTCRC reviewed 19 cases, involving 19 deaths, and generated 46 recommendations.

Reviews and recommendations prepared by the GLTCRC are widely distributed to service and 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 COVID-19 pandemic arrived in Ontario in 2020. It took a devastating toll on the elderly, especially those living in long-term care homes (LTCHs). Families were separated, some during their loved one's last days. Staff were also affected by the disease and by the loss of cherished residents. The pandemic laid bare the weaknesses in long-term care and produced commitments to do better.

The OCC was privileged to assist LTCHs and hospitals in a small way through the implementation of the Managing Resident Death Response process. Although these deaths generally did not fall within the OCC mandate for investigation and hence were not reviewed by the GLTCRC, the committee members were intimately familiar with the impact of the pandemic as it affected their patients and colleagues.

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.

Dr. Roger Skinner
Regional Supervising Coroner, Modernization
Chair, Geriatric and Long -Term Care Review Committee

## Committee Membership (2020)

**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**
Chief Medical Officer

**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 2020, the GLTCRC reviewed 19 cases involving 19 deaths and generated 46 recommendations directed toward the prevention of future deaths. Of the 19 cases reviewed, three resulted in no recommendations.

- One case involved the death of a 31-year-old man with a severe developmental delay characterized by autism, a seizure disorder, and bipolar spectrum disorder, who lived in a group home.

- Of the 19 deaths that were reviewed in 2020, the breakdown for manners of death were:
    - Natural - 5 (three males and two females)
    - Accident - 7 (four males and three females)
    - Homicide* - 3 (three males)
    - Undetermined – 4 (one male and three females)

- Of the 19 deaths reviewed, 11 were male and eight were female.

- The average age of men whose deaths were reviewed was 77 years (excluding the 31-year-old decedent, the average age was 82 years).

- The average age of women whose deaths were reviewed was 82 years.

- The average age of all deaths reviewed in 2020 was 79 years (excluding the 31-year-old decedent, the average age for cases reviewed was 82 years).

- In 2020, the most common areas for improvement identified by GLTCRC through their case reviews and resulting recommendations consisted of:
    - Medical and nursing management
    - Acute care and long-term care industry in Ontario, including the Ministry of Health and Long-term Care (MOHLTC)
    - Communication and documentation
    - Use of drugs in the elderly
    - Use of restraints
    - 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 2020 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: 2004-2020

Between 2004 and 2020, the GLTCRC reviewed a total of 366 cases and generated 833 recommendations aimed towards the prevention of future deaths. On average, the GLTCRC has reviewed 21.5 cases and generated 49 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.

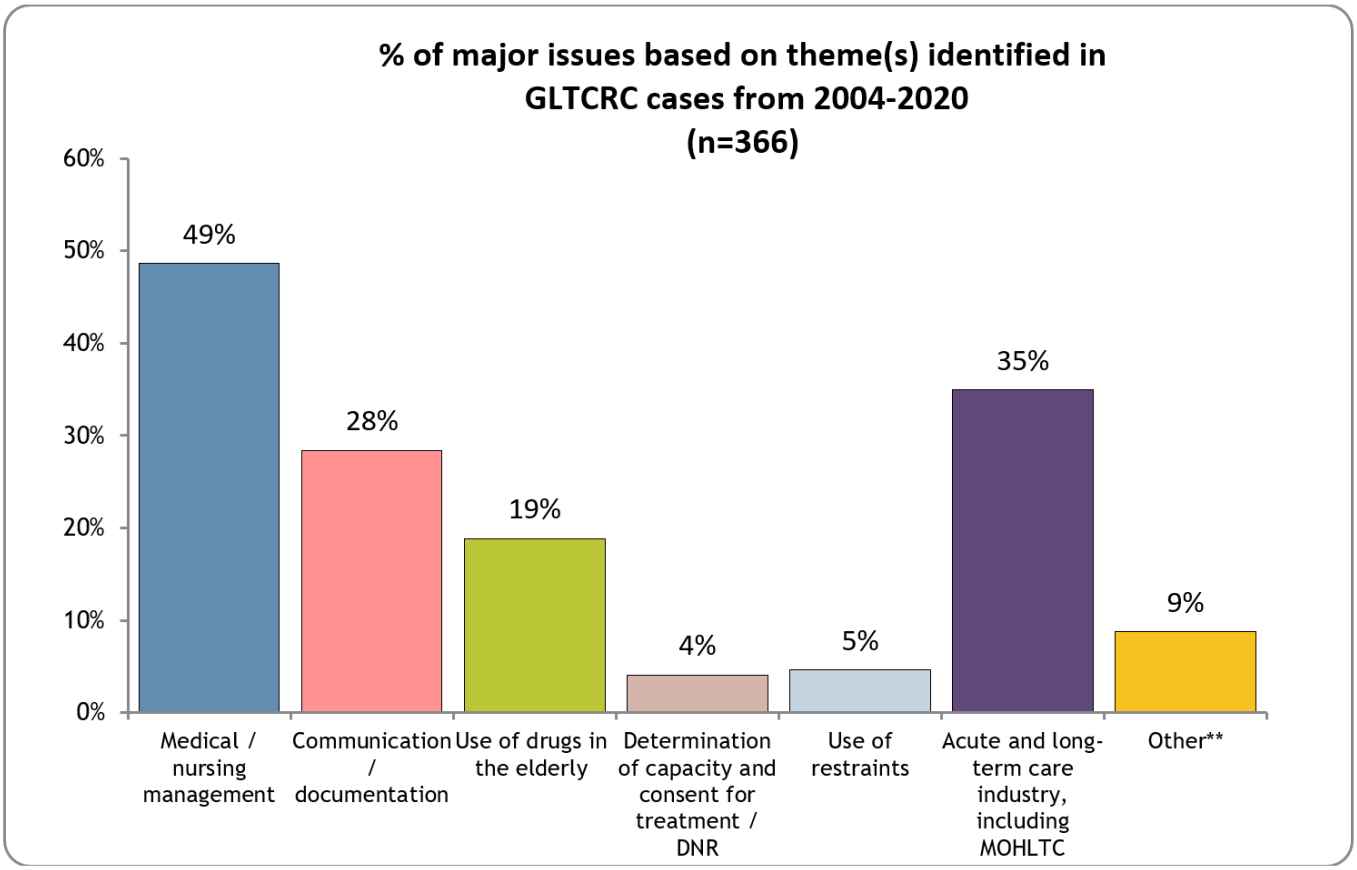
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

