

Patient Safety Review Committee Annual Report 2015-2018

Office of the Chief Coroner of Ontario
May 2021



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Message from the Chair



This is a report of cases reviewed by the Office of the Chief Coroner Patient Safety Review Committee from 2015-2018, inclusive.

Over the past four years, the committee completed 28 reviews of deaths that involved the presence of systemic issues related to the provision of care. From the cases reviewed, the committee made a total of 139 recommendations aimed at preventing future deaths.

Examining deaths from the perspective of enhancing patient safety is an important step in preventing avoidable deaths. It is through the analysis of these cases that preventative approaches can be developed and enhanced to help prevent future morbidity and mortality.

The PSRC is composed of regular and invited members who help contribute to an open, nonjudgmental analysis of cases. It is through the analysis, discussion and knowledge of the healthcare system in Ontario that the recommendations are developed. The quality of the recommendations is our goal, not the number. Through effective, clearly expressed recommendations, there can be a meaningful opportunity for further learning and change within the healthcare system. This, in turn, can support change that is predicated on enhancing patient safety.

Systemic learning is directed at the goal of prioritizing care of the patient (including their family/friends). This can only be achieved through the unbiased and open analysis of organizational policies, resource provision and utilization, use of evidence-based care provision protocols, patient-centred communication policies, and an educationally-focused incident reporting, analysis, and management system. These processes, along with appropriate preventative and mitigation-based processes, will help ensure that healthcare provision in our province is resilient, responsive and effective for today and the future.

On behalf of the committee, thank you for your interest in patient safety, and in the work of the Patient Safety Review Committee.

Reuven Jhirad MD MPH CCFP FCFP

Deputy Chief Coroner

Chair, Patient Safety Review Committee

Committee Membership

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Chair, Patient Safety Review Committee
Deputy Chief Coroner
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Emergency Physician and Research Director
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College of Physicians and Surgeons of
Ontario (Ex-Officio)

Ms. Patti Cochrane (past member)

Former Senior Vice President,
Clinical Strategy,
Trillium Health Partners

Dr. Margaret Doma (past member)

Former Director of Patient Relations,
Risk and Medical Affairs,
St. Joseph's Healthcare, Hamilton

Ms. Kathy Kerr

Executive Lead
Office of the Chief Coroner

History

Historically, issues or concerns relating to patient safety that were identified during a coroner's investigation may have led to individual recommendations being generated by the investigating coroner, or to a public review of the circumstances surrounding the death through a coroner's inquest. The complexity of cases involving patient safety issues, however, often requires specialized knowledge and expertise to fully understand the intricacies of the circumstances of the death. Inquests may take place several years after a death and it may be challenging for a jury comprised of members of the public to fully grasp the complex medical details to make practical recommendations aimed at preventing similar deaths in the future.

The Patient Safety Review Committee (PSRC) was established in 2005 to address the need for specialized knowledge and expertise in helping to expedite the review of coroners' cases with actual or perceived systemic patient safety implications, and where possible, to make recommendations to prevent future similar deaths.

Purpose

The purpose of the PSRC is to assist the Office of the Chief Coroner (OCC) in the investigation and review of healthcare-related deaths where system-based errors or issues appear to be a major factor. The PSRC develops recommendations aimed at preventing similar future deaths, which are sent to the relevant agencies and organizations by the Chief Coroner for Ontario, through the Chair of the committee. The patient and public safety mandate of the OCC is derived from the Coroners Act:

Chief Coroner and duties

3. (1) The Lieutenant Governor in Council may appoint a coroner to be Chief Coroner for Ontario who shall,

(d) Bring the findings and recommendations of coroners' investigations and coroners' juries to the attention of appropriate persons, agencies and ministries of government;

Disclosure to the public

18. (4) The Chief Coroner shall bring the information collected during a coroner's investigation and the investigation's findings and recommendations, which may include personal information as defined in the Freedom of Information and Protection of Privacy Act, to the attention of the public, or any segment of the public, if the Chief Coroner reasonably believes that it is necessary in the interests of public safety to do so. 2018, c. 3, Sched. 6, s. 7 (1).

In the context of the PSRC, the use of the word "error" does not imply blame or responsibility on the part of any individual or organization. For the purposes of this committee, "error" is defined as a system design characteristic that either permits unintended adverse events to occur (latent error) or does not detect deviations from the intended path of care (active error). System design would include not only the design of care processes, but also access to care management (such as delays in receiving care). The

presence of such errors does not mean that an individual or organization should be assigned blame or responsibility for an unintended outcome. The mandate of the PSRC, like that of the OCC, is one of fact-finding, not fault-finding.

The aims and objectives of the PSRC are:

1. To provide expert opinion about the cause and manner of death in healthcare-related cases where systems-based errors appear to be a major factor.
2. To assist coroners to improve the investigation of deaths within, or arising from, the health care system in which systems-based errors appear to have occurred.
3. To stimulate educational activities for professionals through identification of systemic problems, referral to appropriate agencies for action, collaboration with professional regulatory bodies and the dissemination of an annual report. Emphasis will be placed on speedy dissemination of information.
4. To provide expert evidence at inquests on request.
5. To conduct or promote research, where appropriate.
6. To undertake random or directed reviews when requested by the chairperson.
7. To help identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention.

Structure and Size

The committee membership consists of respected practitioners from various disciplines related to health care. The membership is balanced to reflect wide and practicable geographical representation and representation from all levels of institutions, including teaching centres, to the extent possible. Other individuals with specialized knowledge or expertise are invited to participate in committee reviews when required and at the discretion of the chairperson.

The committee membership, and its balance, is reviewed regularly by the chairperson and by the Chief Coroner, as requested.

Limitations

The PSRC 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, relevant information. It is not within the mandate of the committee to re-open other investigations (e.g. criminal proceedings) that may have already occurred.

Information collected and examined by the PSRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to the Coroners Act.

All information obtained as a result of coroners' investigations and provided to the PSRC is subject to confidentiality and privacy limitations imposed by the Coroners Act and the Freedom of Information and Protection of Privacy Act. Unless and until an inquest is called with respect to a specific death or deaths, the confidentiality and privacy interests of the decedents, as well as those involved in the circumstances of the death, will prevail. Medical records, draft and consensus reports (with identifying information) and the minutes of committee meetings are confidential documents and are not publically released. Redacted reports prepared by the PSRC do not contain personal information and are available to the public. Recommendations and responses to recommendations are available to the public.

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 give opinions outside the coroners' system about cases reviewed. In particular, members do not act as experts at civil trials for cases that the PSRC has reviewed.

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.

Recommendations and responses

One of the primary goals of the PSRC is to make recommendations aimed at preventing deaths in similar circumstances. Recommendations are distributed to relevant organizations and agencies through the Chair of the PSRC.

Similar to recommendations generated through coroners' inquests, the recommendations developed by the PSRC are not legally binding and there is no obligation for agencies and organizations to implement or respond to them.

Organizations and agencies are asked to respond back to the Executive Lead, PSRC on the status of implementation of recommendations within six months of distribution. All reports and recommendations are distributed electronically.

