Report on the inquest into the deaths of

Ezzeldine EL ROUBI and Pedro LOPEZ

July 2006

Office of the Chief Coroner

INTRODUCTION

One of the roles of inquest juries is to make recommendations to prevent deaths in similar circumstances. It is through the recommendations made by coroner's juries that significant changes are made to improve the safety and quality of life in Ontario.

This report examines the responses received to the 85 recommendations made by the jury in the inquest into the deaths of Mr. Ezzeldine El Roubi and Mr. Pedro Lopez.

METHOD FOR DISTRIBUTING INQUEST RECOMMENDATIONS

The presiding inquest coroner encourages the jury to submit their recommendations grouped under the headings which reflect the agency, ministry, organization or entity to which the recommendation should be directed. Inquest staff at the Office of the Chief Coroner review and distribute the recommendations to agencies, ministries and organizations identified by the juries, together with a covering letter requesting the respondent to inform the Office of the Chief Coroner regarding the implementation or status of the recommendations.

EVALUATION OF RESPONSES TO JURY'S RECOMMENDATIONS

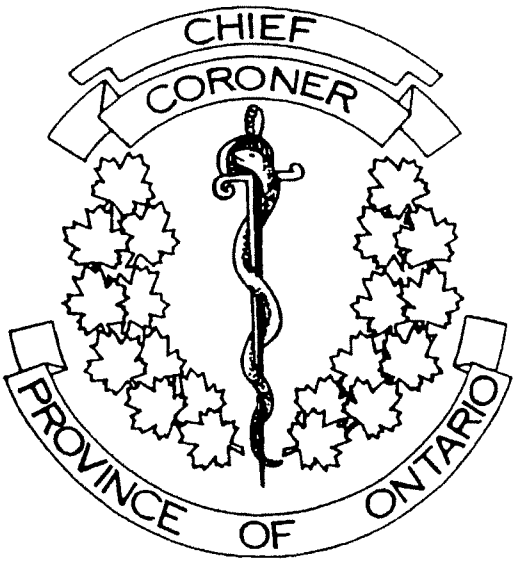
The Office of the Chief Coroner evaluates each response to jury recommendations according to the following codes:

Reponse Code	Explanation
1	Recommendation **has been** implemented.
1A	Recommendation **will be** implemented.
1B	Alternative recommendation **has been** implemented.
1C	Alternative recommendation **will be** implemented.
2	The recommendation is under consideration.
3	There are unresolved issues with the recommendation that need to be addressed.
4	The recommendation is rejected.
4A	The recommendation is rejected due to flaws.
4B	The recommendation is rejected due to lack of resources.
5	The recommendation did not apply to the agency assigned.
6	There was no response to the recommendation.
7	The response could not be evaluated (e.g.: response was vague, response did not address stated recommendation, etc.)

Organizations are encouraged to "self-evaluate" their responses utilizing the above coding guideline.

Section 1

Verdict, Recommendations and Coroner's Explanation



INQUEST

TOUCHING THE DEATH OF

EZZ-EL-DINE EL-ROUBI
and
PEDRO LOPEZ

JURY VERDICT AND RECOMMENDATIONS

April 2005

Office of The Chief Coroner

Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

We the undersigned / Nous soussigné

Steven Nicol	of / de	***Toronto***
Anthony Strimaitis	of / de	***Toronto***
Leonardo Stellino	of / de	***Toronto***
Ivanka Boskovic	of / de	***Toronto***
Angela Quinto	of / de	***Toronto***

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile	Given names / Prénom
El Roubi	***Ezzeldine***

aged / âgé(e) de ***71 yrs.*** held at / qui a été menée à ***the Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario***

From the / du ***31st. January*** to the / a la ***18th. April*** 20 ***05***

By / Par Dr. ***David H. Evans*** Coroner for Ontario / coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1.	Name of deceased / Nom du (de la) défunt(e)	***Ezz-El-Dine El-Roubi***
2.	Date and time of death / Date et heure du décès	***June 9, 2001, at 7:30pm.***
3.	Place of Death / Lieu de décès	***Casa Verde Nursing Home, 3595 Keele Street, Toronto, Ontario***
4.	Cause of death / Cause du décès	***Craniocerebral Blunt Force Injuries***
5.	By what means / Circonstances entourant le décès	***Homicide***

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the / Ce verdict a été reçu par moi le ***18th.*** day of ***April*** 20 ***05***

Original signed by Coroner

Distribution Original – Regional coroner for fowarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef

Copy - Crown Attorney / Copie – Procureur de la Couronne

CC 010 (Rev. 02/04)

Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

We the undersigned / Nous soussigné

Steven Nicol	of / de	***Toronto***
Anthony Strimaitis	of / de	***Toronto***
Leonardo Stellino	of / de	***Toronto***
Ivanka Boskovic	of / de	***Toronto***
Angela Quinto	of / de	***Toronto***

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famile	Given names / Prénom
Lopez	***Pedro***

aged / âgé(e) de ***83 yrs.*** held at / qui a été menée à ***the Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario***