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 2004-2020**

From 2004 until 2020, the GLTCRC has reviewed a total of 366 cases.

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

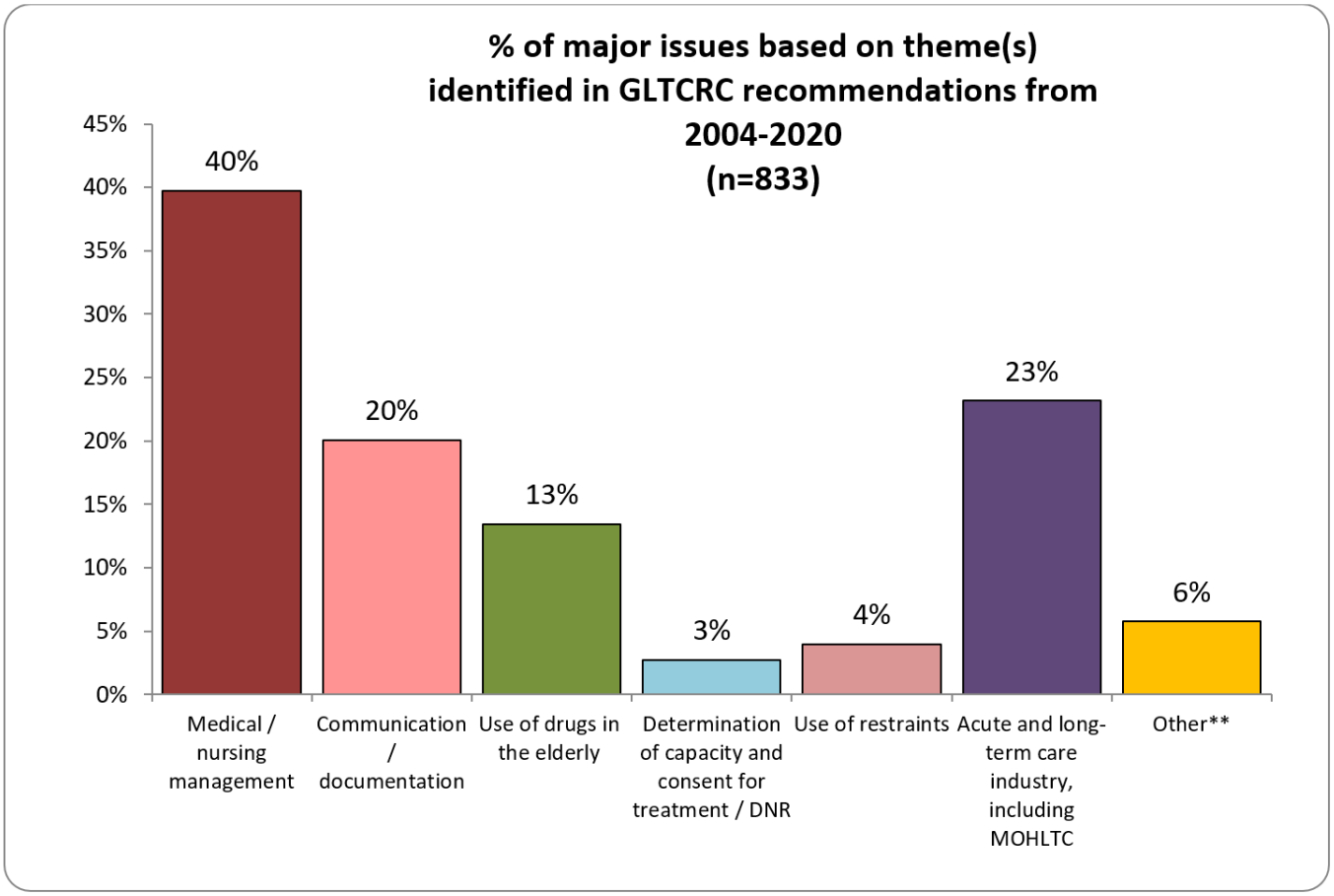



**Note: 'Other' includes recommendations to other ministries or in the legal/justice sector.

**Graph One** demonstrates that in 49% of the cases reviewed by the GLTCRC from 2004-2020, issues relating to medical/nursing management were identified. This is followed by 35% of the cases where issues pertaining to the acute and long-term care industry (including MOHLTC) were noted and 28% of the cases where issues of communication/documentation were present. Other key themes included use of drugs in the elderly (19%), use of restraints (5%), determination of consent and capacity/DNR (4%) and other (9%).

**Graph Two: % of major issues based on theme(s) identified in GLTCRC recommendations (2004-2020)**

From 2004 until 2020, the GLTCRC generated 833 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 2004-2020. 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 (13%), determination of capacity and consent for treatment or DNR (3%), the use of restraints (4%) and other (6%).

# Chapter Three: Cases Reviewed in 2020

In 2020, the GLTCRC reviewed a total of 19 cases involving the deaths of 19 elderly individuals (eight females and 11 males), including residents of long-term care and retirement homes; one case involved a 31-year-old male who lived in a residential group home. Of the 19 cases, three were mandatory reviews resulting from homicides that occurred in long-term care facilities.

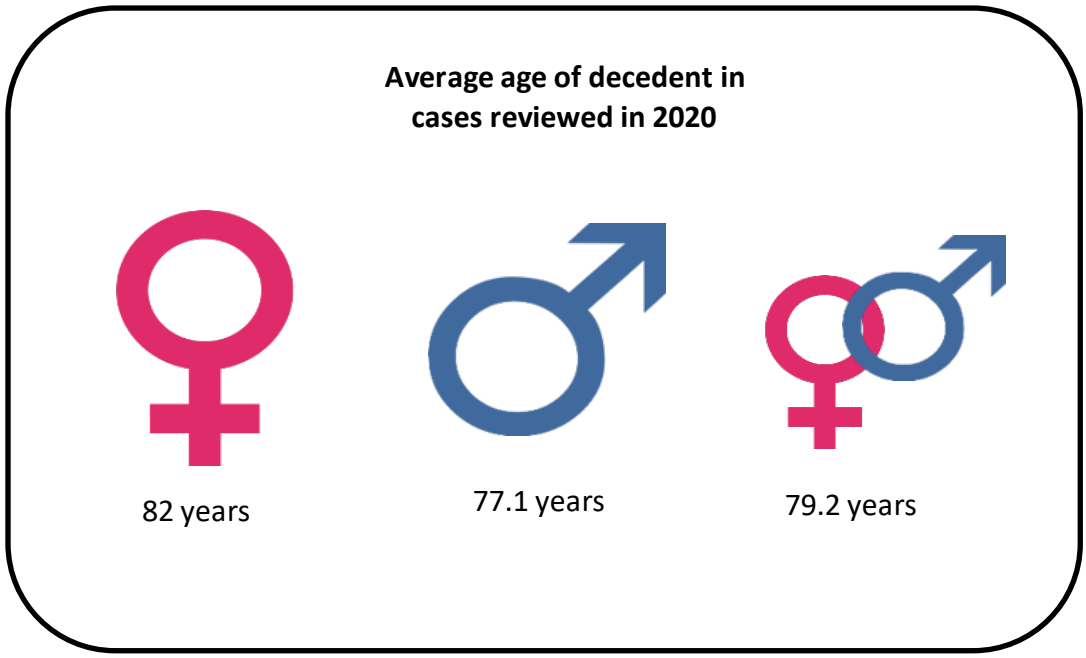
Of the cases reviewed in 2020, one of the deaths occurred in 2016, four in 2017, six in 2018 and eight in 2019.

[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.]