Redacted versions of all reports and responses to recommendations are available to the public upon request at occ.inquiries@ontario.ca.

Summary of Cases Reviewed in 2015-2018

Chart 1 shows that from 2015 to 2018 inclusive, the PSRC reviewed a total of 28 cases and made 139 recommendations aimed towards the prevention of future deaths. Of the cases reviewed, 18 involved natural deaths, four were accidental deaths, five were suicides and one was undetermined. There were an equal number of female and male decedents in the cases reviewed.

The number of recommendations made ranged from one to 11, with an average of five recommendations per case. There were no cases where the PSRC did not make a recommendation.

Chart 1: Summary of cases reviewed by PSRC 2015-2018

Year	# of cases	# of recs	Natural	Accident	Homicide	Suicide	Undetermined	Female	Male
2015	5	28	4			1		4	1
2016	6	24	2	1		3		4	2
2017	9	52	7			1	1	3	6
2018	8	35	5	3				3	5
Total	28	139	18	4	0	5	1	14	14

A summary of all cases reviewed by the PSRC from 2015-2018, together with the recommendations made, is included as Appendix A.

Chart 2: % of Recommendations with theme present (PSRC 2015-2018)

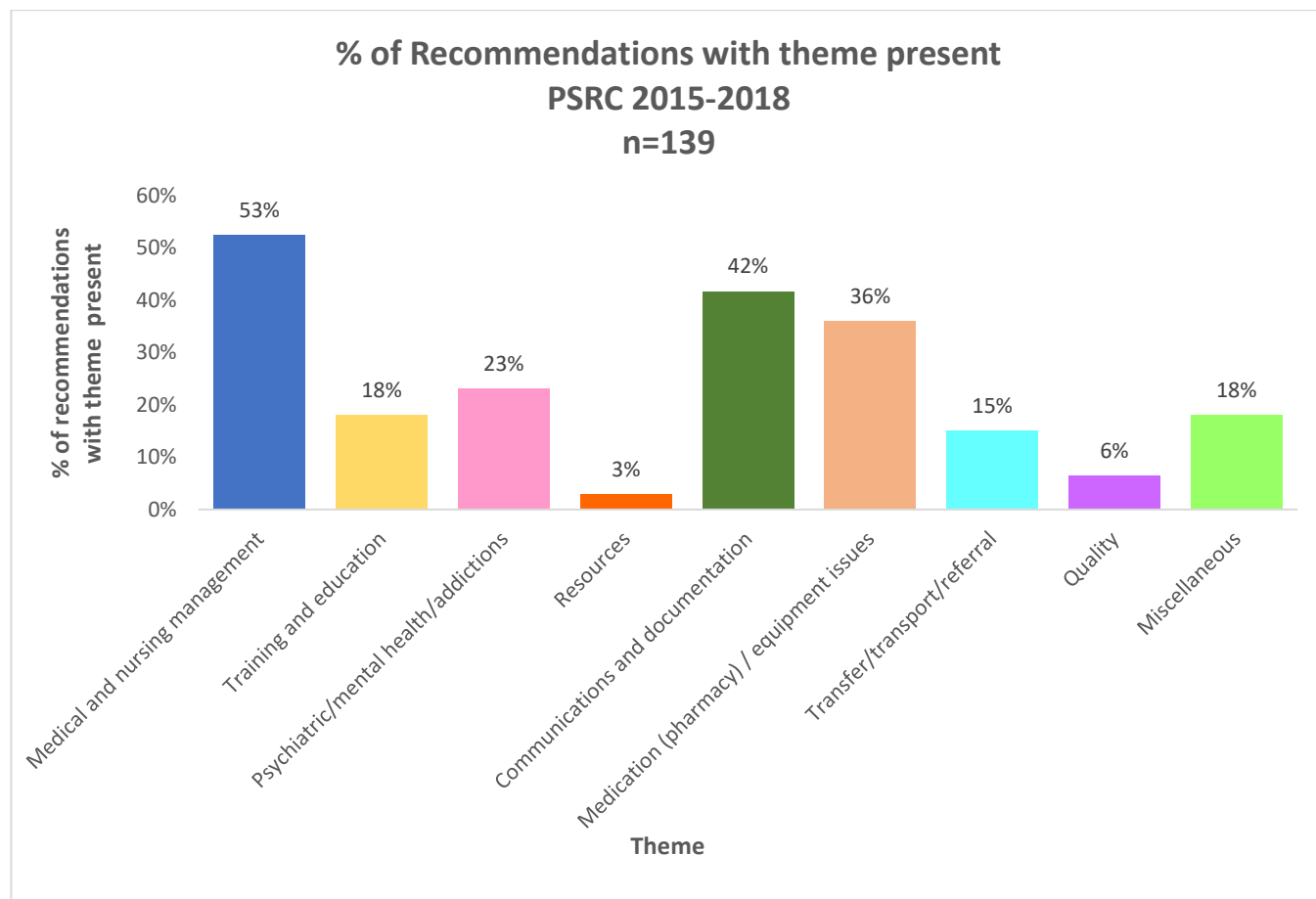


Chart 2 demonstrates that 53% of all recommendations made by the PSRC between 2015-2018 were focused on medical and nursing management. Following this, 42% of the recommendations touched on communications and documentation and 36% on medication (pharmacy) / equipment issues.

Lessons Learned from PSRC Reviews:

Our system of death investigation allows for the appropriate review of medical records and care provision. This review occurs through the process of investigating the death to establish an answer to the five questions (who died, where, when, how and by what means), determining the requirement for an inquest and analyzing all the data generated by the investigation.

Additional examination of deaths where the presiding or supervising coroner believes there are systemic issues allows examination by an interdisciplinary expert group to elucidate opportunities for improvement that can be communicated to agencies in a position to assist with implementation and education. Recommendations issued by the PSRC are non-blaming and targeted to actions that are deemed likely to reduce the likelihood of recurrence of similar deaths. Recommendations issued by the PSRC are not tracked; however, feedback from agencies indicates that they are well-received, and many have been implemented.

The mandate of our office as directed by the Coroners Act is one that involves all non-natural deaths and some natural deaths. The healthcare system, through its various investigative and oversight agencies, can help provide other analytical pathways for some of the natural deaths that are currently managed by the OCC. This coordinated and more effective/efficient system of patient safety is one that our office is working toward further establishing.

Appendix A

Case summaries and recommendations (2015-2018)

Case summaries and recommendations - 2015

Year: 2015

Case #: 1

Manner of death: Natural

Age: 39

Sex: F

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) due to concerns identified by the Regional Supervising Coroner relating to the in-hospital management of the patient.

Themes:

Medical/Nursing Management, Training/Education, Psychiatric/mental health/addictions, Medication/equipment.