From the / du ***31st. January*** to the / a la ***18th. April*** 20 ***05***

By / Par Dr. ***David H. Evans*** Coroner for Ontario / coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1.	Name of deceased / Nom du (de la) défunt(e)	***Pedro Lopez***
2.	Date and time of death / Date et heure du décès	***June 9, 2001, at 7:30pm.***
3.	Place of Death / Lieu de décès	***Casa Verde Nursing Home, 3595 Keele Street. Toronto, Ontario***
4.	Cause of death / Cause du décès	***Craniocerebral Blunt Force Injuries***
5.	By what means / Circonstances entourant le décès	***Homicide***

Original signed by: Foreman/Président du jury

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The verdict was received on the / Ce verdict a été reçu par moi le ***18th.*** day of ***April*** 20 ***05***

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CC 010 (Rev 02/04)

The following recommendations are not presented in any particular order of priority:

Need for MOHLTC to Make Long Term Care A Higher Priority

Recommendation 1:

That the Ministry of Health and Long-Term Care (MOHLTC) should give increased priority to the health care needs of the elderly and, in particular, the serious challenges faced in treating elderly cognitively impaired residents, by immediately developing and implementing a plan (or "Framework") to ensure appropriate standards, funding, tracking and accountability in Long Term Care (LTC) and other facilities treating such individuals.

Recommendation 2:

The Ontario Seniors' Secretariat, in consultation with stakeholders in the long-term care system should initiate a public education campaign to decrease the stigma attached to elderly people with dementia and other cognitive difficulties.

Recommendation 3:

The MOHLTC, in consultation with the College of Family Physicians, should design and implement an expanded and on-going education and support programme for family physicians to assist them in the early detection, diagnosis and treatment of dementia and related behavioural problems and in accessing available community resources for the client and family caregivers.

Recommendation 4:

It is recommended that the MOHLTC take immediate steps to implement the "Ten-Point Plan for Improving the Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario".

Rationale: It is recommended that the MOHLTC recognize that due to health care restructuring LTC facilities have become "new Mental Health institutions" in Ontario, without the funding and resource necessary nor a recognition of the anticipated needs given the demographics in Ontario related to the increased aging population with cognitive impairments. (Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario).

Office Of The Chief Coroner

Recommendation 5:

The Office of the Chief Coroner publish these and all other inquest recommendations on its website.

Recommendation 6:

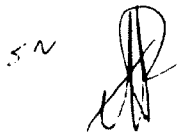
The Office of the Chief Coroner publish all Annual Reports of the Geriatric and Long-Term Care Review Committee on its website. Notification of publication should be sent annually upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.

Recommendation 7:

The Office of the Chief Coroner thoroughly investigates all suspected homicides in long-term care.

Recommendation 8:

The Office of the Chief Coroner review all other potential homicides in long-term care homes which have occurred since 1999 and publish a special report with respect to all of these deaths. This report should be published on the website of the Office of the Chief Coroner, and notification of publication should be sent upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.



The College Of Physicians And Surgeons Of Ontario

Recommendation 9:

The College of Physicians and Surgeons of Ontario communicate to its members the importance of preparing discharge summaries and providing them to the family physician within 7 days from discharge.

Recommendation 10:

The College of Physicians and Surgeons of Ontario clarify the issue of confidentiality when issues of abuse arise. Specifically, the specifics of this case should be reviewed, discussed and the content published by the College in its "Members Dialogue" and on its website.

Recommendation 11:

The MOHLTC, in consultation with CCAC's should revise the Health Assessment Form to ensure the health professional completing the form has a clear understanding of the purpose of the form and the importance of including a detailed diagnosis, prognosis, specialist reports, psychiatric or psychological assessments, behavioural concerns, and all information that would have an impact on the client's ability to be cared for in a long-term care facility in a manner that ensures the safety of both the client and other residents. The structure of the form itself should also be changed in order to accommodate the above noted recommendation.

57

Recommendation 12:

The Health Assessment Form should be amended to include a "drug profile" which analyzes the side effects of prescribed drugs on LTC applicant.

Recommendation 13:

The Health Assessment Form should be amended to include a separate section that seeks information about incidents of aggressive or violent behaviour of the applicant that have occurred in the applicants past.

Rationale: Report from the Geriatric and Long Term Care Review Committee on the Deaths of Mr. El-Roubi and
Mr. Lopez.

The Ministry Of Health And Long-Term Care

Recommendation 14:

The Ministry of Health and Long-Term Care website be amended to include detailed information for physicians and families about the long-term care application process and the importance of providing detailed and up-to-date information to the Community Care Access Centre and upon admission to the long-term care home.

Recommendation 15:

The Ministry of Health and Long-Term Care produce a monthly bulletin to be sent to all long-term care homes, Community Care Access Centres, associations, resident councils, family councils, and other interested parties, providing information regarding policies, programmes and other information of assistance. This bulletin should also be available to the public on the Ministry of Health and Long-Term Care website.

Recommendation 16:

The Ministry of Health and Long-Term Care produce and distribute information pamphlets in all major language groups. Specifically, the pamphlets should include information about long-term care and in-home care, the application process, and living in a long-term care home.

