Geriatric and Long-Term Care Review Committee 2013-14 Annual Report

Office of the Chief Coroner for Ontario

October 2015

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Message from the Chair

It is my pleasure to present to you the 2013-14 Annual Report of the Geriatric and Long-Term Care Review Committee (GLTCRC). Each year, a small percentage of the deaths of elderly persons investigated by the Office of the Chief Coroner (OCC) have issues identified by Regional Supervising Coroners who, in turn, bring them to the attention of the Committee which has been providing expert reviews and recommendations for over twenty years.

Through the publication of its annual report, this information is shared with service providers throughout the province. Our role is to provide information to service providers that inform improvements in their processes, with the goal of preventing future deaths in similar circumstances.

This year, due to a number of resource issues, the annual reports for 2013 and 2014 have been summarized and combined. Readers who wish to obtain the redacted narrative reports can do so by contacting the OCC at occ.inquiries@ontario.ca.

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.

I would like to acknowledge Ms. Kathy Kerr and Ms. Tara McCord, Executive Leads, and Ms. Victoria Snowdon, Project and Research Analyst. Without their efforts, the work of the committee and the production of this report would not be possible.

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

Committee Membership (2013-14)

Dr. Roger Skinner
Regional Supervising Coroner, Committee Chair

Ms. Kathy Kerr
Executive Lead (2013)

Ms. Elaine Akers
Pharmacist

Dr. Barbara Clive
Geriatrician

Ms. Sheila Driscoll
Ministry of Health and Long-Term Care

Dr. Sid Feldman
Family Physician

Dr. Margaret Found
Family Physician/Coroner

Dr. Heather Gilley
Geriatrician

Dr. Barry Goldlist
Geriatrician

Dr. Mark Lachmann
Geriatric Psychiatrist/Coroner

Ms. Margaret Leaver-Power
Registered Dietician

Ms. Tara McCord
Executive Lead (2014)

Ms. Anne Stephens
Clinical Nurse Specialist

Executive Summary

- The Geriatric and Long Term Care Review Committee (GLTCRC) was established in 1989 and consists of members who are respected practitioners in the fields of geriatrics, gerontology, family medicine, psychiatry, nursing, pharmacology, emergency medicine and services to seniors.

- In 2013, the GLTCRC reviewed 24 cases, involving 26 deaths and generated 63 recommendations directed toward the prevention of future deaths. Of the 26 cases reviewed, 4 resulted in no recommendations. In 2014, the GLTCRC reviewed 18 cases, involving 19 deaths and generated 49 recommendations directed toward the prevention of future deaths.

- Of the 26 deaths that were reviewed in 2013, the breakdown for manners of death were:
    - Natural 8
    - Accident 12
    - Homicide* 5
    - Undetermined 1
    - Suicide 0

- Of the 19 deaths that were reviewed in 2014, the breakdown for manners of death were:
    - Natural 3
    - Accident 8
    - Homicide* 8
    - Undetermined 0
    - Suicide 0

- In 2013-14, the most common areas for improvement identified by GLTCRC through their case reviews consisted of:
    - Medical and nursing management
    - Communication between healthcare practitioners regarding the elderly
    - Medical/Nursing documentation
    - Use of drugs in the elderly

***Note:** For the purposes of a coroner's investigation, the finding of "homicide" does not imply a finding of legal responsibility or culpability.

Chapter One: Introduction

The annual GLTCRC report is intended to provoke thought and stimulate discussion about geriatric and long-term care deaths in Ontario. It 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 forwarded to them 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 section 18(2) and the *Freedom of Information and Protection of Privacy Act*.

Structure and Size

The GLTCRC consists of respected practitioners in the fields of geriatrics, gerontology, pharmacology, family medicine, emergency medicine, psychiatry, nursing and services to seniors. This Committee membership reflects practical geographical balance and representation from various levels of institutions providing geriatric and long-term care.

The Chair of the GLTCRC can either be a Regional Supervising Coroner or Deputy Chief Coroner. Committee support is provided by the Executive Lead, Committee Management, of the Office of the Chief Coroner.

Other individuals with specific expertise may be invited to committee meetings as necessary on a case-by-case basis (e.g., investigating coroners, Regional Supervising Coroners, police officers, other specialty practitioners relevant to the facts of the case, etc.).

Membership is reviewed regularly by the Committee Chair and by the Chief Coroner as requested.

Methodology

Cases are referred to the GLTCRC by a Regional Supervising Coroner when expert or specialized knowledge is needed to further the coroner's investigation, and/or when there are significant concerns or issues identified by the family, investigating coroner, Regional Supervising Coroner, or other relevant stakeholders. All homicides that occur within a long-term care setting are referred to the Committee for review.

A minimum of at least one member of the Committee reviews the information submitted by the Regional Supervising Coroner, and then presents the case to the other Committee members. Following Committee discussion, a final case report is produced that includes a summary of the events, their findings and may include recommendations intended to prevent deaths in similar circumstances. 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 temporary substitute member may be asked to participate in the review. Alternatively, the Committee may review the case in the absence of the member with the conflict of interest.

When a case requires expertise from another discipline, an external expert may be asked to review the case, attend the meeting, and/or participate in the discussion and drafting of recommendations if necessary.

Limitations

The GLTCRC is advisory in nature and makes recommendations through the Chairperson. While the Committee's consensus report is limited by the data provided, efforts are made to obtain all available and relevant information. It is not within the mandate of the Committee to re-open other investigations (e.g., criminal proceedings) that may have already taken place.

Information collected and examined by the GLTCRC, as well as its final report, are for the sole purpose of a coroner's investigation pursuant to section 15(4) of the *Coroners Act* and subject to confidentiality and privacy limitations imposed by the *Coroners Act* and the *Freedom of Information and Protection of Privacy Act*. Accordingly, individual reports, review meetings, and any other documents or reports produced by the GLTCRC are confidential and may not be released publicly. 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.

Recommendations

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

Organizations and agencies are asked to respond to the Executive Lead, Committee Management, of the Office of the Chief Coroner on the status of implementation of issued recommendations within one year of receiving them. Similar to recommendations generated through coroners' inquests, GLTCRC recommendations are not legally binding and there is no legal obligation for agencies and organizations to implement or respond to them.

Chapter Two: Statistical Overview: 2004-2014

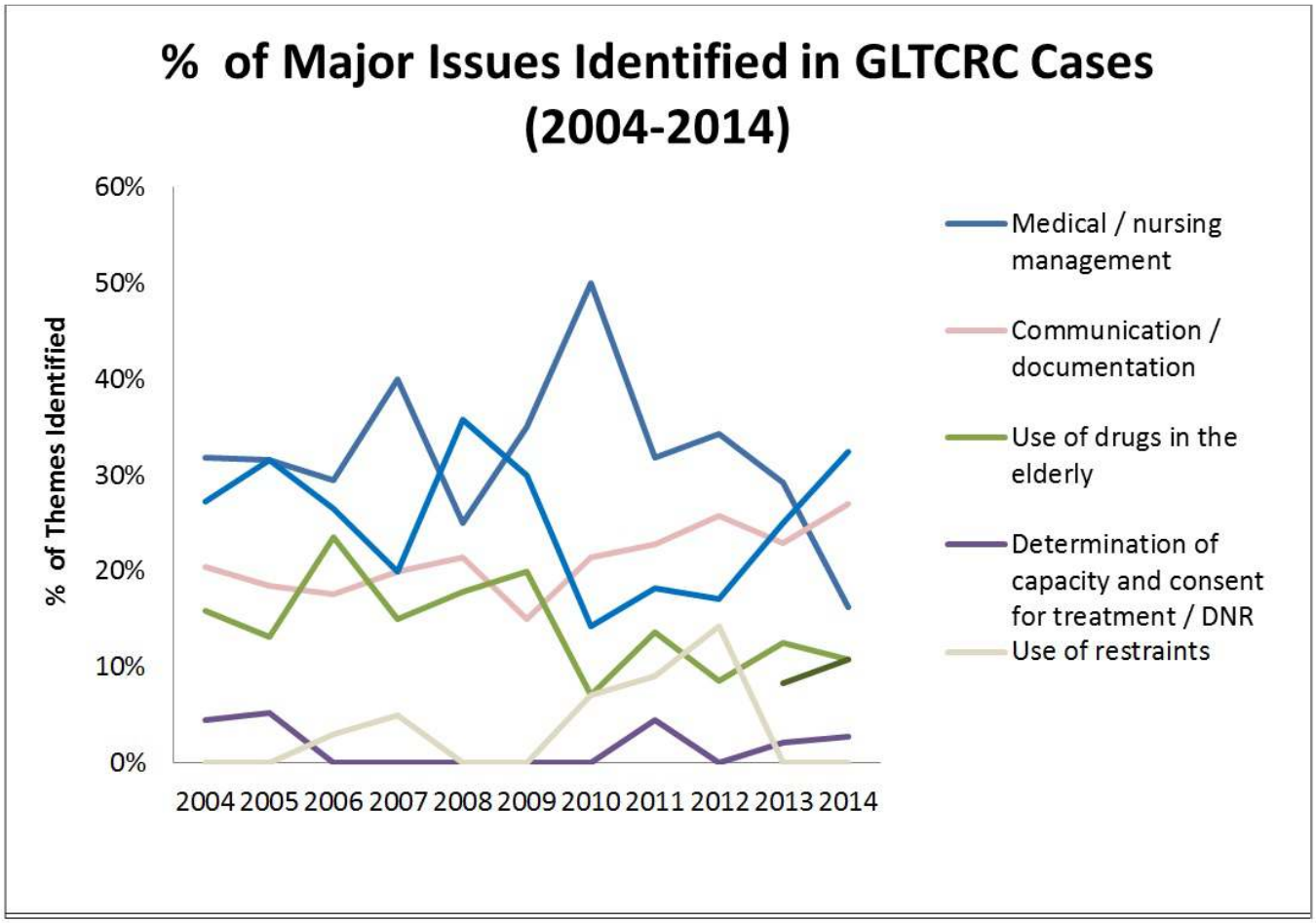
Over the years, the GLTCRC has identified specific themes that have consistently emerged. These include issues relating to:

