Geriatric and Long-Term Care Death Review Committee: 2022 Annual Report

Read the committee's 2022 annual report on geriatric and long-term care deaths in Ontario.

Message from the Chair

The following is the 2022 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 2022, the GLTCRC reviewed 13 cases, involving 13 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.

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

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

Committee membership

Dr. Roger Skinner
Regional Supervising Coroner, Committee Chair

Ms. Cianna Williams
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, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.
- In 2022, the GLTCRC reviewed 13 cases involving 13 deaths and generated 49 recommendations directed toward the prevention of future deaths. Of the 13 cases reviewed, two resulted in no recommendations.
- Of the 13 deaths that were reviewed in 2022, the breakdown for manners of death were:
  - Natural - 5 (one male and four females)
  - Accident - 3 (one male and two females)
  - Homicide[1] - 4 (three males and one female)
  - Undetermined – 1 (one female)
- Of the 13 deaths reviewed, 5 were male and 8 were female.
- The average age of men whose deaths were reviewed was 86.6 years.
- The average age of women whose deaths were reviewed was 80.1 years.
- The average age of all deaths reviewed in 2022 was 82.6 years.
- In 2022, 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
- Education/training
- Transfers (patient and information)
- Other (for example, quality reviews, research, data collection, referrals to other organizations)

Chapter 1: 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* (https://www.ontario.ca/laws/statute/90c37) and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) .

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.

Other individuals with specific expertise may be invited to committee meetings as necessary on a case-by-case basis (for example, 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.

One or more members 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-investigate the death or 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* (https://www.ontario.ca/laws/statute/90c37) and the *Freedom of Information and Protection of Privacy Act* (https://www.ontario.ca/laws/statute/90f31) . 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 (mailto: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 (for example, homicides in long-term care or retirement homes), or discretionary referral (for example, 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 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 for cases reviewed by the GLTCRC in 2022 are included in Appendix A.

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

Chapter 2: Statistical overview (2004-2022)

Between 2004 and 2022, the GLTCRC reviewed a total of 395 cases and generated 931 recommendations aimed towards the prevention of future deaths. On average, the GLTCRC has reviewed 20.8 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 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)
- Training and education (emerged as a new theme in 2022 and has been reflected in the data)
- Transfers (emerged as a new theme in 2022 and has been reflected in the data)
- Other: includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, legal/justice sector, or is case specific

The following statistical analysis of 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** help 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** help 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 2004-2022

From 2004 until 2022, the GLTCRC has reviewed a total of 395 cases.

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

Note: 'Other' includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, or legal/justice sector, or is case specific.

Graph One demonstrates that in 32% of the cases reviewed by the GLTCRC from 2004-2022, issues relating to medical/nursing management were identified. This is followed by 23% of the cases where issues pertaining to the acute and long-term care industry (including MOH and MLTC) were noted and 18% of the cases where issues of communication/documentation were present. Other key themes included use of drugs in the elderly (12%), use of restraints (3%), training and education (1%), transfers (0.5%), determination of consent and capacity/DNR (3%) and other (7%).

Training and education along with transfers has emerged as new themes in 2022. This has been reflected in the data.

Graph Two: Percent of major issues based on theme(s) identified in GLTCRC recommendations (2004-2022)

From 2004 until 2022, the GLTCRC generated 931 recommendations aimed at the prevention of future deaths.

Notes: Some recommendations had more than one theme/issue attributed.
'Other' includes recommendations includes recommendations that do not fall into any of the other listed themes, including recommendations that relate to research, data collection, the referral to another committee, ministry, or legal/justice sector, or case

specific.

Graph Two demonstrates the percentage of common themes/issues attributed to the individual recommendations made from the cases reviewed from 2004-2022. Some complex recommendations may have been recorded as having more than one theme or issue. It was found that 34% 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 (11%), determination of capacity and consent for treatment or DNR (3%), the use of restraints (4%), training and education (1%), transfers (1%), and other (6%).

Chapter 3: Cases reviewed in 2022

In 2022, the GLTCRC reviewed a total of 13 cases involving the deaths of 13 elderly individuals (seven females and six males), including residents of long-term care and retirement homes. Of the 13 cases, five were mandatory reviews resulting from homicides that occurred in long-term care facilities.

Of the cases reviewed in 2022, one of the deaths occurred in 2016, one in 2018, two in 2019, seven in 2020, and two in 2021.

[Note: The OCC has made it a policy to submit all coroners' 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 2022 is included in Appendix A.