Recommendation 17:

The MOHLTC in consultation with health care professionals should take immediate steps to issue standardized monitoring forms for all LTC facilities (i.e. wanderers record, daily flow sheet, medication administration record, screening tools for placement of residents, placement criteria score sheet, residential functional profile, behavioural/aggressive behaviour checklist, etc.)

Rationale: Uniformity will ensure a "continuity of care" across all long-term care facilities throughout Ontario (Report –Commitment to Care: A Plan for Long-Term Care In Ontario – Prepared by Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care – Spring 2004).

Placement of Individuals

Recommendation 18:

It is recommended that the MOHLTC, after appropriate consultation, review eligibility and admissions regulations and policies to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized facilities or LTC facilities with appropriate specialty units.

It is further recommended that if the decision is made to continue to place such individuals in LTC facilities, that the MOHLTC must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others. If unregulated staff are assisting the regulated health professional on these specialty units/facilities they must be U-FIRST trained.

Rationale: Report from the Geriatric/Long Term Care Review Committee on the deaths of Mr. El Roubi and Mr. Lopez.

Recommendation 19:

It is recommended that the MOHLTC and all CCAC's change their policies to ensure that in cases of potential residents with cognative impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.

Recommendation 20:

Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as:

i) appropriate support in their homes up to 24 hours a day to assist the family;
ii) beds available at an appropriate alternative facility (hospital, mental health facility or specialized facility)

Recommendation 21:

That the MOHLTC review the delays in obtaining Psychogeriatric assessments to ensure that such assessments are available in a timely way and to take steps to address the delays, such as increasing the numbers of Psychogeriatric assessors and resources available in every region.

Specialized Facilities and Units

Recommendation 22:

The MOHLTC should fund specialized facilities to care for demented or cognatively impaired residents exhibiting aggressive behaviour as an alternative to LTC facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals (RN's and RPN's) who are trained in PIECES, and in sufficient numbers to care for these complex and behaviourally difficult residents.

Recommendation 23:

The facilities, in consultation with experts in the field, should be designed using the model of the Dorothy Macham Home at Sunnybrook and Women's College Health Science Centre to meet the physical and staffing requirements of these high needs residents.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors (Exhibit 67, p.4)
Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report March, 2001 – (Exhibit 40, p.1)

Recommendation 24:

The MOHLTC should ensure that these facilities are accessible for the individuals who are not appropriate for placement in long term care facilities. This means that there should be sufficient beds for the region's needs, in all regions that there is no barriers to admission for the individuals who require this specialized care (eg. no requirements that the resident be "stable" to be transferred there from long term care facility, no requirement to be a war veteran or only referred by institutions).

Recommendation 25:

The MOHLTC should immediately mandate and fund specialized units in sufficient numbers in each region to care for residents with behavioural problems. The MOHLTC should consult with healthcare professionals and experts working in the field in setting standards for these units. These units should be regulated by the MOHLTC rather than based on the LTC facility's definition of a "specialty unit". The units should include:

i) beds in appropriate physical spaces (ie. Private rooms located close to nursing stations, etc.) in which residents stay for a short period of time while they are assessed and an appropriate care plan is developed.
ii) If appropriate, the resident, once they are assessed and a care plan developed may be transferred to other units where the care plan will then be implemented. Attention must be paid to ensuring that the care plan is transferred completely, and that follow-up resources are available to the unit caring for the resident.
iii) Some of these units may also be set up based on a long term residential model where residents would live in these units for the entire duration of their behavioural complications.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors
Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report - March, 2001
Review of Homicides in Long Term Care Facilities by the GLTCRC

Revision to Long Care Funding Model

Recommendation 26:

That the MOHLTC, in consultation with stakeholders, should revise the funding system presently in place for LTC facilities within the next fiscal year. Any new system (such as the MDS (Minimum Data Set) model presently being contemplated by the MOHLTC) should be designed to ensure that the funding model is sufficient to take into account the higher skill level of staff required for residents with dimentia and other mental health problems and, in particular, give sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC facilities if they are responsible to manage residents with such behaviours.

Rationale: Commitment to Care – A Plan for Long-Term Care In Ontario Prepared by Monique Smith - Spring, 2004

Recommendation 27:

That MOHLTC report back to the Coroner's office, prior to the one year review, with a time line to ensure funding model review is given priority in fiscal year and implemented in a timely way.

Recommendation 28:

That the MOHLTC retain PricewaterhouseCoopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognative impairment and complex care needs in LTC facilities. This would include determining the appropriate amount of direct RN care that is required, the indirect RN care and the total hours per resident per day of overall Nursing and Personal Care (RN, RPN, and HCA) on average.

Recommendation 29:

That the MOHLTC in the interim, pending the evidence-based study should fund and set standards requiring LTC facilities to increase staffing levels to, on average, no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal car for the average Ontario case mix measure. The funding formula for the Nursing and Personal Care envelope must be immediately adjusted to reflect this minimum staffing.