- Medical and nursing management
- Communication and documentation
- Use of drugs in the elderly
- Use of restraints
- The acute care and long-term care industry in Ontario, including the Ministry of Health and Long-Term Care (MOHLTC)
- Other: includes other Ontario ministries, justice and legal systems

Chart One: Number and Percentage of GLTCRC Cases Based on Theme/Issue (2004-2014)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
# of Cases Reviewed	**25**	**28**	**27**	**17**	**18**	**20**	**11**	**16**	**20**	**24**	**18**
Theme/Issue: Medical / nursing management %	14 32%	12 32%	10 29%	8 40%	7 25%	7 35%	7 50%	7 32%	12 34%	14 29%	6 16%
Theme/Issue: Communication / documentation %	9 20%	7 18%	6 18%	4 20%	6 21%	3 15%	3 21%	5 23%	9 26%	11 23%	10 27%
Theme/Issue: Use of drugs in the elderly %	7 16%	5 13%	8 24%	3 15%	5 18%	4 20%	1 7%	3 14%	3 9%	6 13%	4 11%
Theme/Issue: Determination of capacity and consent for treatment / DNR %	2 5%	2 5%	0 0%	0 0%	0 0%	0 0%	0 0%	1 5%	0 0%	1 2%	1 3%
Theme/Issue: Use of restraints %	0 0%	0 0%	1 3%	1 5%	0 0%	0 0%	1 7%	2 9%	5 14%	0 0%	0 0%
Theme/Issue: Acute and long-term care industry, including MOHLTC %	12 27%	12 32%	9 26%	4 20%	10 36%	6 30%	2 14%	4 18%	6 17%	12 25%	12 32%
Theme/Issue: Other** %										4 8%	4 11%
Total Sum of Themes Attributed to Cases*	44	38	34	20	28	20	14	22	35	48	37

Graph One: GLTCRC Cases Based on Theme/Issue (2004-2014)



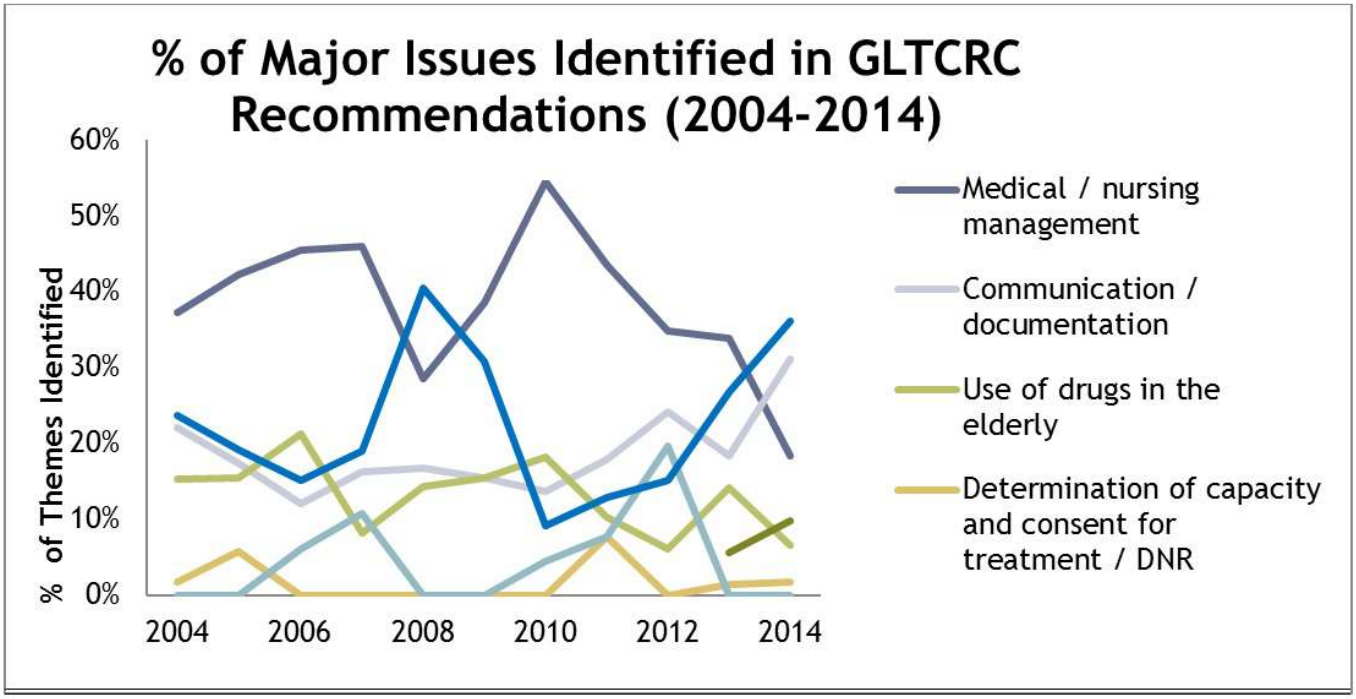
Graph One demonstrates that from 2004 to 2014, the theme/issues that most commonly arose in cases reviewed by the GLTCRC were related to medical or nursing management, communication and documentation and the acute and long-term care industry, including the MOHLTC. The other themes/issues that were present, but observed less frequently, in cases reviewed, were related to use of drugs in the elderly, determination of capacity and consent for treatment or DNR, the use of restraints and other.

Chart Two: Number and Percentage of GLTCRC Recommendations Based on Issue/Theme (2004-2014)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
# of Recommendations	**67**	**59**	**71**	**35**	**46**	**39**	**22**	**32**	**58**	**63**	**49**
Theme/Issue: Medical / nursing management %	22 37%	22 42%	30 45%	17 46%	12 29%	15 38%	12 55%	17 44%	23 35%	24 34%	9 18%
Theme/Issue: Communication / documentation %	13 22%	9 17%	8 12%	6 16%	7 17%	6 15%	3 14%	7 18%	16 24%	13 18%	19 31%
Theme/Issue: Use of drugs in the elderly %	9 15%	8 15%	14 21%	3 8%	6 14%	6 15%	4 18%	4 10%	4 6%	10 14%	4 7%
Theme/Issue: Determination of capacity and consent for treatment / DNR %	1 2%	3 6%	0 0%	0 0%	0 0%	0 0%	0 0%	3 8%	0 0%	1 1%	1 2%
Theme/Issue: Use of restraints %	0 0%	0 0%	4 6%	4 11%	0 0%	0 0%	1 5%	3 8%	13 20%	0 0%	0 0%
Theme/Issue: Acute and long-term care industry, including MOHLTC %	14 24%	10 19%	10 15%	7 19%	17 40%	12 31%	2 9%	5 13%	10 15%	19 27%	22 36%
Theme/Issue: Other** %										4 6%	6 10%
Total Sum of Themes Attributed to Recommendations*	**59**	**52**	**66**	**37**	**42**	**39**	**22**	**39**	**66**	**71**	**61**

Chart Two demonstrates that the most common themes/issues attributed to the recommendations, from the cases reviewed from 2004-2014, were related to medical or nursing management, communication and/or documentation and acute and long-term care industry, including the MOHLTC. The other themes/issues that were present, but that were less frequently assigned to the recommendations were related to use of drugs in the elderly, determination of capacity and consent for treatment or DNR, the use of restraints and other.

