

Geriatric and Long-Term Care Review Committee 2021 Annual Report



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Message from the chair

The following is the 2021 Annual Report of the Geriatric and Long-Term Care Review Committee (GLTCRC). The COVID-19 pandemic contributed to delays in assembling our committee reviews that form the basis of our committee reports.

The GLTCRC was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, 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 2021, the GLTCRC reviewed 16 cases, involving 18 deaths, and generated 49 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 further deaths in similar circumstances.

I would like to take this opportunity to thank Ms. Kathy Kerr (Executive Lead) for her assistance with the ongoing administration and management of GLTCRC activities and data. Kathy retired in February 2022 after 35 years with the Ontario Public Service, most of those with the OCC. Kathy was an integral part of our organization, especially with the expert review committees for which she provided both lead and support services. We miss her and wish her health and happiness in the years to come.

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 (2021)

Dr. Roger Skinner

Regional Supervising Coroner, Committee Chair

Ms. Kathy Kerr

Executive Lead

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 2021, the GLTCRC reviewed 16 cases involving 18 deaths and generated 49 recommendations directed toward the prevention of future deaths. Of the 16 cases reviewed, one resulted in no recommendations.
- Of the 18 deaths that were reviewed in 2021, the breakdown for manners of death were:
 - Natural - 5 (one male and four females)
 - Accident - 7 (five males and two females)
 - Homicide* - 1 (female)
 - Undetermined – 5 (three males and two females)
- Of the 18 deaths reviewed, 9 were male and 9 were female.
- The average age of men whose deaths were reviewed was 84.8 years.
- The average age of women whose deaths were reviewed was 68.1 years.
- The average age of all deaths reviewed in 2021 was 73.5 years.
- In 2021, 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 (MOH) and Ministry of Long-term Care (MLTC)
 - 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, 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 further 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 2021 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: 2004-2021

Between 2004 and 2021, the GLTCRC reviewed a total of 382 cases and generated 882 recommendations aimed towards the prevention of future deaths. On average, the GLTCRC has reviewed 21.2 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 (MOH) and Ministry of Long-Term Care (MLTC)
- 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.

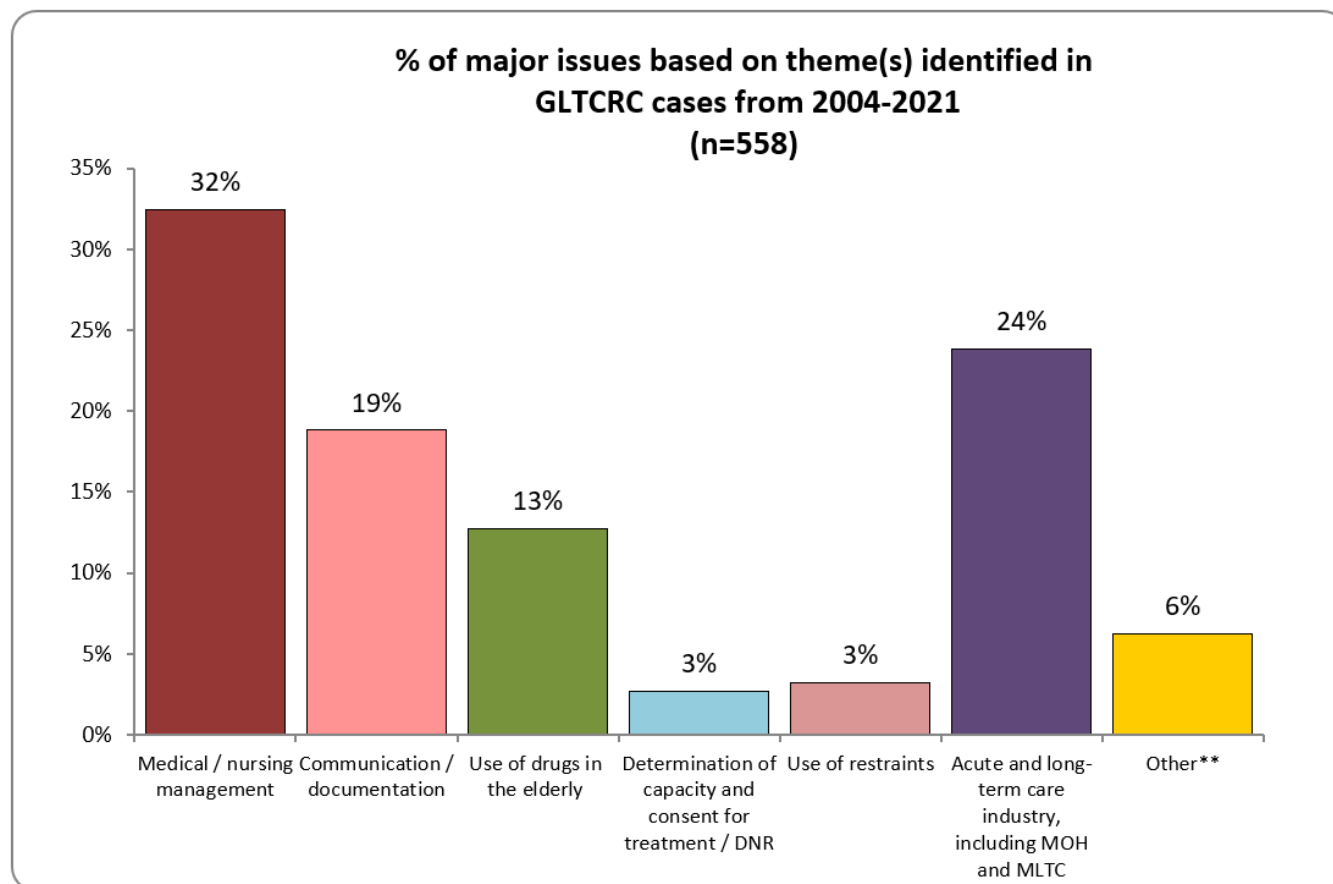
Trends based on themes in **cases** helps to identify what issues or themes are present in the cases that are being referred to the GLTCRC for review. These findings help to identify if there is a trend in the types of cases that are being referred and reviewed.