Recommendations:

1. It is recommended that the hospital involved conduct a review of the care provided to this patient. This review should include:
 - a) Review of policy(s) on health record documentation and implementation of an audit process to ensure compliance;
 - b) Review of healthcare professionals' accountabilities within the circle of care;
 - c) Evaluation of policies and practices around patients with mental health disorders as related to patient safety;
 - d) Assigning of responsibility for auditing chart documentation of responsible physician and presentation of results to Medical Advisory Committee;
 - e) Consideration for enhanced trainee supervision at times of major transitions in care (e.g. academic year end);
 - f) Review and update of policies and practices related to patient and family engagement.

2. The Family Physician involved with the care of this decedent should review the policy of re-ordering patient medications in the context of the frequency of their in-office visits for clinical reassessment.

Year: 2015

Case #: 2

Manner of death: Suicide

Age: 45

Sex: F

Summary:

The decedent was a 45-year-old female who died from hydromorphone intoxication after intentional ingestion of controlled release hydromorphone. The referring Regional Supervising Coroner requested a review of the circumstances surrounding this woman's death to ascertain:

1. Whether the single ingestion would produce the blood levels found post mortem?
2. Was there an opportunity to predict the persistent toxicity and prevent the death?

Themes:

Medical/Nursing Management, Training/education, Psychiatric/mental health/addictions, communication/documentation, Medication/equipment.

Recommendations:

1. When a potential opioid overdose is suspected, Poison Control Officers should be directed to enquire and clarify whether the opioid is an immediate release version, a long-acting or continuous release version, or both/multiple versions. If no identification is possible, advice must consider the possibility that a long-acting version may have been ingested.
2. Hospital A should evaluate medication reconciliation processes to ensure that medications are accurately listed and reconciled at all transitions of care.
3. Hospital A should evaluate record-keeping practices.
4. Hospitals should develop formal protocols for naloxone that include assessment of type and quantity of opioid administered/ingested, recommended minimum duration of infusions for overdoses/toxicity of short- and long-acting opioids, consideration of limitation of absorption, specific criteria for monitoring, and physician notification/action required.

5. Hospitals should provide ongoing education for all healthcare providers about the signs and symptoms of opioid toxicity, including lethargy, dizziness, and loud/unusual snoring and the need to take action when these are observed and appear unusual for the patient.
6. Hospitals should evaluate medication reconciliation processes to ensure that medications are accurately listed and reconciled at all transitions of care.
7. Prescribers should limit the dispensed amount of opioid doses to reduce the potential for accidental or intentional misuse by both patients and those with access to the medications.
8. Prescribers should instruct patients on storage, security and disposal of opioids, keeping the medications out of sight and reach of others at risk of harm from accidental or intentional misuse (e.g., elderly, children, adolescents, those at risk of substance abuse).
9. Health Canada should require manufacturers of long-acting opioids, such as Hydromorph Contin and others, to include information in product monographs on drug half-life, recommended overdose treatment and overdose treatment duration specific to the long-acting formulation of the opioid.
10. Manufacturers of Hydromorph Contin should include information on drug half-life, recommended treatment and treatment duration specific to the long-acting formulation of the opioid in product monographs for Hydromorph Contin and other long-acting opioids.
11. ISMP Canada should review this case and consider suitability for publication in an ISMP Canada Safety Bulletin for shared learning.

Year: 2015

Case #: 3

Manner of death: Natural

Age: 75

Sex: F

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) as the investigating coroner identified several concerns relating to patient transfer and documentation of clinical information.

Themes:

Medical/Nursing Management, communication/documentation, Medication/equipment, Transfer/transport, Quality.

Recommendations:

1. Protocols should be put in place to transport dialysis-dependent patients to a hospital that has hemodialysis capabilities whenever possible, unless cardiac arrest and full advanced life support is deemed imminent. Consideration should be given to establishing a transport window that would minimize the risk to the patient.
2. Minimum standards for intensive care unit (ICU) nursing care should be established and adhered to in Level 2 ICUs. This should include, but not be limited to:
 - Understanding of pharmacology and dosing of medications typically administered in an ICU setting
 - Charting standards
 - Abilities to draw blood and start intravenous lines
 - Communication with family members
3. Quality of care reviews should be done by hospitals after a patient suffers a poor outcome or when requested to do so by patients or family. These must include all levels of professional staff and must be conducted by persons other than those involved in the care of the patient. At times, this may require review by an outside third party.
4. The learnings from such quality of care reviews should be communicated to patients and their families in detail. This should include steps that are being taken to improve outcomes in the future.
5. A standard for when a physician should attend the patient's bedside needs to be in place in all hospitals. At minimum, this should include the need for the most responsible physician (or surrogate), to assess the patient in person when a patient is critically ill. Consideration should be given to include this standard as one of the measures to be used as a quality of care indicator.
6. Standards must be in place for the dictation and signing of discharge summaries in a timely fashion. Consideration should be given to include this standard as one of the measures to be used as a quality of care indicator.
7. Hospitals should be encouraged to provide access to the health records of patients for whom they are providing care, even if this means obtaining pertinent documents from other hospitals or facilities. Access to the electronic patient record of other institutions will facilitate such information sharing.

Year: 2015

Case #: 4

Manner of death: Natural

Age: 54

Sex: M

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) as issues were identified by the Regional Supervising Coroner relating to best practices for recognition and treatment of vancomycin toxicity and methods to ensure medical supervision in large hospitals during the weekends.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Medication/equipment, Transfer/transport, Miscellaneous.

Recommendations:

1. Hospitals and community healthcare providers should convene interdisciplinary teams to review discharge plans for complex patients who will require home care services to continue treatment in the community. These plans should:
 - Assess medication regimens prior to discharge to determine if alternate, less complicated treatment plans are available or possible;
 - Ensure that the most responsible primary care provider (e.g. physician, nurse practitioner, etc.) is identified and contacted prior to discharge and has received detailed information on follow-up requirements, including laboratory monitoring;
 - Ensure that the roles and responsibilities of the post-discharge care providers are firmly outlined and that the community care providers can accept and fulfill the roles demanded;
 - Assess the ability of home care providers to adhere to the precise time requirements of dosing and monitoring prior to discharge. Alternative treatments or delayed discharge may be necessary in the interest of patient safety.
 - Ensure that community care practitioners and patients are provided with contact information for post-discharge management questions (e.g., discharging physician, hospital pharmacist, etc.).

2. Hospitals should work with Community Care Access Centres and other community providers to develop criteria for acceptance of patients receiving complex medication therapies, such as intravenous antibiotics requiring monitoring.
3. Pharmacists and Pharmacy Service Providers should identify medications that require monitoring and dose adjustment and create proactive processes to ensure that required monitoring will take place in a timely way. Prior to dispensing these medications, pharmacists should confirm that required monitoring has been arranged.
4. Primary Care Providers should develop standardized processes to proactively follow up with patients discharged from hospital on complex treatments. This would include identifying areas where assistance may be required (e.g., dose adjustments) and clarify where, and how, to access assistance.
5. ISMP Canada should review this case and consider suitability for publication in an ISMP Canada Safety Bulletin for shared learning.