Graph Two – GLTCRC Recommendations Based on Theme/Issue (2004-2014)



Graph Two demonstrates that consistently over the past ten years, the majority of recommendations made by the GLTCRC addressed issues pertaining to medical and nursing management, communication and documentation and the acute and long-term care industry, including MOHLTC. The other themes/issues that that were identified, but less frequently, were related to use of drugs in the elderly, determination of capacity and consent for treatment or DNR, the use of restraints and other.

Chapter Three: 2013-14 Case Review Summary

In 2013, the GLTCRC reviewed a total of 24 coroners' cases involving 26 deaths involving the elderly, including residents of long-term care homes. Upon reviewing the cases, the Committee generated a total of 63 recommendations aimed at preventing future similar deaths. In 2014, the GLTCRC reviewed a total of 18 coroners' cases involving 19 deaths of the elderly, including residents of long-term care homes. Upon review of these cases, the Committee generated a total of 49 recommendations aimed at preventing future similar deaths.

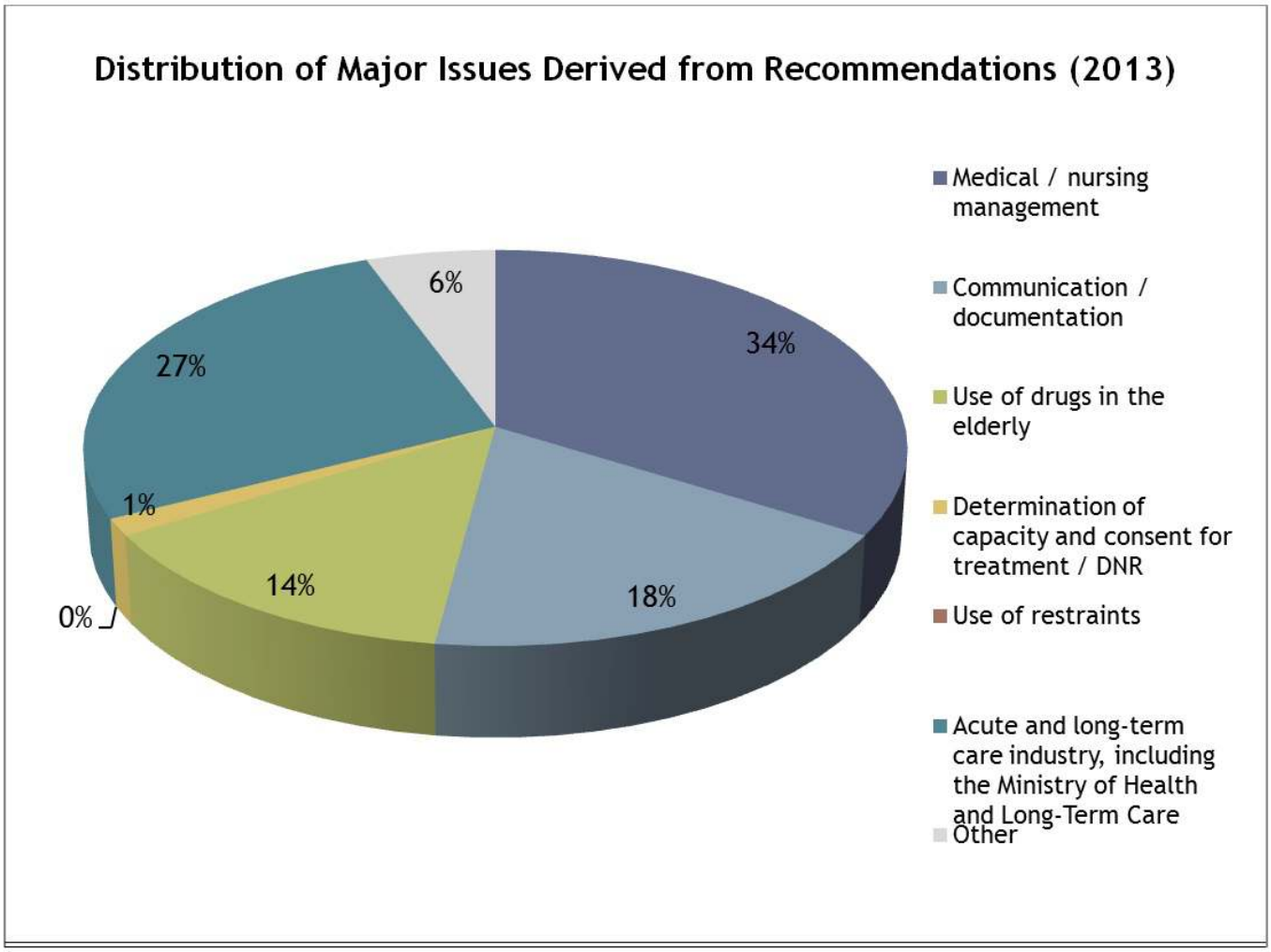
These recommendations were distributed to relevant individuals, facilities, ministries, agencies, special interest groups, health care professionals (and their licensing bodies) and coroners. Agencies and organizations in a position to implement recommendations were asked to respond to the Office of the Chief Coroner within one year. These organizations were encouraged to self-evaluate the implementation status of recommendations assigned to them.

Recommendations were also shared with chief coroners and medical examiners in other Canadian jurisdictions and are available to others upon request.

Chart Three: Review of 2013 Case Themes/Issues

Major Issue / Theme	Number of Cases where theme identified (n=24)	Number of Recommendations where theme identified (n=63)
Medical / nursing management	14	24
Communication / documentation	11	13
Use of drugs in the elderly	6	10
Determination of capacity and consent for treatment / DNR	1	1
Use of restraints	0	0
Acute and long-term care industry, including the Ministry of Health and Long-Term Care	12	19
Other	4	4
Totals*	**48**	**71**

Graph Three: Distribution of Recommendations Based on Theme/Issue – 2013



Note: Some recommendations addressed more than one issue and therefore was grouped accordingly.

Graph Three demonstrates the distribution of themes/issues for the recommendations made for the cases reviewed in 2013. The most commonly identified themes/issues were related to medical or nursing management, communication and documentation and the acute and long-term care industry, including the MOHLTC. Other areas of concern included the use of drugs in the elderly, determination of capacity and consent for treatment/DNR and other. There were no recommendations were related to the use of restraints.