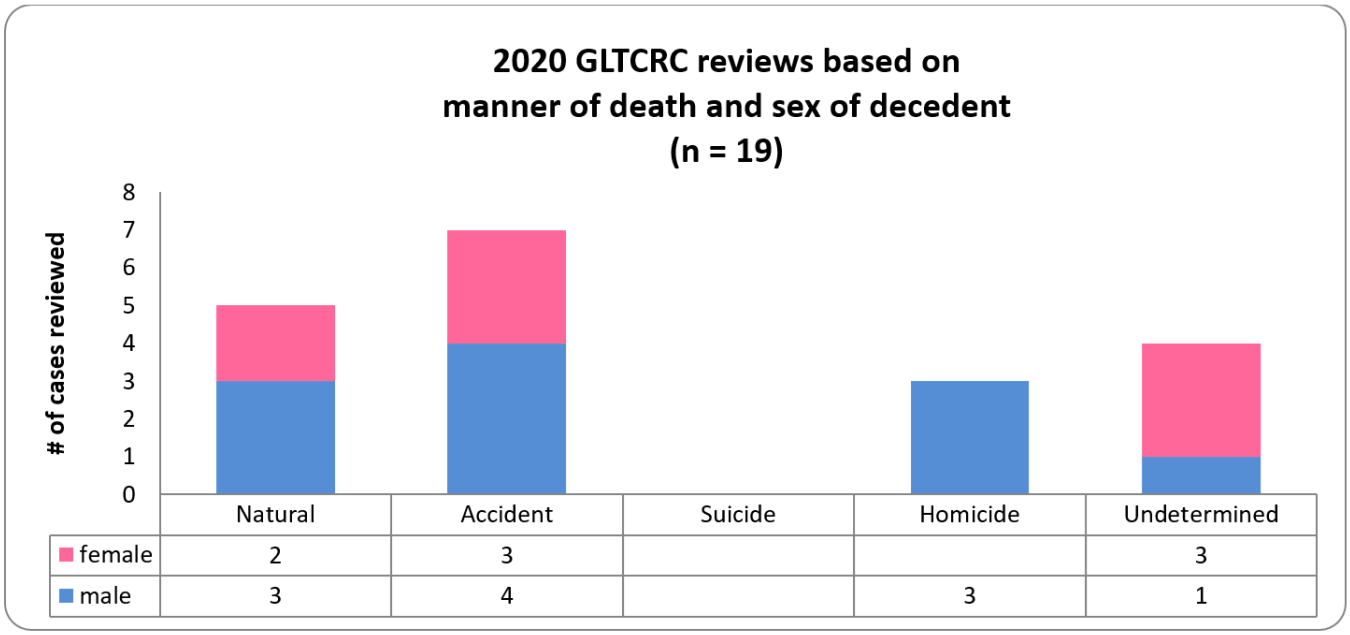
A summary of cases reviewed, and recommendations made in 2020 is included in Appendix A.

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

From the cases reviewed in 2020, the average age of all decedents was 79.2 years.