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: Percent of major issues based on theme identified in GLTCRC cases from 2004-2021

From 2004 until 2021, the GLTCRC has reviewed a total of 382 cases.

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

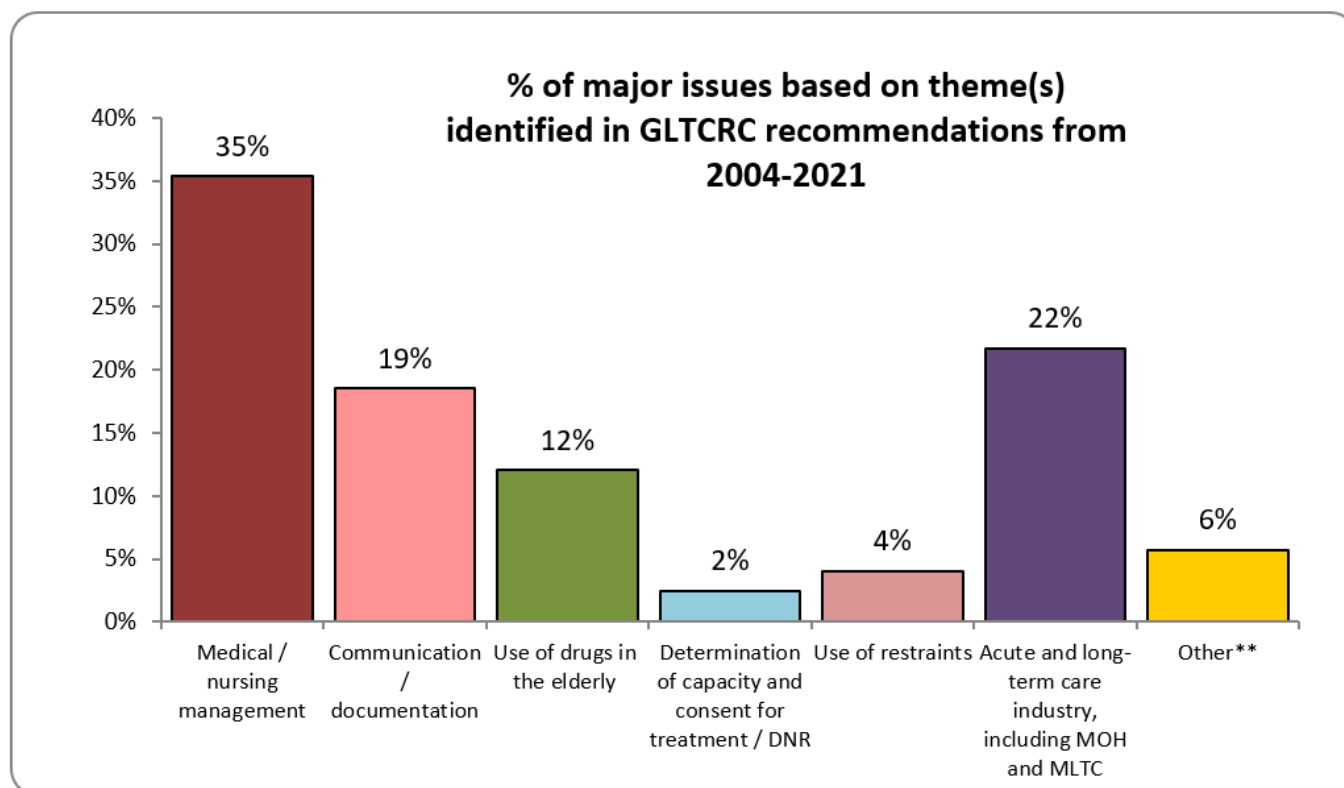


**Note: 'Other' includes recommendations to other ministries or in the legal/justice sector.

Graph One demonstrates that in 47% of the cases reviewed by the GLTCRC from 2004-2021, 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 MOH and MLTC) were noted and 27% 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 (5%) and other (9%).