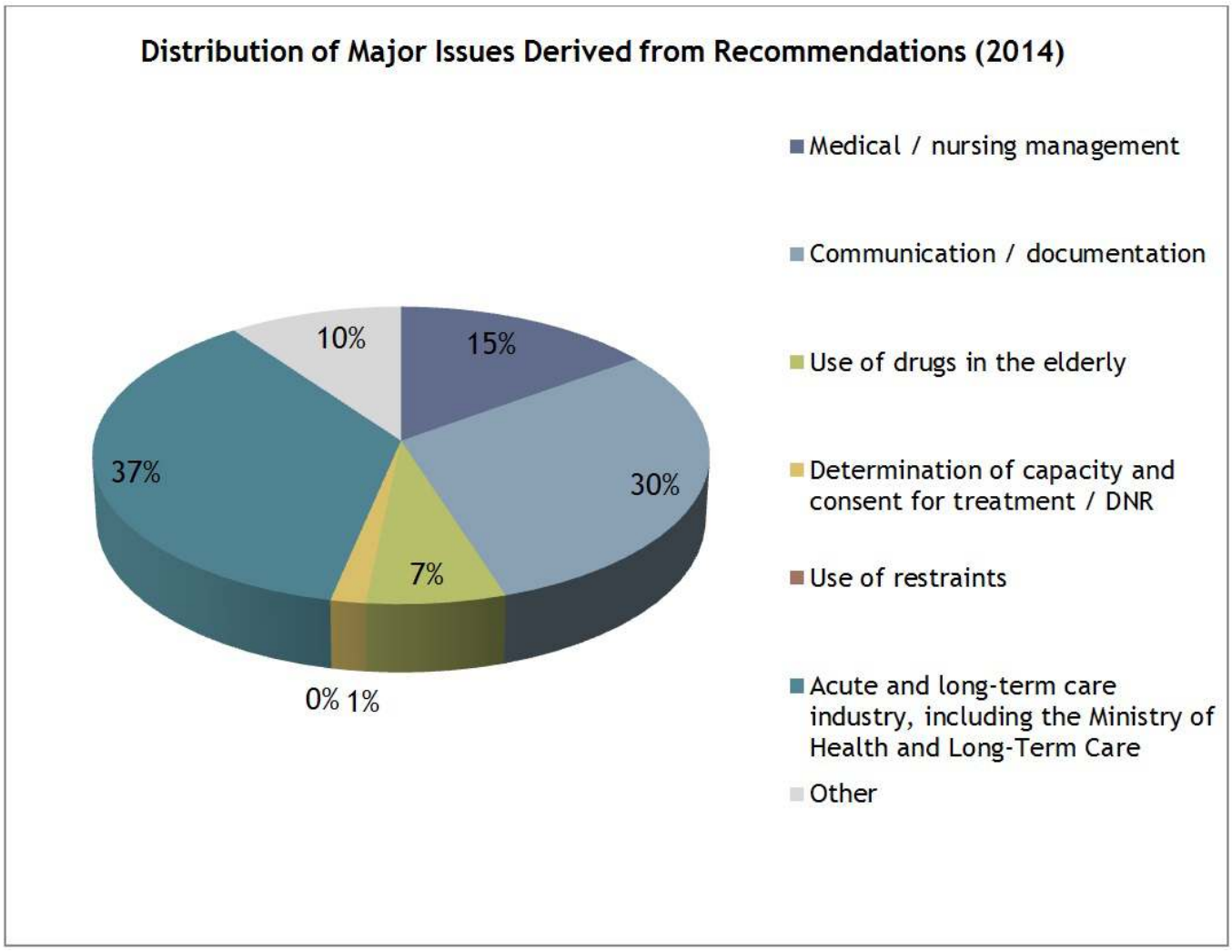
Chart Four: Review of 2014 Case Themes/Issues

Major Issue / Theme	Number of Cases where theme identified (n=18)	Number of Recommendations where theme identified (n=49)
Medical / nursing management	6	9
Communication / documentation	10	18
Use of drugs in the elderly	4	4
Determination of capacity and consent for treatment / DNR	1	1
Use of restraints	0	0
Acute and long-term care industry, including the Ministry of Health and Long-Term Care	12	22
Other	4	6
Totals*	**37**	**60**

*Note: the total number of cases and recommendations where themes were identified is greater than the actual number of cases reviewed and recommendations generated due to more than one theme being identified in many cases/recommendations

Chart Four identifies the issues/themes assigned to the cases and recommendations generated for the cases reviewed in 2014. The most commonly identified themes/issues were related to the acute and long-term care industry, including the MOHLTC, communication and documentation and medical or nursing management. Other areas of concern included the use of drugs in the elderly, determination of capacity and consent for treatment/DNR and other. There were no recommendations were related to the use of restraints.

Graph Four: Distribution of Recommendations Based on Theme/Issue – 2014



Graph Four identifies the issues/themes assigned to the recommendations generated for the cases reviewed in 2014. The most commonly identified theme/issues were related to the acute and long-term care industry, including the MOHLTC, communication and documentation and medical or nursing management. Other areas of concern included the use of drugs in the elderly, determination of capacity and consent for treatment/DNR and other. There were no recommendations were related to the use of restraints.

Summary of Cases Based on Manner of Death Reviewed in 2013

- Total number of cases reviewed: 24
- Total number of deaths reviewed:26
- Manner of death:

    - Natural 8
    - Accident 12
    - Homicide 5
    - Undetermined 1
    - Suicide 0

Overall Summary of Recommendations of Cases Reviewed in 2013

- 24 cases were reviewed and 63 recommendations were made.
- 14 (29%) of the themes identified in the recommendations involved medical/nursing management issues.
- 11 (23%) of the themes identified in the recommendations involved communication and documentation issues.
- Six (13%) of the themes identified in the recommendations touched on the use of drugs with the elderly.
- 1 (2%) of the themes identified in the recommendations touched on issues involving determination of capacity and consent for treatment / DNR.
- 12 (25%) of the themes identified in the recommendations involved MOHLTC and/or LTC industry issues.
- Four (8%) of the themes identified in the recommendations were attributed to the 'Other' category which included direction to the OCC, Regional Supervising Coroner and changes to building codes.
- Some of the recommendations touched on more than one issue.
- Four cases did not have any recommendations.

Summary of Cases Based on Manner of Death Reviewed in 2014

- Total number of cases reviewed :18
- Total number of deaths reviewed: 19
- Manner of death:

    - Natural 3
    - Accident 8
    - Homicide 8
    - Undetermined 0
    - Suicide 0

Overall Summary of Recommendations of Cases Reviewed in 2014

- 18 cases were reviewed and 49 recommendations were made.
- 6 (16%) of the recommendations involved medical/nursing management issues.
- 10 (27%) of the recommendations involved communication and documentation issues.
- Four (11%) of the recommendations touched on the use of drugs with the elderly.
- 1 (3%) of the themes identified in the recommendations touched on issues involving determination of capacity and consent for treatment / DNR.
- 12 (32%) of the recommendations involved MOHLTC and/or LTC industry issues.
- Four (11%) of the themes identified in the recommendations were attributed to the 'other' category which included direction to the OCC, Regional Supervising Coroner and the criminal justice and legal system.
- Some of the recommendations touched on more than one issue.
- Five cases did not have any recommendations.

Note: Trends or themes may exist due to a selection bias of cases that are referred to the GLTCRC for discretionary review. More specifically, Regional Supervising Coroners were asked to refer all cases to the GLTCRC that involved the deaths of elderly individuals where restraints may have been a factor. Similarly, trends or themes may exist due to the selection bias of mandatory referrals of homicides in long-term care homes.

Chapter Four: Learning from GLTCRC Reviews

A primary and recurrent theme of the GLTCRC reports is that, when it comes to medical care, the elderly are a special group. The interplay of multiple medical and social issues requires the effort of a team of professionals to ensure the provision of competent and compassionate care. The recognition by policy makers of the special needs of the elderly is of critical and urgent importance as the population of Ontario ages.

No issue exemplifies the complexity of geriatric care as well as the management of the Behavioural and Psychological Symptoms of Dementia (BPSD). This is a pervasive factor in the safety of the elderly as it relates to falls, the use of restraints and to assaults. More than half of the long-term care home residents in Ontario have a diagnosis of dementia and almost half exhibit aggressive behaviours. The education of care providers in the effective management of BPSD and the appropriate allocation of resources have been identified as priorities by the GLTCRC.

The GLTCRC recognizes the increased complexity and acuity of long-term care residents. Long-term care homes and retirement facilities are home to adults of all ages with a variety of chronic medical and mental illnesses. Long-term care homes are challenged to provide living environments that meet the needs of such a broad spectrum of individuals.