Recommendation 30:

That the MOHLTC, once the updated evidence based study is received, should set out standards based on this information, for all Ontario LTC facilities to ensure that Ontario LTC facility residents are given appropriate nursing and other staff hours. At a minimum the staff hours must be comparable to other similar jurisdictions and are sufficient to meet the needs of present and future Ontario LTC facility residents.

Rationale: Report of a Study to Review Levels of Service and Responses to need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators – January 11, 2001
PricewaterhouseCoopers Report – Report of a Study to Review Levels of Service and Responses to Need in a Sample of Long-Term Care Facilities and Selected Comparators – January 11, 2001

Recommendation 31:

Pending the remodling of the funding system, the MOHLTC immediately review and revise the present CMI system to ensure cognitive impairment and behavioural problems are sufficiently weighted in the CMI system to ensure sufficient funding for appropriate skilled staff for assessment, monitoring and management of residents prone to these behaviours.

Rationale: "Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility" – Interim Report – March 2001

Recommendation 32:

Pending the remodeling of the funding system, the MOHLTC immediately review the present CMI system to ensure that cognative impairment and behavioural problems are properly identified and captured under the system. As the present system depends on charting of behaviours, the system should ensure that those RN's who are assessing and charting the behaviours have sufficient time to actually assess and record the behaviours. In addition, all staff that the RN's are supervising must also have the training and time to report the behaviours in order that the behaviours be appropriately picked up by the system.

Recommendation 33:

Pending the remodeling of the future system and implementation of training for all staff, additional funding must be provided and tracked to ensure that a PIECES trained Registered Nurse at each facility is designated for those residents on each shift, due to the unpredictability of behaviours and level of risk associated with these residents.

Rationale: Service Provisions Manual – Ministry of Health and Ministry of Community and Social Services – Service Provision – Objectives and Functions (1994-1997)

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Working Conditions

Recommendation 34:

In order to attract and retain sustainable Registered Nurses' to provide the skilled continuity of care required, the MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including:

i) immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses; and
ii) increased number of full-time RN positions and increased the total percentage of full-time RN positions significantly;
iii) Monitor and track LTC facilities use of funds in the Nursing and Personal Care Envelope to ensure that funds are used to meet the agreed upon staffing mix and RN/resident ratios;
iv) Monitor and decrease significantly the use of agency nurses and other LTC staff by LTC facilities.

Professional Standards of Regulatory Colleges to Protect the Public

Recommendation 35:

Given the College of Nurses' Ontario mandate is to protect the public and that it has set standards of practice for RN's and RPN's (including different scopes of practice between RN's and RPN's and express responsibilities for RN's in supervision and delegation to unregulated health care workers) the RN staffing levels must be sufficient to allow the RN in the LTC facility to have time to adhere to the standards set out by the Ontario College of Nurses.

Rationale: Chart – "Profile of Practice Expectations for RN's and RPN's – College of Nurses of Ontario Practice Guideline, "Utilization of Unregulated Care Providers (UCP's)

Recommendation 36:

The MOHLTC staffing standards and the implementation of the staffing standards by the LTC facilities must ensure that the RN has sufficient time to ensure that she/he has time for collaboration with physicians, RPN's and Psychogeriatric Resource Consultants and sufficient time to adequately supervise, teach and delegate to the unregulated workers.

Accountability

Recommendation 37:

To ensure that the funding provided to long-term care facilities is sufficient to provide the level of care required by residents and that the assessed needs of the residents are being met, the MOHLTC should, in keeping with the recommendations of the Office of the Provincial Auditor:

i) Develop standards for staffing in LTC facilities including the number of RN hours of direct and indirect care per resident, the mix of registered and non-registered staff and the staff to resident ratios depending on the complexity of care needs of the residents at the facility; and
ii) Track staff to resident ratios, the number of RN hours per resident and the mix of registered and non-registered nursing staff and determine whether the level of care provided are in accordance with the standard, the specific service agreements of the facility and are meeting the assessed needs of residents; and
iii) Monitor to ensure compliance and accountability of funds given to LTC facilities.
iv) Data regarding the facilities staffing levels, including RN to resident ratios and average numbers of RN hours (direct and indirect) per resident, in addition to compliance reports in LTC homes should be public and easily accessible for review by both request and on the public website. This will ensure that all relevant individuals and entities (including the families and CCAC employees) have this information to make decisions regarding appropriate facilities. This information must be kept current.

Rationale: Pricewaterhouse Coopers Report – Report of A Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators – January 11, 2001

Immediate High Needs Funding for Cognitively Impaired/Aggressive Residents

Recommendation 38:

That MOHLTC immediately review and revise their "High Intensity Needs Program" to ensure that every LTC facility has access to additional funding for immediate staffing increases to care for *existing* cognatively impaired residents safely. The revised programme should ensure the funding is used by LTC facilities to provide RN care for all such residents who are prone to or assessed with potential aggressive behaviours.

The program should ensure that the funding is available for an appropriate period of time and, at a minimum until the resident has been appropriately assessed, an appropriate nursing care plan is developed, and in the opinion of a psychogeriatric resource person, the resident is stable enough that he/she does not provide a risk to self or others if not closely monitored.