Graph Two: Percent of major issues based on theme(s) identified in GLTCRC recommendations (2004-2021)

From 2004 until 2021, the GLTCRC generated 882 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 2004-2021. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 35% of all recommendations made were related to medical or nursing management while 22% of the recommendations touched on the acute and long-term care industry, including the MOH and MLTC. The other themes/issues that were present, but that were less frequently assigned to the recommendations, were related to communication/documentation (19%), use of drugs in the elderly (12%), determination of capacity and consent for treatment or DNR (2%), the use of restraints (4%) and other (6%).

Chapter three: Cases reviewed in 2021

In 2021, the GLTCRC reviewed a total of 16 cases involving the deaths of 18 elderly individuals (nine females and nine males), including residents of long-term care and retirement homes. Of the 16 cases, one was a mandatory review resulting from a homicide that occurred in a long-term care facility.

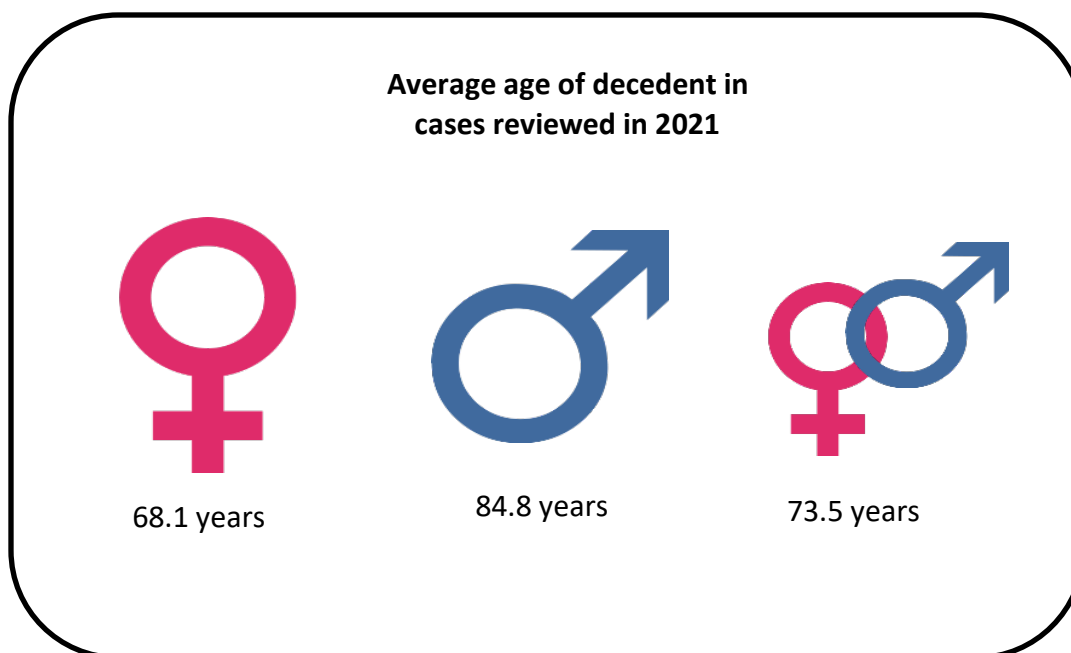
Of the cases reviewed in 2021, one of the deaths occurred in 2016, four in 2018, six in 2019 and seven in 2020.

[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.]

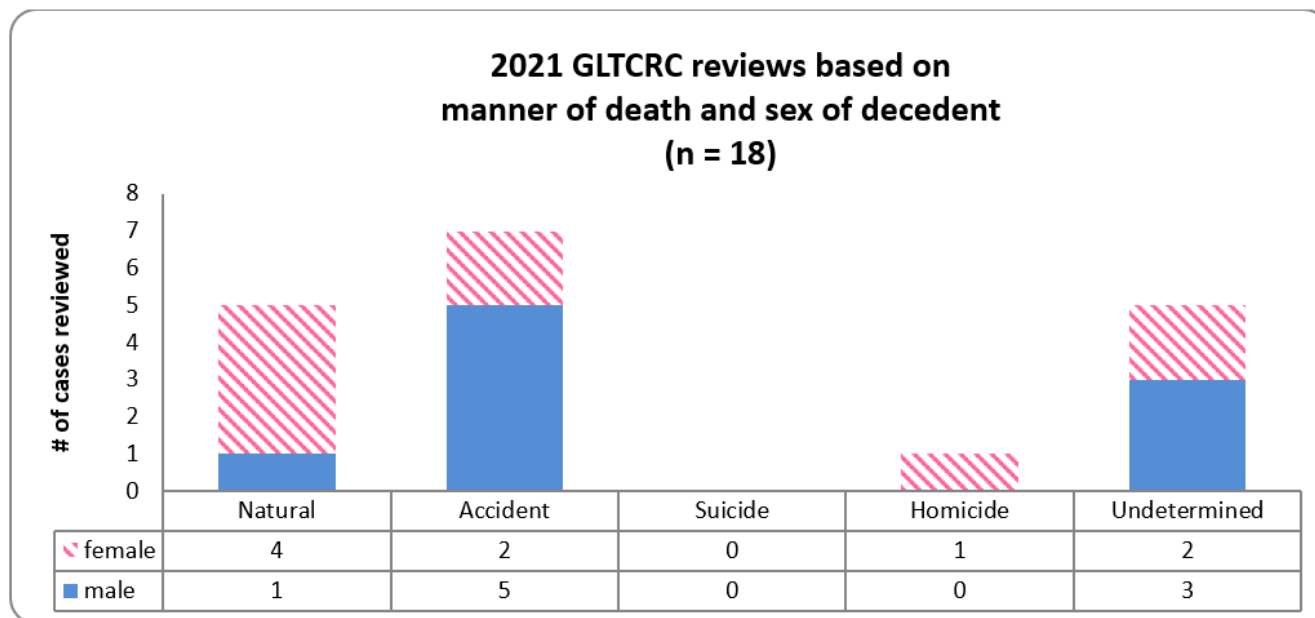
A summary of cases reviewed, and recommendations made in 2021 is included in Appendix A.