**Graph Three: 2020 GLTCRC reviews based on manner of death and sex of decedent**



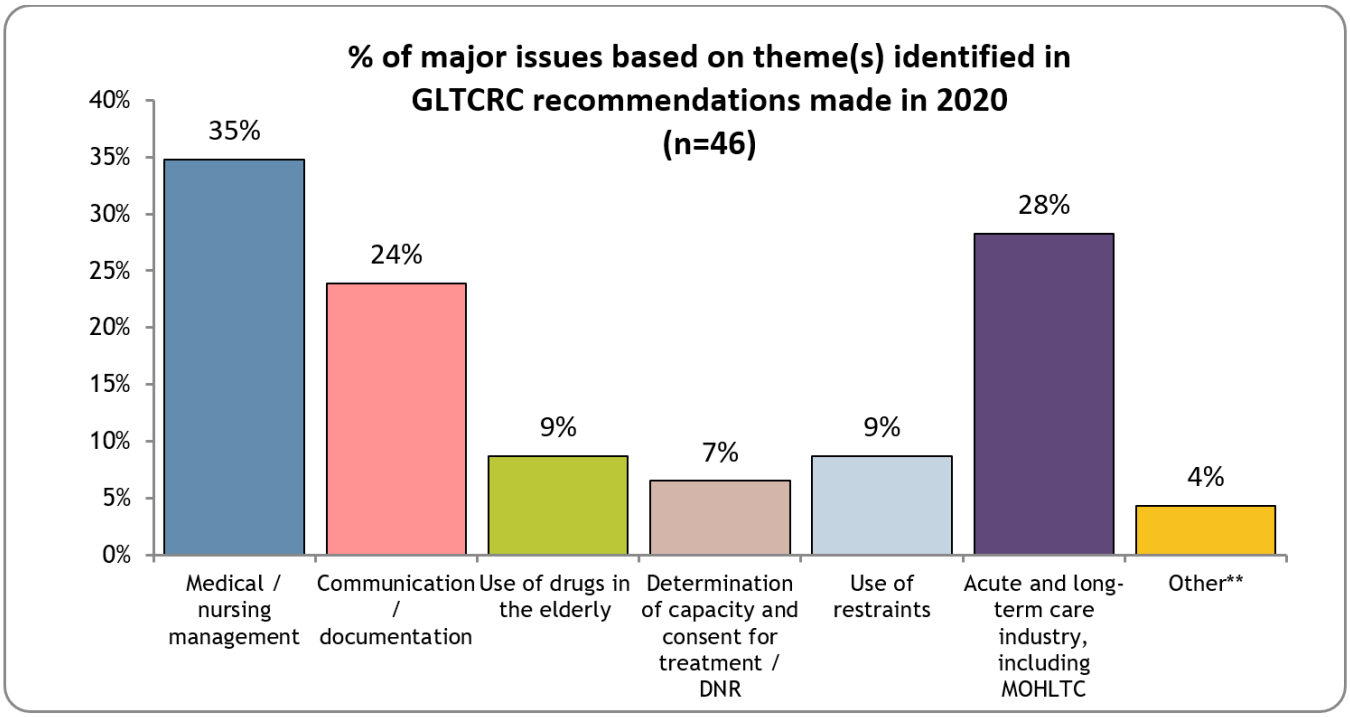

**Graph Three** demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 19 cases reviewed, five were natural (two females and three males), seven were accidents (three females and four males), three were homicides (three males), four were undetermined (three females and one male); there were no suicide cases reviewed.

In 2020, the GLTCRC generated a total of 46 recommendations aimed at preventing future deaths. There were three 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 report on 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 2020**




**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 2020. The most commonly identified themes/issues were related to medical or nursing management (35%), the acute and long-term care industry (28%), communication and documentation (24%), use of drugs in the elderly (9%), determination of consent and capacity (7%), "other" (including recommendations to the police and Regional Supervising Coroners) (4%) and use of restraints (9%).

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 2020:**

- In 2020, there were 19 cases involving 19 deaths reviewed by the GLTCRC. There were 46 recommendations made. Of the 19 cases reviewed, three resulted in no recommendations.

- One case involved the death of a 31-year-old man with a severe developmental delay characterized by autism, a seizure disorder, and bipolar spectrum disorder, who lived in a group home.

- Of the 19 cases reviewed in 2020, the breakdown for manners of death were:
    - Natural - 5 (three males and two females)
    - Accident - 7 (four males and three females)
    - Homicide* - 3 (three males)
    - Undetermined – 4 (one male and three females)

- Medical/nursing management issues were identified in 35% of the recommendations made.

- Communication and documentation issues were identified in 24% of the recommendations made.

- MOHLTC and/or LTC industry issues were identified in 28% of the recommendations made.

- 'Other' (including recommendations to police services and Regional Supervising Coroners, etc.) was identified in 4% of the recommendations made.

- Use of drugs in the elderly was identified in 9% of the recommendations made.

- The use of restraints in the elderly was identified in 9% of the recommendations and determination of consent and capacity / DNR in 7% of the recommendations.

- Some of the recommendations touched on more than one issue.

- There were three cases that did not have any recommendations.

- Of the 19 cases (involving 19 deaths) reviewed, 11 involved female deceased persons and eight male deceased persons.

- The average age of all decedents (i.e. male and female combined) in cases reviewed in 2020 was 79.2 years.

- Of the cases reviewed in 2020, the manner of death for each of the 19 deceased persons was: natural (5), accident (7), homicide (3) and undetermined (4). There were no cases of suicide reviewed in 2020.