Rationale: OANHSS, "Mental Health Issues and Long Term Care"

Recommendation 39:

The MOHLTC should review its High Intensity Needs Program to ensure that transitional beds in long-term care facilities are available for *newly assessed* high risk residents while waiting assessment and/or to ease their transition into a long-term care setting. The Ministry should expand the program to ensure:

i) It is available on admission where aggressive behaviours have been identified;
ii) It is available for residents being admitted directly from the community;
iii) It is available on an on-going basis until a psychogeriatric assessment can be completed and a safe care plan can be implemented;
iv) Funds are available to provide the resident with a private room at the basic ward rate, if necessary;
v) There are sufficient funds to provide one on one care by a PIECES trained RN.

Specialty Training

Recommendation 40:

The MOHLTC should set mandatory standards and provide designated funding to ensure that all staff interacting with cognatively impaired residents in LTC are PIECES/U-First trained. This includes those individuals who make decisions regarding admission and placement, as well as those managing the individual's care.

Rationale: PIECES Manual
Report - Commitment to Care: A Plan for Long-Term Care In Ontario – prepared by Monique Smith – Spring 2004

Recommendation 41:

More specifically, it is recommended, that the MOHLTC create and enforce standards requiring all RN's working in LTC to be PIECES trained as a priority. Such standards should set out timelines such as ensuring that all RN's presently on staff are PIECES trained within one year, and shall include PIECES training as part of the orientation for new staff. The MOHLTC shall ensure that there are adequate classes in each region to address the waiting lists and have all RN's trained within one year.

Recommendation 42:

That the MOHLTC create and enforce standards requiring all administrative and management staff who are involved in admission decisions and staffing decisions to be trained in either the full PIECES course or the ENABLER course.

Recommendation 43:

The Ministry of Health and Long-Term Care, in order to support PIECES trained staff, require that physicians providing services in long-term care homes be knowledgeable about the programme.

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Recommendation 44:

Health Care Aids should have a college or governing body which regulates them. As part of their education they should be trained in psycho-geriatric, aggressive behaviours.

Recommendation 45:

That the MOHLTC create and enforce similar standards requiring that all other staff (RPN's and HCA's) be PIECES/U-FIRST trained in a timely way and that there be adequate classes without waiting lists to facilitate this training.

Recommendation 46:

The MOHLTC set standards, monitor and enforce such standards, to ensure that all facilities have at least one Registered Nurses' with PIECES training on staff on all shifts and available to do PIECES assessments.

Recommendation 47:

That the MOHLTC reinstate funding for all expenses associated with PIECES/U-FIRST training, including travel expenses and wages to backfill for equivalent staff to ensure that all LTC facilities have their staff appropriately trained and continue to have new staff trained.

Recommendation 48:

That the MOHLTC immediately review and address any institutional barriers that may exist that prevent RN's and LTC facilities from accessing PIECES training (ie. Preconditions for administrators, funding issues, waiting lists or being, under-resourced in certain regions).

Recommendation 49:

The MOHLTC, in consultation with psychogeriatric health care professionals, should ensure that Psycho-Geriatric Assessment Teams with established referral patterns are available to all Ontario communities. These teams must be accessible on an urgent basis for CCAC case managers, LTC admissions staff, and PIECES-trained Registered Nurses and other health care providers in order to ensure that all applicants with complex and/or aggressive behavioural concerns can be thoroughly assessed prior to admission to a long-term care facility.

Specific funding and legislation should be put into place by the MOHLTC to develop and maintain these Psycho-Geriatric Assessment Teams.

Rationale: Through the inquest testimony, we the jury believe that in order to properly care for the ever increasing complex care elderly patients, all heath care professionals must be properly trained in order to care for their needs.
Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care In Ontario

Psychogeriatric Assessors and Consultants: Links to the Facilities

Recommendation 50:

That the MOHLTC increase the number of fully funded, full-time Psychogeriatric Resource Consultants and Psychogeriatric Assessors doing assessments through the Geriatric Outreach teams and monitor delays. MOHLTC should ensure that there are sufficient "PRC's" (Psychogeriatric Resource Consultants) and Psychogereatric Assessors available in a timely way to assist the Psychogeriatric Resource persons and other Registered Nurses in managing cognatively impaired residents in LTC facilities (and other facilities where these residents may be placed).

Placement and Admissions

Recommendation 51:

That the regulations and policies regarding long term care should be reviewed by the MOHLTC to ensure that there is an integrated continuum of care. The MOHLTC policies should ensure consistency in managing these cognitively impaired individuals so the risk is managed appropriately both before and after admission to a LTC or other facility.

Recommendation 52:

The regulations, policies and structure of all Ontario CCACs should be reviewed to ensure an integrated continuum of care. Each CCAC should be structured for continuity of care by the case managers to ensure completeness and consistency of information.

Community Care Access Centres

Recommendation 53:

The Community Care Access Centre ensure that when completing the long-term care application, case managers make every effort to interview all family members living with the applicant. Where the applicant is mentally competent, consent must be obtained from the applicant first.

Recommendation 54:

The Community Care Access Centre ensure that where the applicant for long-term care is mentally incompetent, the spouse, if mentally competent and available, must be interviewed as part of the application process.