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

From the cases reviewed in 2021, the average age of all decedents was 73.5 years.



Graph Three: 2021 GLTCRC reviews based on manner of death and sex of decedent



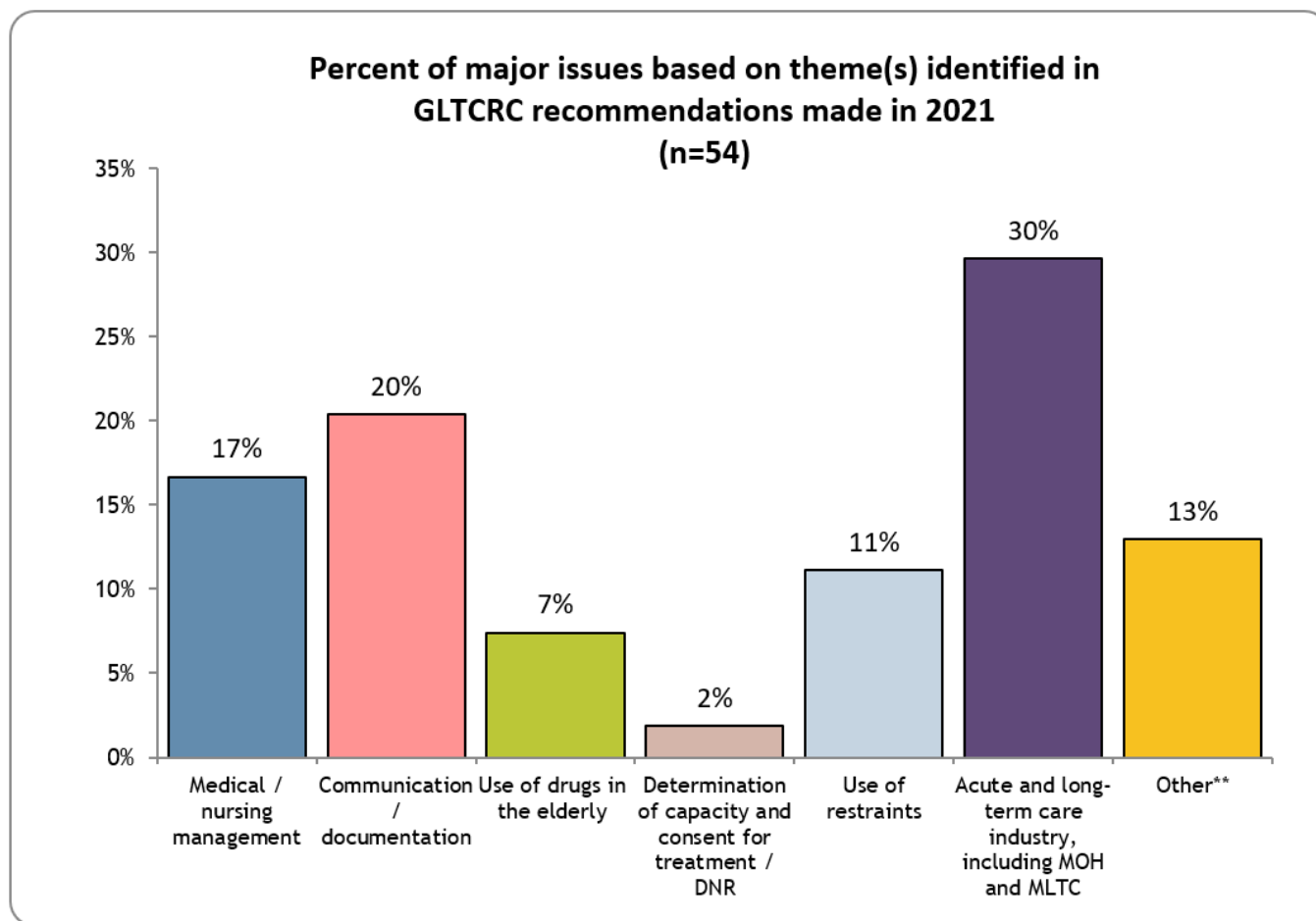
Graph Three demonstrates the breakdown of cases reviewed by the GLTCRC based on manner of death and sex of the decedent. Of the 18 cases reviewed, five were natural (four females and one male), seven were accidents (three females and four males), one homicide (female), and five were undetermined (two females and three males); there were no suicide cases reviewed.