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

Average age of decedent in cases reviewed in 2022

- Male: 80.1 years
- Female: 86.6 years
- From the cases reviewed in 2022, the average age of all decedents was 82.6 years.

Graph Three: 2022 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 13 cases reviewed, five were natural (four females and one male), three were accidents (two females and one male), four homicides (one female and three male), and one undetermined (one female); there were no suicide cases reviewed.

In 2022, the GLTCRC generated a total of 49 recommendations aimed at preventing future deaths. Two cases resulted in no recommendations. Although the GLTCRC may not have generated recommendations in these cases, the analysis of the circumstances and subsequent discussions contributed significantly to the larger coroner's investigations of these 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: Percent of major issues based on theme(s) identified in GLTCRC recommendations made in 2022

Graph Four demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2022. The most commonly identified themes/issues were related to the acute and long-term care industry (20%), communication and documentation (19%), medical or nursing management (17%), training and education (13%), “other” (12%), transfers (9%), use of drugs in the elderly (3%), determination of consent and capacity (6%), and use of restraints (1%).

Notes: Some recommendations had more than one theme/issue attributed.
'Other' includes recommendations that do not fall into any of the other listed themes. In 2022, these recommendations captured issues relating to research, data collection, or was case specific.

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 2022

- In 2022, there were 13 cases involving 13 deaths reviewed by the GLTCRC. There were 49 recommendations made. Of the 13 cases reviewed, two resulted in no recommendations.
- Of the 13 cases reviewed in 2022, the breakdown for manners of death were:
  - Natural - 5 (one male and four females)
  - Accident - 3 (one male and two females)
  - Homicide[1] - 4 (three males and one female)
  - Undetermined – 1 (one female)
- Medical/nursing management issues were identified in 17% of the recommendations made.
- Communication and documentation issues were identified in 19% of the

recommendations made.

- MOH and MLTC and/or LTC industry issues were identified in 20% of the recommendations made.
- 'Other' (captured recommendations relating to research, data collection, or was case specific) was identified in 12% of the recommendations made.
- Use of drugs in the elderly was identified in 3% of the recommendations made.
- Training and education issues were identified in 13% of the recommendations made.
- The use of restraints in the elderly was identified in 1% of the recommendations, 9% of transfers (patient and information), and determination of consent and capacity / DNR in 6% of the recommendations.
- Some of the recommendations touched on more than one issue.
- One case did not have any recommendations.
- Of the 13 cases (involving 13 deaths) reviewed, 8 involved female deceased persons and 5 male deceased persons.
- The average age of all decedents (that is, male and female combined) in cases reviewed in 2022 was 82.6 years.
- Of the cases reviewed in 2022, the manner of death for each of the 13 deceased persons was: natural (5), homicide (4), accident (3), and undetermined (1). There were no cases of suicide reviewed in 2022.

Chapter 4: Lessons learned 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 LTCM, 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 cases reviewed and recommendations in 2022

GLTCRC File number	Number of Recs	Summary of Case	Recommendation(s)	Theme of Recommendation
GL	0	This case involved	Not applicable	Not

TCRC-2022-01		the death of an 86-year-old man who died from complications of hip fracture after being pushed by another resident of the long-term care home where they both resided.		applicable
GLTCRC-2022-02	3	The decedent was an 84-year-old female who lost vital signs at a retirement home. Concerns were raised by the family and the coroner that the deceased did not have the death without intervention that she desired, and that paramedic resources could be better used for patients that required their services.	1. It is recommended that the Ministry of Health and Ministry of Long-Term Care should organize a committee to revise the current do not resuscitate (DNR-C) form. This committee should include broad medical and legal representation as well as representatives from EMS, the retirement and LTC home sectors and someone with lived experience. This review should also include a process to rescind consent for a DNR order. The form should not be overly complex	1. Determination of Capacity/Consent for Treatment/DNR; Acute Care and LTC Industry

			but should be a viable, interoperable, digital format. It should include the designation of the regulated health professional obtaining the consent and their license number. 2. In conjunction with this new form, education should be provided to regulated health care professionals (MD, RN, RPN, RN-EC), through their professional colleges, on the proper process for obtaining consent for a DNR order and completion of this form. This change would also necessitate the updating of the training manuals for EMS workers. 3. The current DNR consent forms of all residents and patients should be reviewed to ensure these forms are valid and properly completed. Homes	2. Education and Training; Determination of Capacity/Consent for Treatment/DNR 3. Determination of Capacity/Consent for Treatment/D