Year: 2015

Case #: 5

Manner of death: Natural

Age: 16

Sex: F

Summary:

This case was referred to the Patient Safety Review Committee as potential systemic issues relating to home and out-of-hospital health care for patients with complex medical needs, were identified.

Themes:

Medical/Nursing Management, Communication/documentation, Transfer/transport.

Recommendations:

1. When providing or transitioning care for complex care patients, a case manager/transition coordinator should be identified who is accountable for the development of a comprehensive care plan that outlines the clinical needs of the patient based on input from all key stakeholders. In addition to this, legislative changes, as required, should be considered to ensure that there is accountability and supervision of care providers regardless of how the care providers were obtained.

2. The case manager/transition coordinator who is accountable for the development of a comprehensive care plan for transitioning of complex care patients should identify the skills and competencies required to meet the needs of the client in the community and communicate these needs with the service provider.
3. The competency of the “case manager/navigator” who is accountable for the development of a comprehensive care plan for transitioning of complex care patients must match the skill requirement required for the complexity of the patient’s needs.

Case summaries and recommendations – 2016

Year: 2016

Case #: 1

Manner of death: Natural

Age: 57

Sex: F

Summary:

This case involved the death of a 57-year-old woman who died from systemic metastases. The decedent’s family raised concerns about her care, follow-up, course of treatment and medication she received.

Themes:

Medical/Nursing Management, Transfer/transport.

Recommendations:

1. Cancers that are rare or infrequent should be referred to a regional cancer centre for assessment by a multi-disciplinary team.

Year: 2016

Case #: 2

Manner of death: Suicide

Age: 43

Sex: M

Summary:

The decedent had been treated for many years by one or more community psychiatrists, as well as intermittently in hospital. He had been diagnosed with both schizophrenia and schizoaffective disorder. The man died by suicide after being given a razor for shaving, while an involuntary patient in a psychiatric facility.

Themes:

Medical/Nursing Management., Training/education, Psychiatric/mental health/addictions, communication/documentation, Transfer/transport.

Recommendations:

1. The hospitals involved should conduct a “lessons-learned” case review of the circumstances surrounding this death with particular attention to:
 - Process and procedures for documenting and sharing information between physicians and healthcare institutions, particularly when transitioning patients.
 - A review of the policy and procedures for addressing suicide (as well as violence) risk assessment and related management and how this information is documented and shared with other members of the healthcare team both internally and with external partners.

Year: 2016

Case #: 3

Manner of death: Accident

Age: 51

Sex: F

Summary:

The decedent died after receiving intravenous infusion therapy from a naturopathic doctor in a complementary health centre. The key areas of concern identified were: 1) the emergency response

at the complementary health centre, 2) the process for preparation, storage and administration of the intravenous Tissue and Wound Healing Formulation at the complementary health centre, and 3) compounding of selenium solution used to prepare the Tissue and Wound Healing Formulation.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. Review the findings of the naturopathic doctor consultant engaged by the Office of the Chief Coroner to address opportunities for improvement.
2. Review the preprinted orders in collaboration with other disciplines who will use the orders to ensure:
 - they contain essential information only
 - they are designed to provide critical information in a logical sequence with consistent terminology (i.e., “mapped” to align with requirements such as infusion pump programming)
 - abbreviations, symbols and dose designations that may be misinterpreted are removed (See [ISMP Canada’s Do Not Use list](https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf), available from: <https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf>.)
3. Engagement of an external consultant with expertise in sterile product preparation, extemporaneous compounding, to conduct a review, that includes cognitive walkthrough, to ensure that processes comply with available guidelines (e.g., [NAPRA Model Standards for Compounding of Non-Hazardous Sterile Preparations](https://napra.ca/general-practice-resources/model-standards-pharmacy-compounding-non-hazardous-sterile-preparations); available from: <https://napra.ca/general-practice-resources/model-standards-pharmacy-compounding-non-hazardous-sterile-preparations>) and medication safety principles.
4. Ensure that an emergency/rescue protocol is in place in case of infusion reactions or emergency situations arising from intravenous infusions.
5. Ensure compliance with the College of Naturopaths of Ontario sterile compounding guidelines and facility inspection criteria.
6. Consider specific accreditation for pharmacies providing specialty compounding services, with criteria to be developed in collaboration with key stakeholders (e.g., National Association of Pharmacy Regulatory Authorities, Health Canada, ISMP Canada), including assessment of compliance with available standards and guidelines, and credentialing of personnel.
7. Pharmacies undertaking specialty compounding should use available technology for safety, such as bar coding, and scales that automatically print the weight of each item. (In the absence of such

technology, pharmacy staff can take photographs of the containers used and the weight readings and attach the photographs to the compounding record.)

8. Pharmacies undertaking specialty compounding should ensure that formulas and worksheets are designed to present information in a logical sequence, with consistent terminology, and that the final measurement units align with the measurement units of the equipment used in the pharmacy (e.g., if the weigh scale only weighs in grams, the amount to be weighed should be presented in grams so that all calculations are included in the check).
9. Pharmacies need to ensure that beyond use dates assigned to compounded preparations are supported by appropriate sterility and stability testing, in accordance with National Association of Pharmacy Regulatory Authorities standards.
10. Consider the suitability of this case review for publication in an ISMP Canada Safety Bulletin for shared learning.

Year: 2016

Case #: 4

Manner of death: Suicide

Age: 27

Sex: M

Summary:

This case involved the death of a 27-year-old military veteran who died by suicide after being released from hospital shortly after presenting with suicidal thoughts. Concerns were identified regarding the psychiatric services received including assessment, treatment and follow-up.

Themes:

Medical/Nursing Management, Psychiatric/mental health/addictions, Communication/documentation, Miscellaneous.

Recommendations:

1. Healthcare practitioners are reminded to document all relevant history (e.g. psychosocial, related stressors, etc.), including attempts to obtain collateral history, when assessing individuals with potential suicidality.
2. Healthcare practitioners should consider consultation with a psychiatrist, either in person or by telephone/other means (e.g. Ontario Telemedicine Network), for a reported first suicidal concern.

If consultation is not feasible, the attending physician should conduct and document a robust mental health assessment.

3. Suicide watch guidelines implemented by the Canadian military should be clarified, documented and shared with hospitals in order to assist with assessment, discharge planning and monitoring of patients.
4. It is recommended that the Department of National Defence conduct additional research into suicidality of current and former members of the Canadian military. Such research could include further investigation into post-traumatic stress disorder and other stressors unique to individuals serving, or having served, within the military. This research could help guide the development of policies and programs to assist individuals and their families in crisis, or potential crisis.
5. When a patient is determined to be at risk to themselves and/or others and in possession of a firearm and Possession and Acquisition License (PAL), the physician should be required to immediately notify local law enforcement and request the seizure of both the firearm(s) and the PAL.
6. Law enforcement agencies are reminded that when seizing a firearm due to immediate public or personal safety concerns, the individual's Possession and Acquisition License (PAL) should also be immediately seized and the Chief Firearms Office notified for consideration of initiating revocation of the (PAL).