Recommendation 55:

The Community Care Access Centre ensure that where the applicant for long-term care is mentally incompetent, the substitute decision-maker is interviewed as part of the application process. No application may be allowed to go forward without such an interview-taking place.

Recommendation 56:

The Community Care Access Centre's policies be amended to require proper documentation in all client files. Included in this documentation must be: (a) the full names and relationship of all persons that they speak to about an applicant, including during telephone conversations and face-to-face meetings; (b) time, date and length of conversations and meetings; (c) content of discussions and all relevant information.

Recommendation 57:

The Community Care Access Centre require that all documentation must be completed at the time of the conversation or meeting, or as soon as possible thereafter. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 58:

CCAC's should include with the assessment package sent to long-term care facilities a social assessment that would include the client's interests, wishes, family dynamics, and ethnic, cultural and religious considerations.

Recommendation 59:

The MOHLTC, in consultation with the CCAC sector, should consider including a provision in legislation and Ministry policy that limits the choice of clients who have been assessed as posing a risk to others due to physically aggressive or violent behaviour. Clients who are assessed as posing this risk, should be required to choose a LTC home with a specialized behavioural unit designed to deal with the clients behavioural concerns.

Recommendation 60:

That the Regulations, including the PCS Manual be revised by the MOHLTC to ensure that there is a requirement that an assessment of risk to self and others is done by the CCAC *prior* to placing the individual in any LTC facility. This revised regulation and the accompanying policy, would require the CCAC to consider a full assessment of the applicant's mental health status and behavioral problems prior to the determination of eligibility. It would also require the CCAC to consider the particular LTC facility and assess its resident population (the frailty of other residents, the competing high needs of other residents, the level of staffing, the numbers of Registered Nurses available, the presence of an appropriate specialty unit etc.) as part of the CCAC process and the determination of whether the resident is eligible for admission to LTC and should be placed in that particular LTC facility.

Rationale: Placement Coordination Service Manual

Recommendation 61:

That the MOHLTC review their regulations and policies to clarify the crisis admission process. At a minimum, standards must be set to ensure that complete and accurate information is obtained prior to decision making about an applicant's eligibility and admission, despite the fact that the family is in crisis. The policy should ensure that no decisions regarding eligibility and placement are made without all relevant information. This information must include, but is not necessarily limited to, information from the entire health care team such as, information from all relevant family members, family physicians, and specialists. Information from other community resources such as psychogeriatric assessments and, where appropriate the police, should also be obtained. If the information is inadequate at the time of the application, the family should be notified and the CCAC should not make the placement arrangements until all relevant information is obtained and should ensure alternative resources are made available to the family in the interim.

Recommendation 62:

That the legislation, regulations and policies be reviewed to ensure that there is a mechanism for the conditional placement of residents in LTC facilities. If, after admission, a resident is found to have a complexity of care such as aggressive behaviors that cannot be safely managed, or to have requirements beyond the staffing ratios and staff expertise of the LTC facility, the CCAC shall be responsible for overseeing the immediate removal of the resident and their placement in a more appropriate setting. The LTC facility should not be left with the responsibility of finding alternative services, such as an acute care hospital, a specialized Centre or another LTC facility with a more appropriate unit.

Recommendation 63:

That the LTC facility, through its Director of Care or delegate, when reviewing the CCAC materials to determine if the facility has the physical and nursing expertise to safely admit the individual, should be given sufficient time, resources and mechanisms to make this determination. This may include the LTC facility meeting with the resident and family prior to the decision to admit being made, and the facility having the means to accept the resident on a conditional basis.

Recommendation 64:

The Ministry of Health and Long-Term Care long-term care home policies be amended to include requirements for the review of applications for long-term care. Specifically, all documentation received from the Community Care Access Centre must be reviewed by the long-term care home, and there must be written documentation stating that all care requirements have been considered and are able to be met within that facility.

Recommendation 65:

The Ministry of Health and Long-Term Care amend the RAI-HC tool to include elements which have been identified as predictors for violence, such as suspicion and paranoia. It is further suggested that a geriatric psychiatrist or other geriatric mental health specialist review the form to ensure that all appropriate mental health issues are captured therein. The form should also be changed to accommodate "progress notes".

Rationale: The RAI-HC was introduced by the Community Care Access Centre to replace the initial client assessment forms. This tool needs to be amended

to provide a more "holistic" view on the patient which would include behavioural issues.

Recommendation 66:

That the MOHLTC and the CCACs should review the requirements for all employees who are applying the RAI-HC tool or who are making eligibility decisions to ensure that they are the appropriate PIECES-trained health professional such as an RN. They should have the appropriate education and qualifications to holistically make assessments, including the abilities and skills to understand underlying medical causes of cognitive impairment, multiple medical diagnosis and treatments, the impact interaction of multiple medications and all assessment tools.

Recommendation 67:

That the CCAC should ensure that there are no inappropriate admissions because LTC facilities are funded based on occupancy levels. At no time should residents be admitted to fill empty beds if that facility is not appropriate for the resident.