			should ensure that they have on site hard copies of the current, valid forms with serial number. Education for regulated staff should be provided on how to obtain consent and complete the current forms.	NR; Acute Care and LTC Industry
GLTCRC-2022-03	0	This case involved the death of an 84-year-old female resident of a LTCH who died of complications of an undiagnosed duodenal ulcer.	Not applicable	Not applicable
GLTCRC-2022-04	5	The case involved the death of a 77-year-old female resident of a LTCH who died following complications of bronchopneumonia with an underlying undiagnosed lung carcinoma. Family expressed concerns related to follow up on	1. Ontario Health should develop an integrated provincial Electronic Health Record (EHR) that provides the opportunity for transfer of information across healthcare sectors including community independent healthcare facilities to support the	1. Communication and Documentation; Transfers

		abnormal imaging.	seamless transition(s) of care. This should include an opportunity for open access to health records to support patient centered approach to care. 2. Primary care providers should ensure that a seamless transfer of care occurs when patients transition between care settings such as transfer from community primary care to retirement home and to long-term care home. This must include all recent and relevant investigations, consultation reports and specialist involvement including pending referrals. In addition, they should ensure there is a process in place to transfer reports, investigation results that they receive to the appropriate provider when no longer the most responsible provider	2. Communication and Documentation; Transfers 3. Acute Care and LTC Industry; Education and Training 4. Determination of Capacity/C

			for the patient. 3. All medical directors and attending physicians working in long-term care homes in Ontario should have competency in care of persons with multi-morbidity, dementia care including diagnosis, assessment and management of behavioural symptoms and a palliative approach to care. 4. A palliative approach to care should be a required competency for clinicians working in long-term care homes with a specific focus on consent to treatment, goals of care discussions and a palliative approach for persons with progressive dementia and multi-morbidity. 5. Long term care homes and retirement homes should develop systems and processes that track	ons ent for Trea tme nt/D NR; Acut e Car e and LTC Ind ustr y 5. Med ical and Nur sing Man age me nt; Acut e Car e and LTC Ind ustr y

			the status and implementation of requests for consultation.	
GLTCRC-2022-05	7	The decedent was a 75-year-old woman who died of smoke inhalation from a house fire on June 26, 2020. Prior to her death in the house fire, she had a number of contacts with health care providers and the police. The GLTCRC was asked to review the death of this individual at the request of the Inquest Advisory Committee (IAC). The GLTCRC was asked to make recommendations to assist in preventing similar deaths in the future, provide an opinion as to whether a discretionary	1. Health care providers, including first responders (paramedics, police and fire personnel), are reminded that seniors living alone, and particularly those with an altered mental status, are vulnerable persons and there is a heightened duty of care for all service providers. 2. In situations in which the possibility of elder abuse has been raised, care providers are reminded to work as a team, including police as necessary, to establish if this is the case or not. An excellent, provincially funded resource is Elder Abuse Prevention Ontario (https://eapon.ca/) 3. In situations in which	1. Other 2. Medical and Nursing Management; Education and Training 3. Communication and Documentation

		inquest may assist in prevention, and if there is a role for collaborating with the Office of the Public Guardian and Trustee.	seniors are unable to access home and community care services by phone or virtual methods, clear and timely assessment and support must be offered in person. 4. An easily accessible, PHIPA compliant, integrated health information system which includes home and community care services, is strongly encouraged. 5. Clinical teams caring for seniors in the community, emergency room and other hospital settings are reminded that delirium is a common and serious presentation in the elderly. All care settings are strongly encouraged to have robust clinical pathways in place to identify, assess, and support seniors with delirium. 6. When discharging seniors from the	4. Communication and Documentation 5. Medical and Nursing Management 6. Communication and Documentation 7. Education and Trai

			hospital on oxygen, it is strongly recommended that there be independent verification that the discharge destination have working smoke alarms. 7. Current educational approaches to support the Health Care and Consent Act in practice are simply not working. The GLTCRC strongly encourages a re-invigorated program of education across the senior care sector to support providers assessing capacity for health care decisions in Ontario.	ning
GLTCRC-2022-06	6	This case involved the death of a 64-year-old woman with schizophrenia, who had been living in a LTCH. The family and Regional Coroner had concerns surrounding hygiene issues and	1. Registered staff should be reminded of the medical concept of sepsis, including the importance of early recognition and early treatment which has been proven to reduce mortality and morbidity.	1. Medical and Nursing Management 2. Edu

		care at the LTCH.	2. There should be renewed emphasis on teaching the importance of full vital signs and that staff must follow up on abnormal vital signs. 3. If a Doctor of Medicine (MD) has been called for a change in resident condition and does not answer, unless the situation is completely resolved, staff should call again to discuss and document the case. If the MD is still not available, consideration should be given to sending the resident to the hospital for examination and treatment. 4. Standing orders for acetaminophen should be restricted to 1-2 doses per illness. Standing orders of several doses might delay diagnosis and treatment.	cation and Training 3. Medical and Nursing Management 4. Use of Drugs in the Elderly 5. Education and Training 6. Communication and Docum