Year: 2016

Case #: 5

Manner of death: Suicide

Age: 58

Sex: F

Summary:

This case involved the death of a 58-year-old woman who died by suicide through a lethal overdose of prescription medication while an in-patient out on pass from a psychiatric facility. Concerns were raised relating to the decedent's ability to obtain previously prescribed medications while under psychiatric care.

Themes:

Medical/Nursing Management, Psychiatric/mental health/addictions, Communication/documentation, Medication/equipment, Quality, Miscellaneous.

Recommendations:

1. In-patient psychiatric teams are reminded of the necessity for clear documentation of diagnosis, formulation, and treatment plan. Regular documentation for in-patient care includes regular documentation of a formal mental status exam.
2. When a patient is admitted for in-patient psychiatric care, the admitting psychiatrist, working with the team pharmacist, is strongly encouraged to cancel any outstanding community prescriptions for the patient. This should become a routine part of the standard medication reconciliation process now done on hospital admission. The cancelling of outstanding community prescriptions should become a quality improvement indicator for in-patient psychiatry units in Ontario.
3. Psychiatrists should follow evidence-based prescription guidelines, and when not possible due to patient intolerance or competent refusal, the details and circumstances should be clearly documented.
4. The hospital involved should conduct a Quality of Care review with particular attention to the lack of diagnosis and care plan for a patient that had been hospitalized for three months.

Year: 2016

Case #: 6

Manner of death: Natural

Age: 44

Sex: F

Summary:

This case involved a patient with a disease, primary pulmonary arterial hypertension (PAH), that is difficult to treat, even in the most compliant patients, and which has a poor prognosis and high risk of sudden death. The patient's care was complicated by the fact that she probably had a limited understanding of her disease and had a mental health condition that may have been causing some delusions with respect to the medications she needed to take, as well as limiting her insight and judgment.

Themes:

Medical/nursing Management, Psychiatric/mental health/addictions, Miscellaneous.

Recommendations:

1. When there is a question regarding the capacity of mental health patients to make decisions regarding treatment of co-existing medical conditions, a formal capacity assessment should be conducted and recorded in the chart.
2. Physicians who care for patients with mental illness who have concomitant medical conditions should be reminded of the need to assess a patient's capacity to understand treatment decisions for their medical illnesses.

Case summaries and recommendations - 2017

Year: 2017

Case #: 1

Manner of death: Natural

Age: 55

Sex: M

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) after concerns were identified relating to the identification, assessment and treatment of medical issues in a patient with a history of mental illness who presented to the emergency department of a hospital.

Themes:

Medical/Nursing Management, Training/education, Psychiatric/mental health/addictions, Communication/documentation, Transfer/transport, Quality.

Recommendations:

1. Hospital A should conduct a "lessons learned" case review of the assessment and care of this decedent from his presentation in the Emergency Department through transfer to Psychiatric Services. This review should include:

- Procedures and protocols for assessment and subsequent transfer of patients from the Emergency Department to Psychiatric Services, including the process for determining and confirming medical clearance prior to transfer and written acknowledgement of clearance by the accepting service (i.e. requirement for physical exam prior to transfer);
 - Procedures and protocols for continued assessment and care of medical concerns in patients managed through Psychiatric Services;
 - Procedure for documenting assessments, recommendations and approval for transfer between services;
 - Procedure and protocols for overseeing the management of medical students (including sign-off protocols, oversight of actions taken and documentation) and;
 - Procedures and protocols for medication reconciliation.
2. The CPSO and the OHA should consider publishing a reminder to physicians and health care leaders regarding the need for health care providers to pay sufficient attention to the physical problems of people with mental health concerns.

Year: 2017

Case #: 2

Manner of death: Suicide

Age: 32

Sex: F

Summary:

This case involved the death of a 32-year-old woman who died by suicide at home approximately one month after discharge from hospital. The woman was known to use drugs and alcohol. Concerns were raised regarding the availability of psychiatric services to the decedent.

Themes:

Medical/Nursing mgt., Training/education, Psychiatric/mental health/addictions, Communication/documentation, Medication/equipment, Transfer/transport, Miscellaneous.

Recommendations:

1. Healthcare practitioners providing mental health services are reminded to:

- distinguish acute from chronic presentations as part of a risk assessment and conduct or refer patients for appropriate assessment and treatment;
 - involve specialists in addiction medicine and addiction psychiatry, when available;
 - provide education to patients regarding symptoms, risks, and treatment options;
 - facilitate access to outpatient and community resources to patients deemed suitable to leave hospital;
 - consider safe management of medication and involve healthcare professionals as needed for monitoring, dispensing and supervision of medications, such as home care nurses or community pharmacists.
2. Healthcare practitioners are reminded that alcohol withdrawal and benzodiazepine misuse can have serious medical sequelae. Benzodiazepines for alcohol withdrawal should be supervised by a home care nurse, pharmacist, or in a medical setting such as a detox centre or hospital.
 3. Healthcare practitioners are reminded to conduct thorough substance use histories when there is a change in status, particularly any changes of substances used, frequency, and/or method of use.
 4. The police service involved should receive additional education and training in:
 - professional behavior and management of situations involving aggressive people or acute psychiatric symptoms;
 - the use, limits, and terminology of the Mental Health Act;
 - conveying accurate legal information to and about people in their custody;
 - avoiding unnecessary use of force and intimidating language.
 5. Establish a process for identifying frequent presentations to the Emergency Department with subsequent procedures for reviewing cases and engaging appropriate resources for the affected person. This procedure should include but not be limited to the referring physicians.
 6. Family physicians should be consulted and/or informed of the disposition plans for depressed and/or suicidal patients.

Year: 2017

Case #: 3

Manner of death: Natural

Age: 35

Sex: F

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) after concerns were identified relating to the detection and treatment of venous thromboembolism in a high-risk patient undergoing fertility treatment.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Quality.

Recommendations:

1. Health care providers are reminded of the importance of complete, legible and accessible medical records and documentation (both hand-written and electronic) as referenced in CPSO Policy Statement #4-12 (Medical Records -updated in May 2012).
2. Health care providers are reminded that venous thromboembolism (VTE) is the leading cause of morbidity and mortality following gynecologic surgery. The risk of VTE is increased in pregnant women and those taking oral contraceptive pills. All health care providers should be vigilant in the detection and treatment of VTE.
3. The hospital and gynecologic health care providers involved should conduct a “lessons learned” review of the circumstances surrounding this death. The review should include:
 - Consideration of implementing Enhanced Recovery After Surgery (ERAS) protocols, particularly in the gynecology program;
 - Consideration of incorporating the risk of malignancy index into their practice when deciding to operate on a pelvic mass versus consultation and possible transfer to a gynecologic oncology service;
 - Protocols for clearly identifying and documenting the Most Responsible Physician (MRP).
4. The fertility clinic involved is reminded of the following:
 - The importance of reasonable and thorough pre-treatment investigation of infertility;

- The importance of clear discussion with clients and documentation about the risks, benefits, rationale and alternative treatment options.