# Chapter Four: Learning from GLTCRC Reviews

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

A prominent theme in this year's reviews was the challenges associated with transitions of care. When the decision is made that a person requires LTC, they should be placed in a LTCH, not temporarily housed in a setting that cannot provide the requisite care. Once there, they require the prompt attention of the care team, including the physician, in order to ensure a safe and successful move. This settling in period is recognized as being a time of risk for delirium, behavioural changes and for violent interactions with other residents. A coordinated, proactive approach can reduce this risk.

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 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 2020 Cases and Recommendations

| GLTCRC File # | # of Recs | Summary of Case | Recommendation(s) and (Theme) |
|---|---|---|---|
| GLTCRC 2020-01 | 1 | This case involved the death of a 63-year-old woman who died from bronchopneumonia due to neurodegeneration with brain iron accumulation, in association with a fractured hip. The etiology of the hip fracture could not be determined. The woman utilized some alternative medicines and just prior to her death, there were allegations that she may have been given a noxious substance. | 1. Clinicians in hospital emergency departments should develop a systematic approach to assessing vulnerable adults. Consideration should be given for a full detailed exam, if possible, by a practitioner or team experienced in forensic medicine, and skeletal survey, for any vulnerable individual in all credible cases of alleged abuse. (**Medical/nursing management**) |
| GLTCRC 2020-02 | 3 | This case involved the death of a 79-year-old man with advanced Alzheimer's Dementia who died after an altercation with another resident LTCH where they both lived. This was a mandatory referral to the GLTCRC as the manner of death was homicide. | 1. Long-Term Care Homes are reminded that newly admitted residents are at higher risk for involvement in violence (either as perpetrators or victims) due to unfamiliarity with a new environment, caregivers and routines. Careful supervision, documentation and behavioural care-planning are essential. (**Medical/nursing management; Communication/documentation**)<br>2. The "normalization" of violence should be considered when developing the Ontario Provincial Dementia Strategy by the MOHLTC. (**Acute and long-term care industry, including MOHLTC**)<br>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 2020-03 | 2 | This case involved the death of a 68-year-old man with a history of alcoholism and multiple co-morbidities who was | 1. Capacity assessors are reminded that decisions regarding capacity cannot be made solely on a face-to-face assessment with the client. Assessment should include information from family, professional care- |