In 2021, the GLTCRC generated a total of 49 recommendations aimed at preventing future deaths. One case resulted in no recommendations. Although the GLTCRC may not have generated recommendations in this case, the analysis of the circumstances and subsequent discussion contributed significantly to the larger coroner's investigation of the death.

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: Percent of major issues based on theme(s) identified in GLTCRC recommendations made in 2021



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

**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 2021. The most commonly identified themes/issues were related to the acute and long-term care industry (30%), communication and documentation (20%), medical or nursing management (17%), use of drugs in the elderly (7%), determination of consent and capacity (2%), “other” (including recommendations to the police and Regional Supervising Coroners) (13%) and use of restraints (11%).

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 therefore 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 2021:

- In 2021, there were 16 cases involving 18 deaths reviewed by the GLTCRC. There were 49 recommendations made. Of the 16 cases reviewed, one resulted in no recommendations.
- Of the 16 cases reviewed in 2021, the breakdown for manners of death were:
 - Natural - 5 (one male and four females)
 - Accident - 7 (five males and two females)
 - Homicide* - 1 (female)
 - Undetermined – 5 (three males and two females)
- Medical/nursing management issues were identified in 17% of the recommendations made.
- Communication and documentation issues were identified in 20% of the recommendations made.
- MOH and MLTC and/or LTC industry issues were identified in 30% of the recommendations made.
- 'Other' (including recommendations to police services and Regional Supervising Coroners, etc.) was identified in 13% of the recommendations made.
- Use of drugs in the elderly was identified in 7% of the recommendations made.
- The use of restraints in the elderly was identified in 11% of the recommendations and determination of consent and capacity / DNR in 2% of the recommendations.
- Some of the recommendations touched on more than one issue.
- One case did not have any recommendations.
- Of the 16 cases (involving 18 deaths) reviewed, 9 involved female deceased persons and 9 male deceased persons.
- The average age of all decedents (i.e. male and female combined) in cases reviewed in 2021 was 73.5 years.
- Of the cases reviewed in 2021, the manner of death for each of the 18 deceased persons was: natural (5), accident (7), homicide (1) and undetermined (5). There were no cases of suicide reviewed in 2021.

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, again, 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 2021 cases and recommendations

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
GLTCRC 2021-01	7	This case involves a 91-year-old man with a history of weakness, falls and weight loss who died from accidental hanging after he slid through, and was suspended by, a thigh belt on the tilt in space reclining chair that he was sitting in.	1. The hospital involved should review their policies and procedures to ensure compliance with the Patient Restraints Minimization Act (PRMA 2001), particularly as it relates to: a. documentation of physician and other health care provider orders, including a detailed explanation as to why restraints are suggested and why alternatives cannot be used and; b. public availability of restraint policy	Use of Restraints
			2. The hospital involved should employ a policy of least restraint explore alternatives to restraint, and conduct a regular review of restraint policies. Families should be involved with, and made aware of, the risks of physical restraints.	Use of Restraints
			3. The complex continuing care unit at the hospital involved should undertake a quality review of the circumstances surrounding this death in order to ensure compliance with the PRMA and best practices with respect to restraint use.	Use of Restraints
			4. The hospital involved should conduct mandatory training for all specific devices used for restraint. There should be no aftermarket or add on devices used for restraint of elderly patients and patients who are retained should be continuously monitored.	Communication/ Documentation
			5. Nurses should be given education with respect to restraint use in each facility that they are employed This	