Year: 2017

Case #: 4

Manner of death: Natural

Age: 20

Sex: M

Summary:

This case involved a decedent with a severe disability who was initially diagnosed with worsening of an existing seizure disorder because of a urinary tract infection. It was recognized early in his care that he also had a poorly functioning VP shunt that was causing a significant degree of hydrocephalus, and that this would require an urgent shunt revision. The initial request to transfer the decedent to a neurosurgical centre resulted in him being placed on an urgent list to await transfer until a bed became available. Once the critical deterioration in the decedent's status had occurred, the transfer process was not seamless and required multiple calls.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Transfer/transport, Miscellaneous.

Recommendations:

1. Patients with complex medical and surgical histories who require transfer to another facility should be transferred to a hospital that has the capabilities to manage all potential problems the patient may have.
2. Physicians are reminded that requests for transfer should go through CritiCall whenever feasible so that the transfer can take place as quickly as possible. This should include education to the physicians regarding the functioning of CritiCall.
3. Physicians are reminded that attempts to refer patients to other facilities should be clearly and thoroughly documented in the patient's charts. This should include a plan of action, should the patient's condition continue to deteriorate.
4. Physicians are reminded that when the condition of a patient on the urgent list for transfer deteriorates beyond the state they were in when the request for transfer was originally made, the

referring hospital should clearly document who should be contacted, when they were contacted and what action plan was committed to or decided upon.

5. Systems should be in place that will permit the referring physician and CriteCall to speak simultaneously to all consultants who may need to be involved in the care of the patient (e.g. Critical Care and Neurosurgery).
6. Consideration should be given to reporting all deaths that occur while awaiting transfer to another institution to the Coroners' office for possible investigation.
7. CriteCall should consider tracking patients who are awaiting transfer. This would include a proactive approach of informing the involved physicians of other hospital options as they become available.
8. CriteCall should consider the documentation and analysis of data regarding transfer process complications.
9. CriteCall should have predetermined intervals for follow up on the status of a patient and their pending transfers to ensure that any predetermined time limits are met. It is during these intervals that the call-receiving centre can determine the patient's status and follow up as required with the involved clinicians.

Year: 2017

Case #: 5

Manner of death: Natural

Age: 68

Sex: M

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) by the Regional Supervising Coroner due to concerns about emergency room management of the patient, specifically:

- Failure to inform the patient of test results at Hospital A
- Inability for Hospital B to access laboratory test results from other institutions through the Ontario Laboratory Information Service (OLIS)

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Quality.

Recommendations:

1. Hospital A and Hospital B should undertake measures to ensure legibility of all health care records associated with the organization by expeditiously implementing comprehensive electronic health records.
2. Hospital A should ensure that policies, education and implementation strategies are in place regarding:
 - a) Appropriate follow-up of test results that become available after the patient has been discharged, including policies on how and when the patient will be contacted (and alternate plans for contacting the patient);
 - b) Documentation in the medical record of laboratory test results received from an outside laboratory to the emergency department or other hospital locales; Access to OLIS by ER staff should be considered.
 - c) Prompt initiation of appropriate antibiotics, particularly in critically ill patients. Antibiotics ordered must be based on antimicrobial susceptibility test results if they are available.
3. Hospital B should conduct an internal review relating to the timing of cardiovascular surgery for the patient involved in this case. Recommendations made from this review should be submitted back to the Office of the Chief Coroner.
4. It is recommended that the results of the review be shared with the Office of the Chief Coroner and also the family.
5. The CPSO should publish a synopsis of this case in their Dialogue publication in order to highlight the issues surrounding management and communication of test results.
6. Hospitals are encouraged to undertake measures to ensure legibility of all health care records associated with the organization by expeditiously implementing comprehensive electronic health records.
7. The Emergency Departments of all hospitals should provide patients with clear and concise written instructions upon discharge.

Year: 2017

Case #: 6

Manner of death: Natural

Age: 78

Sex: M

Summary:

The case involved the death of a 78-year-old man with an undetermined pre-existing neuro-muscular disorder who presented acutely with severe back pain and progressive debilitating weakness. Initial assessment showed limb and neck muscle weakness, altered speech and abnormal liver enzymes. Throughout this case, various clinicians and surgeons assessed the decedent in the ICU setting and provided their consultation reports in dictated form and sometime written notes in the ICU chart. There does not however, appear to be a summative record collating these opinions into a coherent discussion around this very complex clinical case.

Themes:

Medical/Nursing Management, Communication/documentation, Transfer/transport.

Recommendations:

1. The hospital should consider ensuring processes are in place to have a collaborative approach to complex cases such as this. This approach should include, but not be limited to: involving all consultants, timing of re-evaluations, and ongoing updates to all of those involved.
2. Physicians are reminded that improved record keeping in an ICU setting should include an electronic medical record (EMR) that documents all consultations and progress notes. Hand written notes are difficult to read and interpret. An electronic whiteboard for exchange of ideas and information as well as a flow chart that documents all current information and a decision tree could enhance patient care in a critical care setting.
3. Hospitals and physicians should ensure that the electronic medical record allows for clear information transfer and notification of all physician involved in the care of the patient.
4. Referring physicians should ensure documentation is made regarding the recommendations made by consultants and whether they were considered.
5. The role of most responsible physician (MRP) should include the acknowledgement of receipt/consideration of recommendations from other clinical staff. This may be accomplished through case conferences.

6. When there are recommendations made in the clinical record by a clinician, the MRP should be able to single click and see all recommendations without having to go through the progress notes. The ability of an EMR system to give the MRP the opportunity to acknowledge that received and considered is also suggested.

Year: 2017

Case #: 7

Manner of death: Natural

Age: 17

Sex: M

Summary:

The decedent was a 17-year-old male with type 2 diabetes mellitus. There were many factors that prevented optimal management both in the acute illness leading to diabetic ketoacidosis.

Themes:

Medical/Nursing Management, Training/education, Resources, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. When a child or adolescent with a known history of diabetes (type 1 or 2) presents to an emergency department, a glucometer should be obtained.
2. Health care teams responsible for treating children and adolescents should advocate for the involvement of parents, guardians and supports in order to obtain the best possible information, to provide education to patients and their supports, and to ensure proper follow up.
3. Continued follow-up of children and adolescents with diabetes must be ensured and timely. Enlisting the assistance of regional resources to advocate for the best possible education and support for patients with chronic diseases is encouraged.
4. The Ministry of Health and Long-Term Care should consider the development of a telehealth or online resource (like the Kids Health phone, but for health issues) for children and adolescents in the province.
5. Pharmacists involved in diabetic education should consider developing lessons geared specifically towards children and adolescents.