| GLTCRC File # | # of Recs | Summary of Case | Recommendation(s) and (Theme) |
|---|---|---|---|
| | | found incapable for medical, personal and financial decision-making by a geriatric medicine physician. The decedent appealed the decision to the Consent and Capacity Review Board and was subsequently deemed capable. The man was found deceased at home twelve days after the decision regarding his capability. | givers or multi-disciplinary consultants and review of objective records. The assessment should also include a judgement as to the ability of the client to follow through on their intentions. (**Determination of capacity and consent for treatment / DNR**)<br>2. The Ministry of the Attorney General, Ministry of Health, Retirement Home Regulatory Authority and College of Physician and Surgeons Ontario should consider collaborating on a broad educational initiative throughout the medical sector regarding consent and capacity.( **Determination of capacity and consent for treatment / DNR**) |
| GLTCRC 2020-04 | 5 | The decedent was an 83-year-old female who lived in a LTCH. She died from complications of a fractured hip after experiencing a fall out of bed while being cared for by an individual personal support worker (PSW). One month prior to the incident, two half-bed rails had been removed from the woman's bed. Concerns were raised about the use of bed rails and communication with families. | 1. Medical schools and continuing education for physicians and nurses should emphasize least-restraint policies, including the use of partial bedrails and personal assistive supportive devices when they can be safely used. (**Use of restraints**)<br>2. Residents/patients and their substitute decision-makers/families should be consulted when restraint devices like bedrails are implemented or are removed. Discussions regarding the addition or removal of devices should be documented. (**Use of restraints**)<br>3. It is recommended that Health Canada require near miss falls to be reported and acted upon just as near miss entrapments currently are. (**Communication/ documentation**)<br>4. It is recommended that corporate policies in long-term care homes should be developed not to simply eliminate bedrails, but to emphasize resident/patient preference and com-fort, as well as safety, and to fully involve the healthcare team, the resident/patient and their family and/or substitute decision maker.( **Other; Acute and long-term care industry, including MOHLTC**)<br>5. The Ministry of Long-Term Care should amend the Long-Term Care Act to provide more concise direction for the addition and removal of bedrails and personal assistive support devices. (**Acute and long-term care industry, including MOHLTC**) |

| GLTCRC File # | # of Recs | Summary of Case | Recommendation(s) and (Theme) |
|---|---|---|---|
| GLTCRC 2020-05 | 2 | This case involved the death of an 84-year-old woman with a medical history that included chronic obstructive pulmonary disease and congestive heart failure. This case was referred to the GLTCRC due to concerns regarding the quality of care at the LTCH where she resided. | 1. When nurses modify a physician's orders, a full rationale should be provided in the progress notes, and the physician should be notified at an appropriate time. (**Communication/ documentation**)<br>2. The MOLTC should explore the ethical and legal aspects of hidden cameras placed within long-term care homes without the knowledge and/or consent of the facility's administration and staff. This review may benefit from input from a medical ethicist and legal expert. ( **Acute and long-term care industry, including MOHLTC**) |
| GLTCRC 2020-06 | 0 | This case involved the death of an 89-year-old woman receiving palliative care. Concerns were raised by the decedent's family regarding the quality of end-of-life care provided in the long-term care home where the woman lived. | Not applicable |
| GLTCRC 2020-07 | 10 | The case involved the death of an 89-year-old woman who died in the retirement home where she lived. This case was referred to the GLTCRC at the request of the coroner, police and family due to concerns regarding inappropriate "Do Not Attempt Resuscitation" forms and concern regarding treatment delay or omission. | 1. Electronic "do not resuscitate" (DNR) validity forms should be immediately accessible in the Connecting Ontario portal. This should be a living document that is accessible to all healthcare providers. (**Communication/documentation**)<br>2. The regulatory regime should be revised to include a review of quality of care in all long-term care settings regardless of the setting of care (i.e. retirement home or long-term care home) where the care provided should meet the needs of the resident including their medical care needs. (**Acute and long-term care industry, including MOHLTC**)<br>3. A mechanism to implement the Transitions in Care Quality Standard should be developed. (see: https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf). (**Acute and long-term care industry, including MOHLTC**)<br>4. A mechanism should be developed and implemented to communicate with all care providers when a palliative approach to care has been agreed to. This could be similar to work on the coordinated care plan that has |