Recommendation 68:

The Ministry of Health and Long-Term Care take immediate steps to end weekend and evening admissions to long-term care homes. Implicit in this recommendation is that the Ministry's "Sustainability Program" be cancelled.

Assessment Tools

Recommendation 69:

The Ministry of Health and Long-Term Care, in consultation with health care professionals working in the long term care industry, should develop a aggression risk assessment tool for cognitively impaired residents with abnormal behaviours to assist in predicting future aggressive behaviours. The risk assessment tool should address an individuals military history, alcohol and drug addiction.

All assessment tools should be kept current and new tools should be incorporated into mandatory training.

Recommendation 70:

The MOHLTC, in consultation with health care professions working in the industry, should ensure that regulated staff (all regulated health care professions, social workers or other professionals who may be given responsibilities for assessments and admission decisions) are kept current in their training and that appropriate time is designated for these professionals to be able to implement the tools into the assessments and admission decisions.

Communication

Recommendation 71:

Given that families, family physicians and others with relevant information necessary for placement and admission may not readily provide all relevant information, either unintentionally or intentionally, the MOHLTC, CCACs and Long Term Care facilities should review the applicable legislation, regulations, policies to ensure that:

i) the appropriate regulated health professionals, who are trained in both a holistic approach and have probing assessment skills and interview techniques, are responsible for obtaining the information from all relevant members of the families, physicians, hospitals, other health and community sources, and criminal information where appropriate;

ii) the CCACs structure is reviewed to ensure an integrated model to ensure the resident is being followed by a single case manager who has responsibility to ensure the information is consistent, comprehensive thorough; and

iii) any issues, real or perceived, regarding consent to releasing relevant information is addressed systemically to ensure that all relevant medical, social, cultural, criminal, and environmental information is available to the health care team both making decisions regarding eligibility, placement and providing management of care of cognitively impaired residents with aggressive behaviors.

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Recommendation 72:

Given Ontario's ever increasing multicultural population, it should be recognized that language and cultural values may be a barrier to obtaining all relevant information. In light of this reality, the MOHLTC, CCACs and LTC facilities should:

i) where the applicant for long-term care is unable to communicate with the case manager due to a language barriers, the Community Care Access Centre utilize a translator independent of the family or substitute decision-maker: (a) to ensure that the person is aware of the process, (b) if they are capable they are, in fact, agreeing to placement and, (c) if incapable, they are able to voice their opinions and concerns with respect to any placement. Funding for interpreters must be made available to the Community Care Access Centres by the Ministry of Health and Long-Term Care. These translation services should also be made available to all LTC facilities.

ii) ensure that policies and training reflect the heightened need for clear communications in cases of potential aggression, including cultural sensitivity to the issue of domestic assault or placement of elderly in institutions;

iii) ensure that language issues do not increase alienation or trigger aggressive behaviors when individuals become residents of facilities where staff do not speak their language or that language issues not be a barrier to staff adequately assessing and managing such behaviors; and,

iv) that if placement must be to a facility that does not provide services in the language and with the cultural sensitivity required, that admission be delayed until there are assurances that there is all relevant information obtained, that the treatment plan is in place to address the short and long term needs of the individual in being moved to an institution that does not speak their language.

Long-Term Care Homes

Recommendation 73:

All LTC facilities must have a set "admissions team" which consist of:

(i) LTC facility's Administrator,
(ii) The LTC facility's Director of Care,
(iii) The LCT facility's Chief Medical Administrator, and
(iv) One PIECES-trained staff RN.

All members of this "admissions team" must be present on the day the patient is admitted into their respective LTC facility.

Recommendation 74:

Long-term care homes ensure that when a resident is admitted to a long-term care home, all staff who may have direct contact with a resident are provided with all necessary information about that resident.

Recommendation 75:

Long-term care homes have a method (taped or written) of ensuring that staff are provided with all updated patient information if they are unable to attend the shift report, whether due to being on a short shift, being late for work, or having to attend other duties during the report. The resident's chart must be read and reviewed at the start of each shift. All reports whether written or on tape, must place particular emphasis on new admissions and on instructions for monitoring residents who require additional observation. The MOHLTC should establish a half-hour paid "hand-over" to accommodate this recommendation.

Recommendation 76:

Long-term care homes require that their staff document in their progress notes all details of conversations and meetings, include the names of the persons they speak or meet with, the relationship of the person to the resident, and the contents of the conversation. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 77:

Long-term care homes be required to train their staff at least semi-annually on the different type of emergency codes and the responses expected from them. Included should be training for staff on how to deal with physically aggressive patients. All LTC homes should also be required to set out a contingency plan to deal with patients who exhibit aggressive behaviours.

Recommendation 78:

The MOHLTC must make mandatory all core in-service training sessions for HCA's and must ensure that their positions are backfilled if they are on duty, or are remunerated if required to attend courses on their time off or scheduled off day.

Recommendation 79:

All LTC facilities must ensure that pictures of all LTC patients be placed on the front of their respective medical records for easy identification. In addition, LTC facilities should implement identifiers (i.e. colour coded shoe laces) for differing patients who are suffering from cognitive, behavioural or physical issues.