Year: 2017

Case #: 8

Manner of death: Natural

Age: 48

Sex: M

Summary:

The decedent was a 48-year-old man who was on hemodialysis due to polycystic kidney disease. He died as a result of sepsis subsequent to pancytopenia caused by methotrexate which had been prescribed for treatment of sarcoidosis.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. Medications ordered for dialysis patients by a physician who is not a nephrologist should be checked for appropriateness with a nephrologist, unless the physician is thoroughly knowledgeable of their effects in a dialysis patient. It is noted that the appropriateness of medication, and medication doses, can be quite different in dialysis patients.
2. A standardized process should be in place to ensure that new medications not ordered by a nephrologist should be reviewed with a renal pharmacist or nephrologist immediately by nursing staff, unless the nurse knows from previous experience that the use of the medication or the dose is appropriate.
3. Patients should be instructed to notify the dialysis unit when started on a new medication.
4. All immunosuppressive prescriptions for patients with renal disease, including dialysis, should be reviewed with a nephrologist before the patient receives the first dose.
5. Pharmacists should be reminded of the importance of obtaining information from patients about chronic medical conditions and entering this information into pharmacy information systems in a way that supports drug-disease interaction checking.
6. Pharmacists should consider the patient's general medical condition/fragility in decisions about whether to communicate drug interaction alerts with intermediate or low significance with prescribers.

7. Pharmacy information vendors should work on developing concise, readable, patient information sheets that highlight critical information about side effects that are indicative of toxicity and clearly indicate when to see medical attention.
8. Health Canada is encouraged to investigate mechanisms to ensure that new information about drugs currently on the market is incorporated into product monographs and accessible to all Canadian healthcare providers (e.g. through current monographs in the Health Canada Drug Product Database).

Year: 2017

Case #: 9

Manner of death: Undetermined

Age: 61

Sex: F

Summary:

The decedent was a 61-year-old female who underwent laparoscopic sleeve gastrectomy without complication. Her past medical history was remarkable for morbid obesity, diabetes, and depression. She died from the toxic effects of tricyclic anti-depressants approximately six weeks after the surgery.

Themes:

Medical/Nursing Management, Psychiatric/mental health/addictions, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. Psychiatric assessment and follow up should be conducted on bariatric surgery patients, pre and post operatively, by health care practitioners with specific expertise in psychosocial aspects of bariatric surgery.
2. All potential bariatric surgical patients receiving psychiatric care should obtain written clearance from their psychiatrist prior to proceeding with bariatric surgery. A mechanism of identifying patients at risk for psychiatric complications post-operatively should be an integral component of bariatric surgical programs.
3. It is imperative that patients utilizing psychiatric medication post bariatric surgery be monitored closely for clinical efficacy as bariatric surgery may precipitate adverse psychiatric events which may require immediate attention.

4. Post-operative bariatric surgery patients should be closely monitored when blood levels of psychiatric medications are measurable (e.g. lithium). Patients should also be warned that bariatric surgery can precipitate major psychiatric events post-operatively and close observation to their psychiatric status is imperative.
5. Bariatric surgical programs should include pharmacists with expertise in absorption of medications post bariatric surgery.

Case summaries and recommendations - 2018

Year: 2018

Case #: 1

Manner of death: Natural

Age: 72

Sex: F

Summary:

This case involved the death of a 72-year-old woman who died from pulmonary hypertension due to interstitial lung disease and metastatic breast cancer. Concerns relating to communication, delays and discharge planning were expressed.

Themes:

Quality.

Recommendation:

1. It is recommended that hospital A develop a robust, efficient and timely system to address issues and concerns identified by patients and their families. The hospital may wish to consider how a patient advocate or liaison could have been utilized to ensure timely and effective communication with the decedent and her family.

Year: 2018

Case #: 2

Manner of death: Natural

Age: 76

Sex: M

Summary:

This case involved a decedent who had long-standing atrial fibrillation who was taking the appropriate dose of a non- vitamin K dependent oral anticoagulant for stroke prevention. He was seen three times at an urgent care clinic and then referred to an emergency department for further investigation. Care appears to have been compromised by a lack of stretchers due to crowding and the hospital being over occupancy.

Themes:

Medical/Nursing Management, Medication/equipment.

Recommendations:

1. Physicians working in emergency departments should be reminded that spontaneous retroperitoneal hemorrhage can occur in patients taking oral anticoagulants. The investigation of choice to make this diagnosis remains the CT scan. Repeat CT examinations may be necessary in patients with undiagnosed abdominal and/or back pain in the setting of acidosis when other diagnoses have been excluded.
2. While not a factor in this case, a careful review of the dose and dosing schedule of anticoagulants should be part of the assessment of patients with abdominal and back pain when bleeding may be a diagnostic consideration. Other factors such as foods (e.g. grapefruit juice and bilberry, among others) and new medications, some of which may enhance anticoagulant effects, should also be considered.

Year: 2018

Case #: 3

Manner of death: Accident

Age: 42

Sex: M

Summary:

The decedent was a 42-year-old male with a history intravenous drug use who had been admitted to hospital with MRSA sepsis. He had been on a methadone maintenance program for at least five months prior to his death. He was a high risk for recurrent sepsis. He had three visits to the emergency department prior to his death.

Themes:

Medical/Nursing Management, Resources, Medication/equipment.

Recommendations:

1. Physicians working in emergency departments should be reminded that IV drug use places an individual at a high risk for being MRSA positive and they are at especially high risk of sepsis. Whenever these patients come to the emergency department, they should be examined for the possibility that their symptoms are related to an infection. When such patients present to the emergency department with criteria for Systemic Inflammatory Response Syndrome (SIRS) or qSOFA, an immediate septic work-up should be initiated and appropriate antibiotics administered as soon as possible.
2. Physician staffing levels in the emergency department at the hospital involved should be critically examined in order to determine if adequate numbers of physicians are on duty at all times to ensure quality patient care and to avoid delays in initiating definitive patient care.

Year: 2018

Case #: 4

Manner of death: Natural

Age: 52

Sex: M

Summary:

The case was referred due to concerns of an unexpected early postoperative death after an elective laparoscopic cholecystectomy.

Themes:

Medical/Nursing Management, Training/education, Resources, Transfer/transport, Quality.

Recommendations:

1. Hospitals should develop local surge plans and over-capacity protocols such that patients with life threatening illness (especially with the demonstrated decompensating trajectory) are triaged appropriately and re-assessed and re-evaluated to address signs of decompensation.
2. Healthcare providers should act with a sense of urgency to address the needs of critically ill patients. Patients often require urgent, emergency interventions throughout their stay in the emergency department.
3. Clinicians should be reminded that arterial lines and central lines are tools and monitoring devices, not therapeutic interventions. Sometimes their initial placement leads to delays and even complications (e.g. aspiration). The priority should be to resuscitate and place monitoring devices once the crisis is resolved or stabilized.
4. Critically ill outpatients waiting in “off-load” areas should be considered patients of that facility and assessed and managed within an hour. Treatment decisions should be communicated to the referring/base institution.
5. The hospital involved should consider establishing a Critical Care Response Team to assist with consultations within the emergency department and to support paramedics attending to critically ill patients not off-loaded.
6. The hospital involved should conduct a lessons-learned case review of the circumstances surrounding this death. Discussion should focus on:
 - Emergency services protocols for transfer of care between base hospitals and receiving hospitals

- Emergency department staffing and resources
- Establishing structured communication protocols for escalating situations

Year: 2018

Case #: 5

Manner of death: Natural

Age: 85

Sex: M

Summary:

This case was referred to the Patient Safety Review Committee (PSRC) after concerns were raised regarding delays in access to specialized care as well as recognition and management of sacral ulcers/sacral ulcer infection.