| GLTCRC File # | # of Recs | Summary of Case | Recommendation(s) and (Theme) |
|---|---|---|---|
| | | | previously been developed. (**Communication/documentation**)<br>5. All new admissions to retirement homes should require a comprehensive history and physical upon admission in addition to any information completed in the initial application. (**Medical/nursing management; Acute and long-term care industry, including MOHLTC** )<br>6. Retirement homes should implement mechanisms to support quality transitions in care on admission as per the Health Quality Transitions between hospital and home Quality Standard (see: https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf) (**Communication/documentation**)<br>7. Retirement homes should be required to implement electronic medication administration records (MARs) to avoid the potential medication errors with paper MARS particularly with acute changes in resident status. (**Communication/documentation**)<br>8. Prescribers are reminded that a substantial change in therapeutics requires clear documentation. (**Communication/documentation**)<br>9. Physicians are reminded of continuity of care policy and potential harm that can occur with inadequate transfers of care. (**Medical/nursing management**)<br>10. While appreciating the pressure for timely discharge from acute care, discharge planning should include an understanding of the medical and nursing care needs of individuals when finalizing discharge plans. (**Medical/nursing management**) |
| GLTCRC 2020-08 | 2 | This case involved the death of a 100-year-old woman residing in a LTCH who died from neck compression after slipping down the seat of a wheelchair that had a seatbelt lap restraint. | 1. Long-term care homes and families should be made aware that, though rare, deaths can be caused by lap belt wheelchair restraints in dementia patients. (**Use of restraints**)<br>2. Clear indications should exist for the initiation of wheelchair lap belt restraint, with risks and benefits discussed with substitute decision makers/family, and documentation of these discussions in the clinical record. (**Use of restraints; Communication/documentation**) |
| GLTCRC 2020-09 | 4 | The decedent was a 76-year-old man. Concerns | 1. Nurses and physicians in long-term care homes are reminded that when there is a change in the health |

| GLTCRC File # | # of Recs | Summary of Case | Recommendation(s) and (Theme) |
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| | | were identified regarding his oral intake of food and fluid, increased number of falls and the lack of a complete physical examination by a primary care provider upon admission to a LTCH. | status of a resident, a comprehensive assessment should be done to diagnose and treat whatever the underlying medical problem may be, particularly when the changes occur immediately upon or after admission. (**Medical/nursing management**)<br>2. The long-term care home involved should conduct a medication review for residents under the care of the attending physician. (**Medical/nursing management; Use of drugs in elderly**)<br>3. The Ministry of Long-Term Care should consider reviewing the function and purpose of long-term home investigations and inspections. The current focus of reviewing compliance to a set of regulations does not adequately review medical and nursing quality of care provided. (**Acute and long-term care industry, including MOHLTC**)<br>4. When conducting assessments of high-risk residents in long-term care homes, every effort should be made to determine estimated food intake. An entry of "not applicable / not available" is insufficient. (**Medical/nursing management**) |
| GLTCRC 2020-10 | 5 | The decedent was a 31-year-old man with a severe developmental delay characterized by autism, a seizure disorder, and bipolar spectrum disorder, who lived in a group home. The man was found deceased in a vacant room where he was being isolated during a behavioral crisis. This case was reviewed by the GLTCRC as the decedent lived in a long-term residential setting in which he was dependent on staff for care of his complex developmental and psychiatric conditions. | 1. Group Homes providing residential care to adults with developmental delay are reminded of their obligation to provide care consistent with the standards stated in SIPDDA, 2008, and in accordance with Ontario Regulation 299/10. In particular, group homes are reminded to:<br>• have well-documented behavioural care plans<br>• adopt a least-intrusive approach<br>• work with health care providers in the development of behavioural care plans<br>• clearly document indication, observation, and consequence of more intrusive behaviourial management supports such as "quiet rooms." (**Medical/nursing management**)<br>2. The MCCSS should establish a regular inspection regime to perform in-person annual inspections of all group homes in Ontario to ensure compliance with legislation and regulation, specifically involving support of adults with developmental delay and complex behavioural needs. (**Acute and long-term care industry, including MOHLTC**)<br>3. The MCCSS should develop regulations and supports for group homes to ensure that all staff who provide medication to residents have the knowledge, skill, and |