The GLTCRC also recognizes and 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 2013-14 Recommendations

2013 Recommendations

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
2013-01	1	• Health care professionals should be reminded of the importance of Advanced Care Planning in the long-term care setting, particularly as residents enter the last year of life. Good communication with residents and families, with supporting documentation, is the cornerstone of good end-of-life care.	• Communication / Documentation
2013-02	4	• Health care providers are reminded of their responsibilities under the Health Care and Consent Act. Committee comments: The treating physician of any discipline must discuss a proposed treatment with the patient and evaluate capacity. If the physician feels that an individual is incapable, then the physician must inform the patient of the finding of incapacity. If the patient agrees with the incapacity finding then a substitute decision maker is sought. If the patient disagrees with the incapacity finding then the physician offers the patient the Form A so that the patient may complete and submit to the Consent and Capacity Board for a hearing. • Health care providers are reminded that communication is essential between the treating team and a substitute decision maker (SDM). A SDM cannot help with decision making unless he or she knows what is going on. • In poly-trauma cases, a psychiatrist should be incorporated into the trauma team where the patient is known to have a serious psychiatric illness such as schizophrenia or bipolar disorder. Committee comment: Individuals suffering from serious mental illness struggle to obtain care in complex acute care systems often geared to treating specific acute problems. • Health care providers are strongly encouraged to communicate with each other when faced with patients with multiple complex problems.	• Determination of capacity and consent for treatment / DNR • Communication / Documentation • Medical / Nursing Management • Communication / Documentation
2013-03	2	• The shelter should ensure that all shelter staff interacting with clients have basic training in recognition and management of severe alcohol intoxication. This should include a protocol for evaluation and decision-making regarding	• Medical / Nursing Management • Medical / Nursing Management

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
		referral to hospital in cases where a client appears to be severely intoxicated. • A hospice palliative care program should be included in the plans for redevelopment of the shelter site and services. A model for such a hospice can be found at the Ottawa Mission - Diane Morrison Hospice (http://ottawamission.com/hospice/).	
2013-04	0	No recommendations	
2013-05	0	No recommendations	
2013-06	0	No recommendations	
2013-07	6	• Physicians are to be reminded that accurate communication between referring and consultant physician is essential • Physicians are reminded that communication with patients and families is crucial when making treatment recommendations • Physicians are reminded that hyponatremia is a potential significant side effect of SSRI type antidepressant medications. Physicians are reminded that for citalopram and escitalopram, there are specific warnings regarding cardiac toxicity • Physicians working with the elderly are reminded that there are aids to prescribing that may help avoid common pitfalls. One of the most common references is the Beers Criteria • Physicians are reminded that prescribing antidepressant medications, and any psychotropic medication, in the elderly will require careful medical work-up and closer follow-up than in younger patients • Although much study has taken place on post-marketing drug surveillance in Canada, the provincial and federal ministers of health should establish an effective post-marketing drug surveillance system	• Communication / Documentation • Communication / Documentation • Medical / Nursing Management • Medical / Nursing Management • Medical / Nursing Management and Use of drugs in the elderly • Other
2013-08	2	• Ontario LTC Physicians should consider providing periodic updates on the management of atrial fibrillation in patients with acute injuries at its annual educational conference. These updates should highlight the role of newer oral anticoagulants. • LTC home staff should use structured communication tools such as SBAR to improve the quality of communication between LTC facility staff and to facilitate action in situations of acute change in a resident's health status.	• Medical / Nursing Management • Communication / Documentation
2013-09	3	• Responsive behaviours in persons with dementia should be managed with an inter-disciplinary team	• Medical / Nursing Management

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
		including visiting consultants. An assessment of internal and external factors which may contribute to responsive behaviours should inform the plan of care which must include both non-pharmacologic and pharmacologic strategies • The GLTCRC is aware of, and supports the ongoing work of Behavioural Supports Ontario in the education of staff in the management of persons with dementia with behavioural symptoms in the long-term care setting. (http://www.akeresourcecentre.org/BSO) • The MOHLTC and long-term care homes should explore models of care that can increase staff time with residents such as the Releasing Time to Care quality improvement initiative	• Medical / Nursing Management • Acute and long-term care industry, including MOHLTC
2013-10	2	• Building codes in the Province of Ontario should require all new LTC homes to have environmental solutions incorporated to allow residents with dementia who wander to have access to a safe area for roaming where the ability to wander into the rooms of other residents is minimized. • Staff in LTC homes should be reminded that environmental and behavioural strategies should be utilized to minimize likelihood of altercations for residents with wandering behaviour.	• Other and Acute and long-term care industry, including MOHLTC • Medical / Nursing Management
2013-11	4	• The retirement home should review its policies on documentation with special reference to: a. standardizing how dates are written; b. ensuring notes are not dated incorrectly without 'late entry' alert; c. all forms on a written record should be selected for the ability to photocopy and or scan with legible results. • Health care providers are reminded that falls prevention in any seniors' facility requires an inter-professional approach, and the physician is an important part of that approach. Falls should prompt a review. • Health care providers are reminded that use of narcotics for musculoskeletal pain in the elderly may be appropriate. However appropriate use requires: a. accurate diagnosis and description of the pain; b. frequent re-evaluation and appropriate titration; c. use of short acting opiates for treatment of acute musculoskeletal pain in the elderly. d. description of goals of therapy (e.g. severity, mobility) • To the Ontario Ministry of Health and Long-Term Care, Ontario Association of Long-Term Care Physicians, College of Physicians and Surgeons, Ontario College of Family Physicians, Ontario	• Communication / Documentation • Medical / Nursing Management • Use of drugs in the elderly • Acute and long-term care industry, including MOHLTC and Use of drugs in the elderly

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
		College of Pharmacists and medical schools in Ontario: Education directed to the appropriate health professionals regarding drug therapy for the elderly should be a national priority at all levels: undergraduate, graduate, and continuing education.	
2013-12	7	• Health care providers should be reminded that acute delirium is a common clinical syndrome in hospitalized adults, particularly older adults. Delirium has a significant morbidity and mortality attributable to it that is independent of the underlying cause. All health professionals working in a hospital setting should be knowledgeable in the prevention and recognition of the clinical syndrome of acute delirium. Health providers should be reminded that the investigation and management of acute delirium in hospitalized patients requires a coordinated, interprofessional team approach. Health care teams in acute care hospitals should have interprofessional clinical protocols for delirium, which include non-pharmacologic and pharmacologic management strategies. • Physicians who are prescribing treatment for hospitalized elders with delirium should ensure that they are familiar with commonly cited literature regarding pharmacologic management of delirium (e.g. Campbell N, Boustani MA, Ayub A, et. al. Pharmacological management of delirium in hospitalized adults--a systematic evidence review. J Gen Intern Med. 2009;24(7):848). In particular, use of "prn" medications for treatment of agitation is rarely indicated or helpful. If needed, clear guidelines as to when to use a "prn" medication should be written and followed. Physicians should also routinely access the expertise of colleagues for this purpose, including pharmacists, and specialists in geriatric medicine and psychiatry. • Practitioners prescribing and administering narcotics to the elderly should follow standard practice guidelines for the recognition and management of narcotic-induced side effects, including narcotic toxicity and constipation. Constipation should be an anticipated side effect of narcotic use in elders, and should be managed proactively, not reactively. • Health professionals should be reminded that fentanyl transdermal should not be prescribed as a first narcotic in a narcotic-naïve patient. Hospital pharmacies should consider having a Pharmacist review all prescriptions for fentanyl transdermal to ensure that it is a progression from short-acting	• Medical / Nursing Management • Use of drugs in the elderly • Use of drugs in the elderly • Use of drugs in the elderly • Medical / Nursing Management and Communication/documentation • Medical / Nursing Management and Use of drugs in the elderly • Other

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
		narcotics or an ongoing prescription, and not a first narcotic prescription. • Health professionals practicing in acute inpatient care should have regular team meetings to discuss and document plans of care for all patients. This is particularly important for complex, clinically challenging cases. Physicians, as a key member of the team, should attend these regular meetings as part of their duty of care to the hospitalized patients. • The Chief of Staff of this hospital should review the findings and recommendations of this committee with the physicians involved in this case. The physicians should undertake education aimed at improving their skills and knowledge in the areas touched on in this review. For example, the course in narcotic prescribing offered by the College of Physicians and Surgeons (see http://www.cepd.utoronto.ca/opioidprescribing/). • The Regional Supervising Coroner should bring the committee's review and recommendations to the attention of the Residency Program Director in Family Medicine for the University which places family medicine residents at this hospital site for education and training.	
2013-13	2	• Acute Care Hospital 1 should conduct a Quality of Care review of the management of the patient's postural hypotension during his hospital stay. This should include a review of the timing of preparation and quality of the discharge summary and discharge prescription. This review should include representatives from the long-term care home. • In response to an adverse event within a long-term care home, the MOHLTC in-depth inspection should include root cause analysis embracing the principles of a Blame Free or Just Culture as promoted by the Institute of Healthcare Improvement (www.ihi.org), the Canadian Patient Safety Institute (www.patientsafetyinstitute.ca) and the Institute for Safe Medication Practice (www.ismp.org).	• Medical / Nursing Management • Acute and long-term care industry, including MOHLTC
2013-14	3	• The Ontario Retirement Communities Association should ensure that retirement homes provide the right mix of staff with appropriate training and skill sets to meet the needs of the clientele they are serving. • The MOHLTC should ensure that retirement home staff are appropriate in number and training in order to meet the needs of the residents of the home. • To the Ministry of Health and Long Term Care	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC

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		(MOHLTC) and the Retirement Homes Regulatory Authority: Retirement home staff should be made aware of the psychogeriatric resources in the community and be familiar with the process for accessing those resources.	
2013-15	6	• Physicians should familiarize themselves with the American College of Physicians Chest guidelines (February 2012) with respect to the use of venous thromboembolic (VTE) prophylaxis outside of the acute care setting. • Physicians should be sure to estimate the creatinine clearance of patients given prophylactic anticoagulation. Hospital protocols for VTE prophylaxis should include decision support for dosing in high risk situations such as extremes of age, weight or renal function. • Hospital pharmacists should review and provide advice to prescribing physicians regarding appropriate dosing of anticoagulation for hospital inpatients. • Long-term care homes in Ontario, along with their physicians and pharmacists, should develop a protocol for VTE prophylaxis to ensure appropriate use in the long-term care home setting. • Hospitals should ensure interdisciplinary charting to facilitate communication regarding the patient's status between health professionals. • The Institute for Safe Medication Practice should highlight the need for reassessment of VTE prophylaxis in patients discharged from the acute care setting.	• Medical / Nursing Management • Medical / Nursing Management • Use of drugs in the elderly? • Acute and long-term care industry, including MOHLTC and Medical / nursing management • Communication / Documentation • Use of drugs in the elderly
2013-16	1	• All health care organizations should have formal medication reconciliation processes in place for times of transitions in patient care (admission, transfer, discharge). The medication reconciliation processes should occur according to best practices defined by the Institute for Safe Medication Practices (Canada), and Accreditation Canada.	• Use of drugs in the elderly
2013-17	2	• Patient safety in any venue requires a team approach. Although the doctor wrote an incorrect order, there were opportunities for the pharmacist and nurses to recognize this error. Nurses and pharmacists have an important role to play in medication safety, and they should be encouraged to exercise that role. • Electronic medication prescribing with appropriate warnings incorporated in the software can reduce medication errors. Long-term care homes would benefit from having such electronic ordering capabilities.	• Medical / Nursing Management and Use of drugs in the elderly • Use of drugs in the elderly and Acute and long-term care industry, including MOHLTC
2013-18	3	• To Health Canada and the manufacturer:	• Acute and long-term care

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		Health Canada through its Medical Devices Regulatory Division does not appear to regulate mobility aid devices used in home care and long term care settings. There is a reporting form and mechanism for bed entrapment and fall incidents. The committee suggests this form be modified to allow for tracking of adverse events related to assist pole equipment. The committee feels there is a lack of research into the safe use of assist poles in long term care and home settings. Research into the use of assist poles is essential in determining overall safety profile of these devices. • To Health Canada and the manufacturer: Clarify directions for installation, and highlight the risks for potential entrapment, particularly as individuals advance through the course of a dementia. • To the long-term care and retirement homes: Staff should review the placement of assist poles with a view to the risk of entrapment. Care home staff are reminded about risks of anti-psychotic medications when used to treat the behavioural and psychological symptoms of dementia. Anti-psychotic medications in the treatment of behavioural and psychological symptoms of dementia (BPSD) are a chemical restraint requiring clear indication, documentation, and evaluation of effect. Anti-psychotic medications in BPSD also require frequent re-assessment for their on-going use, and planned regular trials (every three to six months) to discontinue these medications are recommended, as they are often no longer needed as a dementia progresses.	industry, including MOHLTC and Commuication/documentation • Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC
2013-19	3	• To the Ministry of Health and Long Term Care (MOHLTC) and the Ontario Long Term Care Association: Non-pharmacologic approaches to wandering should be incorporated into the behavioral care plans of residents with aimless wandering and evaluated for efficacy. • To the Ministry of Health and Long Term Care (MOHLTC) and the Ontario Long Term Care Association: Directors of Care in LTC facilities are reminded of the requirements for notifying police and the MOHLTC in the event of resident to resident contact resulting in injury. • To the Ministry of Health and Long Term Care (MOHLTC) and the Ontario Long Term Care Association: Reinforce use of the Licensee Reporting of Physical Abuse decision tree	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC and Communication/documentation • Acute and long-term care industry, including MOHLTC
2013-20	Deferred to next		

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	year		
2013-21	3	• To the College of Physicians and Surgeons and the Ontario Association of Long-Term Care Physicians: Physicians should be reminded that they have an important and critical role to play in interprofessional care teams. In collaboration with the care team, the physician must establish diagnosis, prognosis, and a treatment plan. In the absence of this, the care team is not able to provide the right interventions and support to the patient. • To the College of Physicians and Surgeons and the Ontario Association of Long-Term Care Physicians: Rapid weight loss in any elderly person should prompt a thorough assessment and evaluation by any physician asked to see the person. A broad differential diagnosis should be considered. Appropriate investigations and a thorough medication review should be undertaken. Along with the interprofessional team, an appropriate treatment plan based on the outcome of the assessment should be developed and implemented. • To the College of Physicians and Surgeons and the Ontario Association of Long-Term Care Physicians: Physicians should be reminded that, as a part of the interprofessional care team, communication with the patient and/or substitute decision-maker, as well as the interprofessional care team, is critical in all health care settings. This communication should always be documented in the health record. Communication should occur, at a minimum, regarding the initial diagnosis, prognosis and treatment plan, and whenever significant changes in any of these occur.	• Medical / Nursing Management • Medical / Nursing Management • Communication / Documentation
2013-22	2	• The MOHLTC and LTC Homes should meet to discuss and review the increasing needs of residents in LTC Homes with respect to two person transfers and care. This review should address the need to increase the availability of staff for bedside care. This review should include an assessment of alternatives to tub baths. • Health Canada should be notified of the potential risk of tipping a resident in a lift when raising a bathtub if the resident is not clear of the edge of the tub. Manufacturers' instructions with respect to "Ending the Bath" should include a warning to insure the resident is clear of the bathtub edge prior to raising the tub to avoid tipping the resident in a lift.	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC
2013-23	0	No recommendations	
2013-24	2	• The Office of the Chief Coroner should consider producing a comprehensive report covering all the	• Other • Acute and long-term care

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		cases of resident-related homicide in LTC facilities in Ontario in the past 15 years. This summary report should be shared publicly and particularly with the MOHLTC and other interested stakeholders (for example, the Ontario Long Term Care Association, physician and nursing professional groups), to provide added perspective regarding the magnitude and urgency of the problem. • The MOHLTC should develop a concrete action plan to address resident-to-resident violence in LTC facilities. The current investments in Behavioural Support Teams and training are not a replacement for sufficient numbers of caring staff who have time to spend with residents.	industry, including MOHLTC
2013-25	5	• The CPSO should consider a requirement for minimum mandatory training and continuing maintenance of competence in assessment and management of Behavioural and Psychological Symptoms of Dementia for all physicians providing primary care in LTC. This would be similar to the requirements for physicians working in other highly specialized areas of practice, for example the methadone maintenance program. • To the College of Family Physicians of Canada and the Ontario College of Family Physicians: The Colleges should ensure that family physicians who are providing primary care in LTC facilities have access to, and are encouraged to engage in, high quality continuing professional development programs focused on assessment and management of dementia in Long Term Care. Examples could include collaboration with the Alzheimer's Knowledge Exchange in delivery of the P.I.E.C.E.S program for physicians (www.piecescanada.com), and the four-hour MainPRO-C workshop on Behavioural and Psychological Symptoms of Dementia (BPSD). • To CPSO: Physicians should be reminded of the College of Physicians and Surgeons of Ontario Policy on Medical Records (May, 2012 http://cpso.on.ca/Policies-Publications/Policy/Medical-Records#toc9). In particular, physicians are to be reminded that, "Clinical notes must capture all relevant information from a patient encounter. This requires physicians to reflect on the care provided for a specific patient and document nuances of the encounter."[i] A single standard sentence regarding stability does not meet this policy standard. • To CPSO: Physicians should be reminded of the	• Medical / Nursing Management • Medical / Nursing Management • Communication /Documentation • Medical / Nursing Management • Acute and long-term care industry, including MOHLTC

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		importance of their leadership role and engagement with the interdisciplinary health team in the management of medically complex elders in LTC facilities. Care of elders in LTC facilities is one of the most challenging practice settings in medicine today. Professional practice in LTC requires physicians to be current in their medical knowledge in their role as medical expert, work collaboratively with the health team including reading all electronic documentation, and have a good knowledge of local expert resources for assistance and be knowledgeable about when and how to use those resources. • To the Ministry of Health and Long Term Care: LTC staff should receive training in assessment and management of responsive behaviours, including the potential consequences of aggressive behaviours and when to access specialized behaviour support services in their community.	