			5. Training of LTCH staff should include care of residents with non-cognitive psychiatric disorders (for example, schizophrenia). 6. Residents with non-cognitive psychiatric disorders should have care plans that reflect any specific care issues in that regard.	ent atio n
GL TC RC - 20 22 -0 7	1	This case involved an 81-year-old male who died as a result of being pushed by another resident in his LTCH.	1. LTC Homes in Ontario should be reminded to specifically include fracture prevention and not just fall prevention in their quality improvement activities (for example, through mandatory falls prevention and management programs). The Fracture Risk Scale in MDS-RAI may be useful to identify those at highest risk of fracture.	1. Acu te Car e and LTC Ind ustr y

GLTCRC-2022-08	1	This case was referred to the committee as a mandatory review. The manner of death was determined to be a homicide after an 88-year-old woman died from complications of a hip fracture that she sustained after being pushed by another resident in the long-term care home where they both resided.	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, routines and interactions with those already residing in the home. Careful supervision, documentation and behavioural care-planning are essential.	1. Communication and Documentation; Acute Care and LTC Industry
GLTCRC-2022-09	5	This is a case of an 87-year-old male discharged from hospital Against Medical Advice (AMA) by his son who had Power of Attorney for Personal Care. The issues raised in this case and expressed by next of kin included “deficient care	1. In cases in which a decision has been made to provide palliative care, the Primary Care Provider should be encouraged to continue to provide care. In addition, consideration should be given to a. e. referring to a Home and	1. Other

		which led to the development of a large sacral ulcer, failure to provide proper infection treatment, and inadequate home care treatment for the sacral ulcer (paramount to neglect)".	Community Care Support Services (HCCSS Palliative Care Nurse Practitioner to provide in-home palliative support to the patient, family and contracted service providers (even if there is a Primary Care Provider involved) b. f. referring to a Community Palliative Care Team for 24/7 support. 2. Reinforce the importance for all contracted Service Provider Organizations staff to be compliant with the provincial (HCCSS) SAFE Reporting system for all patient safety events. 3. Where a family member and/or legal Substitute Decision Maker (SDM) decides to take the patient home Against Medical	2. Communication and Documentation 3. Medical and Nursing Management 4. Acute Care and LTC Industry 5. Other; Communication

			Advice (AMA), a Hospital Ethicist should participate in the discharge-planning meeting with the family members/SDM. 4. The Ministry of Health should ensure sufficient resourcing of HCCSS teams in order to support complex clients requiring 24/7 services. 5. Safety indicators for home care to support reporting and quality improvement should be developed.	and Documentation
GLTCRC-2022-10	4	The case involved the death of a 90-year-old male resident of a LTC home who died following an injury sustained during a transfer using a mechanical lift. The referral to the GLTCRC was made at the request of the Regional Supervising	1. The LTC home involved in this case should complete a quality review of this incident and practices regarding the use of mechanical lifts to identify improvements to prevent a similar incident in the future. 2. When using mechanical lifts for	1. Medical and Nursing Management; Acute Car

		Coroner due to concerns of care issues expressed by the coroner and family.	patient/resident transfers, all providers should be aware of the risk of head and neck injury if the sling becomes loosened or undone during transfer. The risk of injury is heightened for those with underlying health conditions that may increase the severity of injury (that is, osteoporosis). 3. Providers need to follow manufacturers' instructions on the appropriate use of mechanical lifts including the use of 2 persons during the transfer. There should be a process in place to confirm prior to each patient transfer that the appropriate size of sling is being used and that there is a regular process to reassess the appropriate sling size on a regular basis for those requiring mechanical transfers on an ongoing basis.	e and LTC Industry 2. Medical and Nursing Management; Other 3. Transfers; Education and Training 4. Transfers; Education and Training