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| | | | attitudes to be able to do so safely. (**Medical/nursing management**)<br>4. Transitions in care are a time of particular risk for patients who are developmentally delayed. Clear discharge plans, including key instructions for seeking assistance if the patient's condition deteriorates, are essential. (**Medical/nursing management**)<br>5. Physicians working with the developmentally delayed population are reminded that all treatment must occur with informed consent under the Health Care and Consent Act. This means explicit documented conversations with the patient if capable, and if incapable, with a substitute decision maker as defined within the Health Care and Consent Act. (**Determination of capacity and consent for treatment / DNR**) |
| GLTCRC 2020-11 | 2 | This case involved the death of an 85-year-old man following a motor vehicle collision. Concerns were raised as the man had mild cognitive impairment (MCI) and still had a valid driver's license. | 1. It is recommended that the Ministry of the Solicitor General and the Ministry of Transportation consider the development of a provincial alert system to rapidly locate older adults who are missing, including when they are thought to be driving a motor vehicle. (**Other**)<br>2. It is recommended that the College of Physicians and Surgeons Ontario remind physicians (perhaps through the CPSO publication Dialogue) about the importance of assessing and documenting driving safety in all patients with neurocognitive disorders, including mild neurocognitive disorders, and reporting to the Ministry of Transportation those individuals who may no longer be fit to drive due to cognitive impairment, based on accepted criteria. (**Communication/documentation**) |
| GLTCRC 2020-12 | 2 | This case involved the death of an 83-year-old man who was a resident of a LTCH. The man died after a medication error where he was prescribed morphine 1-2 mg and inadvertently administered 10 mg. | 1. It is recommended that the Ministry of Health add morphine 10mg/ml and 2mg/ml to the regular Ontario Drug Benefit (ODB) formulary. These dosages are currently listed as "limited use" for palliative patients only. (**Use of drugs in the elderly**)<br>2. Naloxone, together with staff training on how to administer it, should be available in all long-term and retirement facilities where residents may be on opioid therapy. (**Use of drugs in the elderly**) |
| GLTCRC 2020-13 | 2 | This case involves the death of a 77-year-old man following a physical altercation with another resident of the LTCH where | 1. The Ministry of Long-Term Care and Behaviour Supports Ontario should develop at tool kit of escalating resources for each community to support them in addressing the needs of individuals with violent and aggressive behaviours who reside in long-term care |

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| | | they lived. His family expressed concerns regarding the care he received in the home and the delay in sending him to hospital. | homes. This should include access to virtual assessments where needed with a goal of safety in long-term care for all residents and staff. (**Acute and long-term care industry, including MOHLTC**)<br>2. The requirements to obtain supplemental staffing should be reviewed and revised to facilitate the use of extra staffing for the safety of the residents and staff of long-term care homes. Long-term care homes are reminded that a physician's order is not required to obtain supplemental staffing. (**Acute and long-term care industry, including MOHLTC**) |
| GLTCRC 2020-14 | 1 | This case involved the death of a 74-year-old woman with several medical comorbidities and delirium. The woman had multiple visits to hospital and had been assessed by geriatrics and psychiatry. Concerns were identified about the level of care provided at the hospital, particularly the attribution of her presenting symptoms to non-medical causes. | 1. A structured approach to delirium recognition and management is a key component of hospital care for seniors. This must include clear communication between patients and families, and the clinical team about diagnosis, treatment, and prognosis of delirium in the elderly. (**Medical/nursing management; Communication/documentation**) |
| GLTCRC 2020-15 | 3 | This case involved the death of a 94-year-old woman who died from complications of an unwitnessed fall while a resident in a LTCH. Concerns were identified regarding management of responsive behaviours in the LTCH and care provided to the decedent after the fall. | 1. Physicians providing services in long-term care homes are reminded that resident/patient reassessment should occur in a timely and comprehensive manner whenever there is a change of status. (**Medical / nursing management**)<br>2. Physicians providing services in long-term care homes should consider continuing professional development regarding appropriate prescribing with tools such as the BEERs criteria'. (**Medical / nursing management**)<br>3. Nursing staff that administer 'as needed' opioids for analgesia should conduct pain assessments that are anchored to validated assessment scales e.g. PAINAD scale. (**Use of drugs in the elderly**) |
| GLTCRC 2020-16 | 1 | This case involved the death of a 69-year-old woman. This case was referred to the GLTCRC because of complications regarding wound care post | 1. Healthcare providers are reminded that any fall involving an elderly person requires a thorough evaluation, including a critical review of all medications. It is recommended that the evaluation include internal medicine, geriatrics and nursing. (**Medical/nursing management**) |

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| | | fall and a medication error during hospital admission. | |
| GLTCRC 2020-17 | 0 | The decedent was an 84-year-old man who died from congestive heart failure and an upper gastrointestinal bleed after experiencing a hip fracture and being placed on anticoagulation therapy. Concerns were raised as to whether post-operative anticoagulation contributed to the death. | Not applicable |
| GLTCRC 2020-18 | 1 | The case involved the death of a 93-year-old male resident of a LTCH who died following diagnosis of a subdural hematoma while being treated in an acute care hospital. Concerns were raised regarding fall prevention and the assessment of an elderly person on anticoagulants who falls and then develops an altered level of consciousness. | 1. Physicians are encouraged to have a low threshold when considering a CT head in older adults receiving anticoagulation in the context of an unwitnessed fall, particularly with a history of change in level of consciousness if consistent with goals of care for surgical intervention. (**Medical/nursing management**) |
| GLTCRC 2020-19 | 0 | This case involved the death of an 84-year-old man who died after being pushed by another resident in the LTCH where they both resided. This was a mandatory referral to the GLTCRC as the manner of death was homicide. | Not applicable |

Questions and comments regarding this report may be directed to:

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