2014 Recommendations

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2014-01	1	• The issue of resident-on-resident violence in LTC homes is an urgent and persistent issue. The Committee is regularly asked to review homicides in LTC homes, where one resident causes the death of another. The current MOHLTC response of staff training in LTC, "Behavioural Support Teams" and the new Behaviour Support units in LTC homes do not sufficiently address this issue. Indeed, our recent case reviews show that these incidents occur even in existing specialized behaviour units. There is urgent need to address this complex problem in a more comprehensive manner. The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, law enforcement and elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia, including the ADARDS home in Tasmania and the Dorothy Macham home in Toronto, Ontario. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	• Acute and long-term care industry, including MOHLTC
2014-02	3	• Health care providers are reminded that falls are an important contributor to morbidity and mortality in the elderly and require a thorough assessment and search for modifiable risk factors. LTC home staff are reminded of the importance of completing a post-fall assessment using a clinically appropriate assessment instrument immediately after the resident's fall, and where the condition or circumstances of the resident require, conduct a re-assessment. Ongoing significant hip/back pain and a significant change in mobility after a fall should prompt recognition and action to rule out a fracture, including communication to the physician. When conducting assessments/reassessments on	• Medical / Nursing management and Acute and long-term care industry, including MOHLTC • Communication / documentation • Communication / Documentation and Medical / Nursing management

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		residents with cognitive impairment, staff should also consider non-verbal signs of pain. • Physician documentation of a resident's care should be included in the long term care health record as part of the comprehensive interdisciplinary care of these complex residents, including any significant discussions with the family. • Good communication plans and protocols need to be in place when transitioning early discharge post hip surgery patients between settings in the healthcare system. The responsibility for discharge rests with the sending facility particularly with an early discharge. Measures should be taken to fully ensure that post-operative care needs can be met in the receiving facility.	
2014-03	5	• The MTO process that is used to identify persons with traffic violations for further evaluation should be improved so that reviews can occur in a timely manner. Consideration should be given to "flagging" drivers for further review regardless of age. • There is an urgent need to develop effective screening tools to identify impaired drivers, and the MTO should develop strategies to encourage and fund that research. • Physicians should be reminded that when patients complain of memory problems, cognitive testing is an appropriate procedure. • Physicians should be reminded that significant impairment of visuospatial/executive functioning warrants more intensive evaluation of driving ability. • When physicians prescribe drugs that can impair cognition, they should warn patients not to drive until they are sure the drug is not affecting them. This warning should be recorded in the chart.	• Other • Other • Medical / Nursing management • Medical / Nursing management • Medical / Nursing management and Communication / Documentation
2014-04	4	• Improve access for residents of LTC homes and their families to mental health support. • Improve family access to caregiver support programs such as those run by the Alzheimer's Society. • Educate staff at all levels providing care for the elderly to recognize signs and symptoms of depression and enable staff to take concrete action to assist individuals in accessing mental health supports. • The Ministry of Health and Long Term Care should foster a family oriented approach to elderly care, explicitly recognizing that	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC • Medical / Nursing management and Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC

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		individual's age in relationship with others. Multidisciplinary team health care should be recognized as the standard of care in Ontario, particularly when caring for elderly patients.	
2014-05	2	• Directors of Care in LTC facilities are reminded of the requirements for notifying police and the MOHLTC in the event of resident to resident contact resulting in injury. • Reinforce use of the Licensee Reporting of Physical Abuse decision tree.	• Acute and long-term care industry, including MOHLTC • Communication / Documentation
2014-06	4	• LTC homes are reminded of the requirements in the *Long-term Care Homes Act* and regulations related to wound care. This includes the mandatory obligation to have an effective skin and wound-care program that meets regularly, reviews data and makes revisions to care processes on the basis of data collected and analysed. Staff in LTC Homes must receive adequate education about best wound care practices. • LTC homes are reminded of the importance of all staff quickly recognizing and reacting to acute changes in health status of their residents. Clear and established channels of communication must be in place to allow for prompt reassessment of LTC home residents who appear to have had an acute change in health status. • Physicians who work in long-term care are reminded of their important leadership role in the development of goals of care that are reflective of the prognosis, and their critical role in communicating with, and advising substitute decision makers. These plans must be clearly documented and incorporated into resident care plans. • Physicians in LTC homes are reminded that documentation is "used to show the thought process leading to a diagnosis and plan of care". Notes must "tell a story", and must be in keeping with the standards of the profession.	• Acute and long-term care industry, including MOHLTC • Communication / Documentation and Acute and long-term care industry, including MOHLTC • Communication / Documentation • Communication / Documentation
2014-07	6	• Health professionals must remember that a death occurring any time following a fall, even weeks later, must be reported to the local coroner immediately. This requirement holds even if the health professional is not certain that the fall and the cause of death are related. • Physicians and nurses caring for frail elders post-hip fracture surgery in LTC homes should be familiar with the expected course of recovery for an elderly person post-surgery. This basic knowledge is essential in order to determine	• Communication / Documentation • Medical / Nursing management • Medical / Nursing management and Documentation / Communication • Use of drugs in elderly • Acute and long-term care industry, including MOHLTC and

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		whether the person is exhibiting abnormal/unexpected symptoms and signs that would require further evaluation. • Physicians and nurses working in LTC homes are to be reminded that a significant change in health status, whether acute or subacute, in a frail elder, requires a thorough assessment to determine the cause and potential treatment. At a minimum, a history, physical examination and drug review are required, a differential diagnosis developed and investigations as appropriate for the goals of care should be undertaken. Clear communication with the LTC home resident and/or their substitute decision maker must occur throughout this process. Thorough documentation of assessments, goals of care and treatment is required as a standard of practice for all health professionals. • Health professionals are to be reminded that the potential for adverse drug effects in the frail elderly increases significantly with the number of medications prescribed. Drug prescriptions should be thoughtfully reviewed regularly, and in the face of new symptoms or a change in health status. The goal of "de-prescribing" should be at the forefront of every drug review in an elderly person in LTC. • Persons at the end of their life have a right to choose their place of death. Increasingly, LTC homes will be that place for many older Ontarians. LTC home physicians and nurses should have the skills and knowledge to hold end of life care discussions with residents and/or their families in advance of death, and collaboratively develop a palliative plan of care. LTC physicians must take a leadership role in initiating these discussions, as it is often the physician who has the most detailed knowledge of diagnosis and prognosis. LTC home health professionals should know how to obtain support from palliative care resources, in case of a need for specialized assistance with symptom management and prescribing. • The LTC home administrators, along with the medical director, should perform an analysis of the events of May 28-29, 2012 to determine why an on-call physician could not be reached that night. A protocol should be in place to allow the physician to be reached by means other than "pager,"	Communication / Documentation • Acute and long-term care industry, including MOHLTC and Communication / Documentation
2014-08	3	• All LTC Home staff are reminded that transition	• Acute and long-term care industry, including

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		back from hospital is often a time of medical instability. LTC Homes should have protocols in place to ensure timely physical assessment of residents and communicate any significant change in health status to the physician/Nurse Practioner. This timely assessment includes statutory holidays. • LTC Home staff should heed the concerns of family who know the resident best. • The Director of Care and the Medical Director should arrange a review of the care provided in this case and report their findings and recommendations back to the Regional Supervising Coroner. This review should include a process to ensure safety and knowledge of anticoagulation therapy. In accordance with the LTCH Act Section 114(1) the "LTCH shall develop an interdisciplinary medication management system that provides safe medication management and optimize effective drug therapy for residents".	MOHLTC and Communication / Documentation • Communication / Documentation • Communication / Documentation and Use of Drugs in the Elderly
2014-09	2	• To the MOHLTC: LTC Facility Compliance inspections triggered by a "Critical Incident System (CIS) Report" should be different from the annual Resident Quality Inspection. A CIS Inspection should focus on the cause of the event and the processes immediately leading up to and following the incident when ensuring compliance with the resident's quality of care and safety based on the *Long-Term Care Homes Act, 2007* requirements. Identification of any non-compliance that may have contributed to the incident is the best way to raise awareness of the related issues and prevent similar incidents in the future. • To the MOHLTC: The issue of resident-on-resident violence in LTC homes is an urgent and persistent issue. The Committee is regularly asked to review homicides in LTC homes, where one resident causes the death of another. The current MOHLTC response of staff training in LTC, "Behavioural Support Teams" and the new Behaviour Support units in LTC homes do not sufficiently address this issue. Indeed, our recent case reviews show that these incidents occur even in existing specialized behaviour units. There is urgent need to address this complex problem in a more comprehensive manner. The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC

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		resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, law enforcement and elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia, including the ADARDS home in Tasmania and the Dorothy Macham home in Toronto, Ontario. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	
2014-10	1	• The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, representatives of the criminal justice system, elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	• Acute and long-term care industry, including MOHLTC
2014-11	0	No new recommendations.	
2014-12	2	• The Office of the Chief Coroner should consider producing a comprehensive report covering all the cases of resident-related homicides in LTC homes in Ontario in the past 15 years. This summary report should be shared widely with the MOHLTC, as well as other interested stakeholders including the LTC home associations (e.g. Ontario Association of Non-profit Homes and Services for Seniors, Ontario Long Term Care Association); advocacy groups; and all health care professions	• Other • Acute and long-term care industry, including MOHLTC

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		involved in long term care, in order to provide added perspective regarding the magnitude and urgency of the problem. • The issue of resident-on-resident violence in LTC homes is an urgent and persistent issue. The Committee is regularly asked to review homicides in LTC homes, where one resident causes the death of another. The current MOHLTC response of staff training in LTC, "Behavioural Support Teams" and the new Behaviour Support units in LTC homes do not sufficiently address this issue. Indeed, our recent case reviews show that these incidents occur even in existing specialized behaviour units. There is urgent need to address this complex problem in a more comprehensive manner. The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, law enforcement and elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia, including the ADARDS home in Tasmania and the Dorothy Macham home in Toronto, Ontario. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	
2014-13	2	• The LTC home should review its protocols regarding violent incidents, specifically on how to deal with the presumed assailant. • The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief	• Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC

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		Coroner, representatives of the criminal justice system, elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened.	
2014-14	6	• Hospital staff working with LTC homes regarding residents with responsive behaviours should support and respect the decision of a LTC home regarding a resident in a situation like this. The committee supports the practice and regulations in place that allow LTC homes to refuse admission or re-admission to residents who present an active and ongoing danger to other vulnerable residents of a LTC home. In the words of the LTC Home Act S. 44 (7) "the home lacks the physical facilities necessary to meet the applicant's care requirements", for example the home is unable to manage the resident's violent/aggressive behaviours in an open environment where residents with these behaviours are mixed in with other residents with dementia who do not exhibit violent/aggressive behaviours (in shared bedrooms, common lounges, dining areas, hallways, etc.). In this case, the LTC home's decision to refuse re-admission likely averted the injury or death of a resident of the LTC home. • The MOHLTC should increase the numbers of inpatient geriatric psychiatric beds, and should develop a mechanism for coordinated, province-wide access to these beds. An example of such a coordinated access system is the "CritiCall system" for access to critical care beds in Ontario. • The criminal justice and legal systems should develop a mechanism to respond to violent elders who have dementia. The current legal framework does not allow for an appropriate response. Law reform to allow for the early involvement of the forensic psychiatric system in these cases should be pursued. • Both hospitals involved should review this case. The review should include whether there was adequate information provided in the assailant's initial application for admission to the specialized hospital, and what, if any, ongoing communication there was following the initial rejection of the assailant's application for	• Medical / Nursing management • Acute and long-term care industry, including MOHLTC • Other • Communication / Documentation • Acute and long-term care industry, including MOHLTC • Other

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		admission. The two hospitals should work together to improve their processes and communication regarding persons such as the assailant who require more specialized psychiatric care. • The MOHLTC should immediately convene a widely representative, multi-stakeholder expert panel to develop a concrete plan to address resident-to-resident violence in LTC homes. The panel membership should include, but not be limited to, the MOHLTC, the LTC home associations (OANHSS, OLTCA), experts in dementia care and mental health in the elderly, representatives of consumer advocates (for example, the Advocacy Centre for the Elderly), representatives of the Office of the Chief Coroner, representatives of the criminal justice system, elder abuse experts, experts in behaviour management and experts in environmental design. The panel is encouraged to look at world-wide best practices in care of physically violent persons with dementia. The report and implementation plan of this expert panel should be delivered to the Ontario Minister of Health and to the public within a year of being convened. • The Office of the Chief Coroner should produce a comprehensive report covering all the cases of resident-related homicides in LTC Homes in Ontario in the past 15 years. This summary report should be shared widely with the MOHLTC, as well as other interested stakeholders including the LTC Home associations (e.g. Ontario Association of Non-profit Homes and Services for Seniors, Ontario Long Term Care Association); advocacy groups; and all health care professions involved in long term care, in order to provide added perspective regarding the magnitude and urgency of the problem.	
2014-15	1	• Ontario hospitals should develop a standard approach to documenting medication errors in the clinical record including a clear description of the error, communication of the error to the patient or substitute decision maker, clinical consequences of the error, and steps taken if required to address any clinical consequences of the error.	• Communication / Documentation and Use of Drugs in the Elderly
2014-16	1	• Physicians and staff in acute care hospitals should be reminded that primary prevention of delirium is the key to reduction of risks associated with delirium. Robust protocols for non-pharmacologic	• Use of drugs in elderly and Determination of capacity and consent for treatment/DNR and Communication /

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		and pharmacologic prevention of delirium should be in place and part of routine hospital practice. Physicians who are prescribing treatment for hospitalized elders with delirium should ensure that they are familiar with commonly cited literature regarding pharmacologic management of delirium. In particular, use of "prn" medications for treatment of agitation is rarely indicated or helpful. If needed, clear guidelines as to when to use a "prn" medication should be written and followed. As well, good pain control with scheduled analgesics is a cornerstone of delirium management. Health care providers should be reminded that in non-emergency situations all treatment decisions require informed consent. Consent needs to be obtained prior to the treatment. It is the responsibility of the treating practitioner to assess the capacity of the patient to make treatment decisions. In incapable persons the substitute decision maker should be informed of the planned treatment.	Documentation
2014-17	4	• To the Regional Supervising Coroner: A report should be made to Health Canada regarding this accident and death. The report should emphasize that the risk is associated with this entire class of walkers (4 wheeled walker with seat), not only the specific model involved here. • The Medical Devices Bureau should publish public safety information for persons using 4-wheeled walkers about the dangers of moving a walker while a person is seated on the seat of the walker. This information should be in plain language, disseminated through multiple channels, and easily searchable on the internet. • Health Canada should develop a warning sign regarding the hazards of moving a walker with a seat while a person is sitting on it. Health Canada should then issue a requirement to all manufacturers of 4-wheeled walkers with seats in Canada affix the sign permanently to all walkers sold in Canada. • Given the safety information regarding falls, injuries and hospitalizations associated with the use of walkers, Health Canada should undertake a review of these medical devices. The committee strongly recommends that these devices should be re-classified as a Class II or Class III medical device, with the associated requirement for adherence to safe design and manufacturing standards.	• Other • Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC • Acute and long-term care industry, including MOHLTC
2014-18	Deferred to next		

GLTCRC File Number	# of Recs	Recommendation(s)	Theme
	year		
2014-19	Deferred to next year		
2014-20	Deferred to next year		
2014-21	2	• Transitions in location of care are clinical decisions in that where a resident/patient is cared for determines the intensity of care delivered to that individual. Transitions of care include admission to a long term care facility, transfer from one floor to another within the same facility, re-admission from hospital back to long-term care, and transfer out of long term care to a hospital setting. Clear documentation from clinical staff should be included in the health record indicating the reasons for a transition of care, in the same way a medication treatment decision is documented. Clear communication both verbal and written should occur between sending and receiving care environment about the care needs of the individual resident/patient • Administration in long term care should recognize that transition in location of care for residents are times of increased risk for adverse events. A resident safety focus with tools enabling staff to formally document rationale for a transfer and communicating care plans is recommended.	• Communication / Documentation • Communication / Documentation

Questions and comments regarding this report may be directed to:

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