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			education should cover specific devices used by the facility and the medical unit. When wheelchair lap belts are to be applied to patients with dementia or cognitive impairment, the patient must remain under direct supervision by nurses 6. The College of Physicians and Surgeons Ontario and College of Nurses Ontario are encouraged to publish a n article in their respective organizational publications to remind member s that for non natural or sudden and unexpected deaths, the body and death scene must not be altered pending direction from the coroner 7. The Ministry of Health, Ministry of Long-Term Care and Ontario Health should provide educational material (e.g. online courses, videos etc) to educate healthcare providers in the proper use, risks, and alternatives to physical restraints. The education should address general concepts of restraints and alternatives, as well as the specific restraint devices to be used in the healthcare setting. The EXBELT program might be considered as a research proven template to reduced restraint use.	Communication/ Documentation Use of Restraints Use of Restraints
GLTCRC 2021-02	1	This case involved a 74-year-old woman who died from pneumonia complicated by chronic obstructive pulmonary disease (COPD). The decedent's family identified concerns about the dosages and choice of medications, care for her underlying illness of COPD, assessment and treatment of her delirium, pain	1. The post-acute care hospital should conduct a quality-improvement focused review of the circumstances surrounding the care provided to this decedent. The focus of the review should be on identifying factors that will allow the care team to better care for similar patients in the future. Areas to address include, but are not limited to:	Acute and Long-Term Care Industry, Including MOH and MLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		control and communication.	- communication with families and - appropriate non-pharmacologic/ pharmacologic management of patients with dementia complicated by delirium.	
GLTCRC 2021-03	1	This case involved the death of a 78-year-old man who died after allegedly being pushed by another patient in the acute care hospital where they were both admitted. The incident was not witnessed. The decedent died from bronchopneumonia and bacteremia in the setting of chronic subdural hematomas and Alzheimer's disease.	Hospitals and healthcare providers are reminded that if an assault or possible assault has occurred on the hospital premises, police should be immediately notified.	Communication/ Documentation Use of Drugs in the Elderly Acute & Long-Term Care Industry Including MOH and MLTC
GLTCRC 2021-04	3	The decedent was a 92-year-old man who had a sequence of falls during a gastrointestinal illness and subsequently died following surgical treatment of a hip fracture. The decedent's family raised concerns regarding management of the gastrointestinal illness and falls prevention.	- When there is a change in resident status (e.g. emesis, diarrhea) medications should be reviewed and changed where necessary similar to the "SADMANS" sick day medication list recommended by Diabetes Canada. - Facilities caring for people who are unable to provide consent for treatment should have clear and consistent protocols on documentation of contact information for substitute decision makers during absences. - Tools should be developed for staffing adjustments to meet the needs of residents of long-term care homes when there is a change in	Use of Drugs in the Elderly Determination of Capacity & Consent for Treatment/DNR Communication/ Documentation Acute & Long-Term Care

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			workload or care needs (such as an outbreak).	Industry Including MOH and MLTC
GLTCRC 2021-05	3	This case involved the death of a 77-year-old woman who died from sepsis. The woman was living in Canada with her family and was on a visitors' visa. When the woman's health declined, her family attempted to access medical resources, but were declined due to lack of health insurance coverage.	1. The Ministry of Health should actively promote resources available through Community Health Centres, particularly as they relate to services available to new immigrants and those without medical insurance. The promotion of this initiative should be far-reaching and include healthcare providers, social services organizations, immigrant resources and faith/spiritual organizations. 2. Healthcare providers should educate themselves on available resources for information, referrals and services to individuals who do not have medical insurance in Ontario. 3. Citizenship and Immigration Canada should provide information to immigration applicants (including refugees) regarding housing, health care and legal services available before, during and after the application process.	Acute and Long-Term Care Industry, Including MOH and MLTC Communication/Documentation Medical Nursing/Management Other
GLTCRC 2021-06	3	This case involved the death of a 59-year-old man who died from septicemia due to septic arthritis of the right knee joint. The decedent presented with confusion to his local emergency department (ED) two months after a right total knee replacement. He became increasingly confused and agitated, was placed in restraints, and after about 12 hours, was intubated/ventilated before sustaining a cardiac arrest. He was transferred	1. The hospital involved should undertake comprehensive education for medical and nursing staff about delirium and its presentation in the emergency department. 2. The hospital involved should establish procedures for the rapid recognition of neurologic emergencies, with appropriate longitudinal charting (i.e. neurovitals, use of CAM). 3. The hospital involved should conduct a formal review of their restraints policy to ensure that policies, procedures and practices are consistent with provincial standards	Medical Nursing/Management Use of Restraints Communication/Documentation Acute & Long-Term Care Industry Including MOH and MLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
		to a regional referral centre where he died within 72 hours. Concerns were identified regarding the care provided in the ED.	outlined in the Patient Restraints Minimization Act 2001.	
GLTCRC 2021-07	7	These cases involved elderly individuals with cognitive impairment who died after falls from their power recliner life chairs. In all three cases, these individuals accessed the remote-control unit for the power-lift chair they were sitting in and were able to raise the seat to elevate them into a standing position. Once elevated, the individuals fell and suffered injuries that lead to their deaths.	1. It is recommended that the relevant Regional Supervising Coroner report these three incidents to the federal government through the Canada Consumer Product Safety Act online portal 2. Health Canada should encourage manufacturers to consider principles of Accessible and Universal Design for products being utilized by elderly patients and cognitive differences, in the same way child safety has been prioritized. Best practices should be established for categories of products such as power recliner chairs to help manufacturers design safer products 3. Manufacturers of power lift chairs should consider lockout mechanism or mechanism to unplug the remote controller to restrict access to cognitively impaired individuals. 4. Manufacturers of power lift chairs should improve their website and consumer information. The risk of falls must be emphasized in print and internet literature. Also, literature should include warnings for elderly with cognitive difficulties. 5. Long term and retirement homes should ensure that all medical devices used within their facilities meet safety standards and appropriately reflect the cognitive and physical needs of the resident they are assigned to. This will include ongoing monitoring of the devices and any recall or safety notices	Other Acute & Long-Term Care Industry, Including MOH and MLTC Other Other Medical Nursing/ Management