			4. All providers should receive ongoing education and training on the safe use of mechanical lifts, including the importance of consistency in measurement and application of appropriate sling during patient/resident transfer and the use of 2 persons during the transfer. The committee recommends that this case and previous cases reviewed by the committee should be used in training for the sector.	
GLTCRC-2022-11	9	The Regional Supervising Coroner requested a review of this case of an 83-year-old female who died of acute and chronic dehydration after being transported from a Regional Hospital by a	1. Hospitals should consider the regional hospital's quality review recommendations such as: • the development of a check list for use prior to long or complex transfers	1. Communication and Documentation

		ground transport service, then a contractor for air ambulance, then ground transport to a Long-Term Care Home (LTCH). Her transfer was considered non urgent as she was an Alternate Level of Care (ALC) patient awaiting admission to the LTCH of choice. There were concerns that delays in her transfer may have contributed to her death.	• review and documentation of any family concerns prior to transfer and escalation of these concerns to the most responsible physician • ensure food, fluids and medications are provided to the transport team in the event there are delays in the transport • encourage physician to physician communication for non-hospital transfers. 2. In person examination of a patient for stability prior to transfer out of the hospital should be performed. 3. Physicians should be aware of where to find nutritional intake data in the electronic health record.	2. Medical and Nursing Management; Transfers 3. Medical and Nursing Management; Communication and documentation 4. Communication

			Nursing staff must communicate poor oral intake of a patient to the physician. Management of the poor oral intake should be discussed with the patient or their decision makers in the context of the patient's disease and life expectancy. 4. Patients with poor oral intake should be weighed on a regular basis. 5. Hospitals should explore ways to support patients who require hand feeding such as communal dining tables with staff assigned to feed several patients where infection control practices permit. 6. Physicians should be made aware of the impacts of trimethoprim/sulfamethoxazole on renal function in the elderly and that renal function should be	and Documentation 5. Acute Care and LTC Industry 6. Use of Drugs in the Elderly 7. Use of Restraints 8. Transfers 9. Medical and Nur

			checked once treatment is started. 7. Hospital staff and physicians should be reminded that physical restraints are a barrier to patients self-feeding and being able to meet their own nutritional needs. 8. Transport services should ensure that all phases of a patient's transfer are fully coordinated and confirmed prior to the transfer. The transport team should be aware of the nature of the patient's diet and have diet and texture appropriate food and fluids in the event of delays in transport. 9. A further review of this death should be completed by the hospital involved with consideration of the findings and recommendations of the committee.	sing Management

GLTCRC-2022-12	6	This case involved an 89-year-old male who was the victim of resident-on-resident violence within a long-term care facility. This was a mandatory GLTCRC review of events since this death was classified as a homicide in Long-Term Care.	1. Strategies to counteract the 'normalization' of violence should be considered when developing the Ontario Provincial Dementia Strategy. 2. It is recommended that the Ministry of Health and Ministry of Long-Term Care consider, as a component of the configuration of a system-wide approach to responsive behaviours/ behavioural and psychological symptoms of dementia (BPSD), the establishment of an increased number of non-transitional long-term care home behaviour support units throughout the province for carefully selected individuals with severe and prolonged behavioural symptoms, adequately resourced	1. Communication and Documentation 2. Acute Care and LTC Industry; Other 3. Acute Care and LTC Industry 4. Acute Care

			and staffed with individuals trained to manage BPSD. 3. Behavioral Supports Ontario should consider increasing transitional care planning with behavioral supports in the LTC facility when an individual suffering dementia syndrome with behavioral symptoms relocates to the LTC facility. 4. Long Term Care facilities should consider increased staffing/higher intensity supervision while attempting to wean antipsychotics for behavioral symptoms of dementia. 5. It is recommended that the Ministry of Long-Term Care consider increasing resources to support training and education of long-term care home staff and physicians in the management of	and LTC Industry 5. Medical and Nursing Management; Education and Training 6. Acute Care and LTC Industry; Other

			responsive behaviors/BPSD), as well as to support increased staffing levels in long-term care homes geared towards mitigating responsive behaviors as opposed to basic functional needs. 6. It is recommended that the Ministry of Long-Term Care consider funding research to investigate strategies to assess, predict, and manage resident to resident violence in long term care home with attention to variation among different long term care homes.	
GLTCRC-2022-13	2	The Geriatric and Long-term Care Review Committee has been asked by the Regional Supervising Coroner to review this death. The decedent was an 86-year-old	1. It is recommended that the Ministry of Seniors and Accessibility and the Ministry of the Solicitor General explore whether a “silver alert” system for missing seniors should be	1. Other 2. Other

		woman who died of hypothermia after becoming lost. The GLTCRC was asked to make recommendations to assist in preventing similar deaths in the future and provide an opinion as to whether a “Silver Alert Policy” might have been beneficial.	implemented in Ontario. 2. Police services should consider working with community agency partners to implement social work crisis outreach to follow-up on domestic incidents involving seniors.	