Themes:

Medical/Nursing Management, Resources, Communication/documentation, Quality.

Recommendations:

1. Healthcare providers are reminded of the importance of regular medical documentation when charting, including for patients awaiting transfer to another institution.
2. The community hospital involved should review their policy/procedures for administration of subcutaneous enoxaparin to ensure they are consistent with product monograph recommendations (including sites and method of injection and dosing/ re-evaluation of dosing and continued treatment).
3. The tertiary care hospital involved should review their policies and procedures in order to ensure that there is a consistent evaluation of high-risk patients, including comprehensive charting of Braden scale results and staging of pressure ulcers. Procedures should emphasize the importance of shared accountability between physicians and nurses for pressure ulcer detection and management, including when there is a transfer of care between various services.
4. The LHIN involved should conduct an evaluation of the timeliness of services for patients with NSTEMI-ACS requiring angiography within their jurisdiction.

Year: 2018

Case #: 6

Manner of death: Accident

Age: 52

Sex: M

Summary:

This case involved the death of a 52-year-old man from acute oxycodone toxicity. Concerns were identified regarding communication amongst care providers involved in opiate addiction treatment and prescribers of opiates involved in an individual's care.

Themes:

Medical/Nursing Management, Training/education, Psychiatric/mental health/addictions, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. Pain clinics should assess patients for opioid use disorders and initiate evidence-based treatment (i.e. opioid agonist treatment with methadone or buprenorphine), if indicated.
2. Residential treatment programs should always seek information on prescribing physicians for incoming patients and inform the most responsible physician for the opioid prescription that their patient has been changed/discontinued. The dispensing pharmacy should also be informed.
3. Pain clinics, residential treatment programs, and pharmacists should dispense naloxone kits to patients on chronic opioid therapy (regardless of dose) and especially for high doses of opioids or opioid agonist treatment as well as provide education to patients and family caregivers on their use.
4. Residential treatment programs should advise patients that opioid agonist maintenance treatment is the current standard of care for opioid use disorders and that tapering or “medical detox” has a high risk of relapse, overdose, and death.
5. If patients insist on tapering off their opioids and reject opioid agonist treatment, residential treatment programs should make sure that the patient understands the risks and ensure that the opioid withdrawal is complete and symptom resolution has been sustained without any buprenorphine or opioids prior to discharge. If the taper cannot be completed prior to discharge, then the taper should be completed as an outpatient under medical supervision.

6. Residential treatment programs should arrange a follow-up appointment with an addiction medicine physician post discharge and any discharge prescription for opioid agonist treatment should last until that appointment date.
7. The Narcotic Management System should be updated with all changes to a patient's narcotic prescriptions and these changes should be accessible to the clinicians/pharmacists involved in their care.
8. Pharmacists should be aware of the criteria for opioid use disorders and encourage patients to seek treatment; pharmacists should also share concerns related to opioid use disorder with the prescriber as well as concerns regarding altering the dates of a prescription.
9. Pharmacists should consider dispensing naloxone kits to patients on chronic opioid therapy (regardless of dose) and educate patients and family caregivers on their use.
10. Physicians and pharmacists should establish communication protocols and policies that will allow them to identify and share information on patients at risk of losing tolerance to opioids (e.g. tapering, prescription running out or expired, prescription not picked up, etc.) as these individuals are at a high risk for opioid toxicity.
11. Physicians and pharmacists should educate patients on the risks of rapid tapering of opioids and ensure that patients are aware of treatment options for substance use disorder or at-risk opioid behavior. Additional attention should be given to patients where there are gaps in dispensing or prescribing of opioids.

Year: 2018

Case #: 7

Manner of death: Accident

Age: 51

Sex: F

Summary:

The decedent was a 51-year old woman who was under psychiatric care for depression and was also receiving methadone for opioid dependence. The decedent's psychiatrist was not aware that she was also receiving methadone.

Themes:

Medical/Nursing Management, Communication/documentation, Medication/equipment, Miscellaneous.

Recommendations:

1. All physicians treating a patient should be aware of all medications, changes to medications and other physicians involved in the treatment of that patient.
2. Methadone prescribers, although acknowledged as often not the most responsible physician (MRP) for many patients, should conduct a detailed medication history on admission to the program. This would include verification through pharmacy records, and periodic reassessment (e.g. every 3-6 months) to ensure that changes in the patient's health status or medication use do not compromise their suitability for continued use of methadone. Transfer to a new clinic location should require a review of the patient's health status and medication use.
3. Pharmacists are encouraged to monitor for potential drug interactions and need to be aware of methadone and other medications patients are taking. Some pharmacies require patients to sign treatment contracts that include an expectation that the patient will obtain all their medications from the same pharmacy, or inform the pharmacy if situations arise where they need to fill a prescription elsewhere to assure continued safety.
4. The Ontario government should implement a plan/program that would maintain information about all dispensed medications in a digital health drug repository (DHDR), which would be accessible to both prescribers and pharmacists.

Year: 2018

Case #: 8

Manner of death: Natural

Age: 60

Sex: F

Summary:

This case involved the death of a 60-year-old woman with chronic diarrhea who presented to hospital with a five-day history of unremitting vomiting and intermittent fever. The cause of death was thought to be hypertensive heart disease and advanced coronary atherosclerosis; it was felt that significant hypokalemia might have precipitated an arrhythmia that led to her death. Concerns were raised regarding potassium replacement.

Themes:

Medical/Nursing Management, Training/education, Communication/documentation, Medication/equipment.

Recommendations:

1. Physicians and nurses should use the circumstances of this death as a “lessons learned” case review. Items to discuss could include:
 - Communication amongst nurses and between nurses and physicians;
 - Concerns regarding what medications are required and the appropriate doses;
 - Clear understanding on when to follow up electrolyte abnormalities in the blood.
2. Emergency physicians are reminded that severe hypokalemia is a life-threatening condition. Treatment of severe hypokalemia should include:
 - A 12 lead ECG
 - Admission to a monitored bed
 - Intravenous administration of KCl at a rate of 10 mEq per hour
 - Oral administration of KCl as soon as this becomes practicable
 - Repeat electrolytes every 2-4 hours until the potassium is normalizing
 - Correction of hypochloremic metabolic alkalosis, if this is present, by the administration of significant volumes of IV normal saline
3. Nurses are reminded that:
 - Severe hypokalemia is a life-threatening condition and requires admission to a monitored bed;
 - They should advocate for their patients if they feel that orders given may put a patient at potential risk.
4. Hospitals are encouraged to support their staff through the establishment of collaborative models of care. This will encourage nurses to question orders if they feel they are incomplete or in any way put their patient at risk.
5. ISMP should consider publishing the circumstances surrounding this death in order to share the valuable lessons learned.

Questions or comments pertaining to this report may be directed to:

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