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			issued, as well as ongoing monitoring of the resident's need and ability to safely use to the device. 6. Long term and retirement homes should report concerns with any medical device to Health Canada through their online reporting portal. 7. Lift or recliner chairs should be included in home assessments with consideration of safety in patients with cognitive decline.	Communication/ Documentation Medical Nursing/ Management
GLTCRC 2021-08	0	This case involved the death of a 94-year-old man who was cognitively impaired and suffered complications of a left hip fracture after falling in their long-term care home.	N/A	N/A
GLTCRC 2021-09	1	This case involved the death of an 81-year-old woman who died following an altercation with another resident of the assisted living facility where they both lived.	1. The Retirement Home Regulatory Authority should perform an inspection of the facility involved to ensure compliance with RHA 2010 65(5)3 requiring that all staff receive training in behaviour management and specifically with O. Reg. 166/11, s. 23 (1) and (2) relating to the development of a written behaviour management plan.	Medical Nursing/ Management
GLTCRC 2021-10	2	This case involved the death of a 67-year-old woman with dementia who lived in a retirement home that reportedly offered specialized care for individuals who wandered. The woman died from positional asphyxia after eloping through a window in the retirement home where she lived.	1. Retirement Homes that provide specialized services (e.g. dementia care, 'locked wards', etc.) should be inspected to ensure that the physical layout of the home can provide the advertised specialized care. 2. The Ministry of Long-Term Care and Ministry of Seniors and Accessibility should ensure that the care of frail elders with complex chronic health conditions (including dementia) is provided with similar standards, requirements, regulations and oversight regardless of where they	Communication/ Documentation Acute & Long-Term Care Industry, Including MOH and MLTC

GLTCRC File #	# of Recs	Summary of Case	Recommendation(s)	Theme of recommendation
			reside. The ministries should review the discrepancies between the Long-Term Care Homes Act, Retirement Homes Act and the Home and Community Care Services Act to ensure that the standards set meet the needs of frail seniors no matter what setting they live in. This is increasingly important as the concept of "Aging in Place" becomes a cornerstone of our system of health and community care.	
GLTCRC 2021-11	4	This case involved the death of a 65-year-old woman with a long history of psychiatric illness. Concerns were identified regarding care and follow-up in the community of a vulnerable person with chronic mental health issues.	1. Clinicians in acute care hospitals that are discharging vulnerable patients should ensure the discharge destination is affordable, sustainable and provides appropriate care for the patient's needs. 2. Facilities that provide congregate housing accommodations to vulnerable seniors should clearly indicate to residents and their families (or other care providers) the level of service provided, preferably with a written contract. If provision of meals is part of this service, and if meals are discontinued, help should be sought to ensure the resident has nutrition provided or mental health agencies should be contacted to explore alternatives. These facilities need to ensure they are following the steps outlined in the Residential Tenancies Act if rent is not paid. 3. The Ministry of Health and the Ministry of Children, Community and Social Services should develop a robust housing plan to support the special needs of vulnerable persons in our province. This should include funding agencies that can facilitate access to sufficient income to support housing needs and have the knowledge of how to seek	Acute & Long-Term Care Industry Including MOH and MLTC Other Other

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			assessments of financial capacity. These duties should not be delegated to informal caregivers. 4. Ontario Health Teams should prioritize the development of care plans to meet the needs of, and support the transitions of, care and ongoing care for vulnerable persons with mental health challenges.	Acute & Long-Term Care Industry Including MOH and MLTC
GLTCRC 2021-12	4	This case involved the death of an 85-year-old woman who died from sepsis 43 days after admission to a long-term care home (LTCH). Her family expressed concerns regarding lack of care and possible elder abuse.	1. Transitions of care for complex older adults to long-term care facilities should be executed more effectively and with better planning. This process should involve an interdisciplinary transition of care team meeting that occurs prior to the transfer of care and includes the acute care hospital team members as well as the long-term care home team members. Pre-existing patient care issues and their management should be reviewed in detail including the optimization of skin care management. 2. Long term care homes should implement agreements with medical directors and physicians to include responsibility for admission history and physical exams earlier than seven days after admission and direct care more frequently than once monthly. 3. Residents in isolation should benefit from the same levels of care from the entire health care team as do non-isolated residents. This includes physiotherapy interventions. 4. Medication appropriateness for older adults should be incorporated into the long-term care admission assessment and into ongoing regular medication review.	Acute & Long-Term Care Industry Including MOH and MLTC Acute & Long-Term Care Industry Including MOH and MLTC Communication/Documentation Use of Drugs in the Elderly

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GLTCRC 2021-13	5	This case involved the death of a 79-year-old woman who died from complications of metastatic pancreatic neuroendocrine cancer following discharge from hospice to a retirement home. Concerns were identified relating to the lack of consistent and continuous community palliative care, expectations of care, interprofessional communication and communication with families.	1. HCCSS is encouraged to develop a provincial framework for Care Coordinators to advocate for clients/residents to remain in current places of care until criteria have been met to ensure a safe discharge. This would include the development of a "CRISIS over-ride decision tool." This tool would be used in conjunction with the clinical judgment of the care coordinator and would create standardized practices around crisis override use. The use of Crisis Identification and Situation Improvement Strategies (CRISIS) override function should be minimal and reserved for "extreme" situations only. 2. Home and Community Care Support Services (HCCSS) should consider the development of standardized discharge care protocols to support care coordination for clients/residents who transition out of hospice into another place of care. These protocols should focus on comprehensive symptom management and psychosocial support for the client/residents and family in addition to service ordering needs. A crisis designation to long-term care should be considered for these clients/residents depending on needs 3. Where the needs of an individual exceed what can be reasonably or safely provided in a congregate living situation (i.e., a retirement home), the HCCSS Care Coordinator should escalate the situation to the HCCSS Management Team to advocate for the appropriate level of care. 4. The Retirement Home Regulatory Authority should create policies (or	Acute & Long-Term Care Industry, Including MOH and MLTC Communication/Documentation Medical Nursing/Management Communication/Documentation

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			advise the Minister of necessary policy changes) such that no licensee be able to admit (rent a unit or bed) a. any person who requires skin and wound care or assistance for feeding if the retirement home is not licensed to otherwise provide those services, b. any person who is palliative and requires 24/7 care (i.e. bedbound/ADL dependent) 5. Clients who are disqualified due to stable PPS scores and are identified for discharge to another “place of care” should remain in hospice until an appropriate and safe discharge is in place. Close attention should be paid to the client’s total condition and not just the PPS scores. The hospice and the care coordinator should ensure that a safe transfer can take place and that the necessary services are in place at the time of transfer rather than at a later date.	Acute & Long-Term Care Industry, Including MOH and MLTC
GLTCRC 2021-14	1	The decedent was an 85-year-old man who was reportedly pushed by another patient in a Special Behaviour Unit (SBU) on a mental health ward in a hospital. The fall was unwitnessed by staff and there was no video surveillance. He sustained a pelvic fracture leading to immobilization, pulmonary embolism, and death.	1. A provincial system with reliable access to safe forensic units should be developed for the small minority of individuals with dementia and serious behaviour challenges. This discussion should include clarification of the roles of police, hospitals and the forensic system.	Acute & Long-Term Care Industry, Including MOH and MLTC Other
GLTCRC 2021-15	1	This case involved the death of an 86-year-old man after being pushed by a 66-year-old woman with Alzheimer’s disease. They were residents of the same	1. Practitioners should be reminded that while hydromorphone can be very helpful in older patients with chronic pain, it should not be used before trials with less toxic analgesics	Use of Drugs in the Elderly

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		long-term care home (LTCH).	(e.g. acetaminophen given on a regular basis).	
GLTCRC 2021-16	6	This case involved the death of a 92-year-old woman who died after being pushed by another resident in the long-term care home (where they both resided. The incident happened within one month of both residents being admitted to the facility. This was a mandatory review by the Geriatric and Long-Term Care Review Committee as the manner of death was homicide	1. It is recommended that standing orders for dextromethorphan, diphenhydramine and guaifenesin be reviewed. 2. The staff to resident ratio and the number of transfers taking place from June to July 2019 should be reviewed and procedures established to ensure adequate numbers of registered and nonregistered staff and appropriate resources for the volume of transfers in the long-term care home 3. Consideration should be given to increasing staff levels during periods when new residents are admitted /transferred to the facility as this is a high-risk period for increased resident to resident aggression (RRA). 4. A low threshold for 1:1 staffing should be considered for residents with histories of dementia aggression suspicious, paranoid or wandering behaviour, or overprotection of boundaries. This should be strongly considered during admitting/transfer periods when staff and residents are interacting for the first time. 5. It is recommended that the Ministry of Long-Term Care explore funding and partnership opportunities for research into resident-to-resident aggression and its prevention. 6. It is recommended that the Ministry of Long-Term Care consider funding opportunities to assist long term care homes address understaffing, particularly during admitting	Use of Drugs in the Elderly Medical Nursing/ Management Medical Nursing/ Management Medical Nursing/ Management Acute & Long-Term Care Industry, Including MOH and MLTC Acute & Long-Term Care Industry, Including MOH and MLTC

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			/transfer periods which presents unique challenges and risks	

Questions and comments regarding this report may be directed to:

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