Recommendation 80:

The MOHLTC should ensure that doctors who head LTC facilities should either have a degree in geriatrics or should have geriatric training.

Investigations

Recommendation 81:

Where the police investigate an incident in a long-term care home or an incident involving a Community Care Access Centre, the Ministry of Health and Long-Term Care shall complete their own, thorough investigation as soon thereafter as possible, to determine whether there have been any breaches of the legislation or policies.

Recommendation 82:

The Ministry of Health and Long-Term Care track violent incidents in long-term care homes using the FMIS system. A specific report of violent incidents should be produced on a monthly basis.

Recommendation 83:

The Ministry of Health and Long-Term Care adapt the FMIS system to include homicides as a specific catégory of unusual/accidental deaths in its "Accidental Deaths" database or, alternatively, create a specific database to track homicides.

Publication of Circumstances of the Deaths of P. Lopez and E. El-Roubi

Recommendation 84:

It is recommended that the Office of the Chief Coroner for the Province of Ontario should request that the Geriatric and Long Term Care Review Committee publish a comprehensive account of the circumstances surrounding and leading to the deaths of Pedro Lopez and Ezzeldine El-Roubi, including the recommendations arising from this Inquest. This report and the recommendations of this jury should also be distributed to all LTC facilities, all CCACs, all educational institutions for both regulated and unregulated health care professionals and all Colleges regulating health care professions and Social Workers in the Province of Ontario and the professional association and Unions representing staff at long term care facilities and CCACs.

Recommendation 85:

That the office of the Coroner within one year of this inquest follow up on the implementation of the jury's recommendations and provide a report to be made public and directed to all relevant parties working in the long term care sector in Ontario.

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Verdict Explanation

Mr. Ezzeldine El-Roubi and Mr. Perdo Lopez
Jan 31st to February 4th, inclusive
February 7th to 11th inclusive
February 14th to 18th inclusive
February 28th to March 4th inclusive
March 7th, 8th, 10th 11th,
March 14th to 17th inclusive
March 29th to April 1st inclusive
April 4th and 5th
Jury Deliberation April 5th, 6th, 7th, 8th, 11th, 12th, 14th, 15th
Verdict received April 17th
Coroners Courts, 15, Grosvenor Street,
Toronto.

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and recommendations of the jury and it is not intended to be considered as actual evidence presented at the inquest. It is in no way intended to replace the jury's verdict.

PARTICIPANTS:

Counsel to the Coroner:	**Mr. Robert Ash**
Investigating officer:	**P.C. Michael Burrows MTPS 13 Div.**
Coroner's Constable:	**Const E. Drumond**
Court reporter:	**Ms. Ala Kleinberg Network Reporting 100 King St. West Toronto. M5X 1E3 416.359.1611**

Parties with standing:	Represented by Counsel
1. Concerned Friends	Ms. Jane Medus
2. Ontario Nurses Association	Ms. Kate Hughes Mr. Philip Abbink
3. Ministry of Health	Ms. Lise Favero and Mr. Robert Ratcliffe
4. Dr. S. Ralh	Ms. Bombier Mr. J. Goldblatt
5. Etobicoke Community Care Access Centre	Ms. Cindy Clark
6. Employees of Etobicoke Community Care Access Centre	Ms. Terri Hilborn
7. Employees of Casa Verde Health Centre	Ms. Heidi Rubin
8. Casa Verde Health Centre	Mr. Peter Pliszka

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

The two deceased persons, Mr. El-Roubi and Mr. Lopez were residents of the Casa Verde Health Centre Long Term Care Facility and the innocent parties in this event. A Mr. Pira Sing Sandhu was an elderly Sikh gentleman who suffered from Atrial fibrillation, Asthma and Dementia. He had been hospitalized in March 2001 for an embolic stroke which had presented with loss of vision. The left parietal lobe of the brain was affected by the stroke. During his hospitalization he became aggressive and confused; it would appear that because of his behavior he was discharged from hospital late in the evening of the fourth day of his hospital stay. Apart from follow up by the neurologist and being told to see his family doctor for his INR follow up no home care services were arranged. Mr. Sandhu saw his family doctor the day after discharge on March 29th and did not see him again until June 2nd. His INR was monitored with phone calls to adjust the Coumadin dosage. It appears the patients confusion improved when he was home but his aggressiveness and sleep disruption continued so he required round the clock observation most of which was carried out by his wife. The son, his wife and two grandsons occasionally helped when not at work. In general the family's routine was disrupted by Mr. Sandhu's behavior.

On about May 30th the family took Mr. Sandhu's spouse to see the family doctor because she had sustained an injury to her right eye after being hit with a closed fist by her husband during an aggressive outburst. The doctor noted the injuries indicating that the family should take the patient to hospital for X-Rays and Mr. Sandhu to be assessed, as this was a case of domestic violence. The family indicated it was a family matter and they would deal with it as Mr. Sandhu had been like this most of his life. Three days later the family returned to the doctors office with Mr. Sandhu and a Medical Assessment form from the Etobicoke Community Care Access Centre (ECCAC) for admission to a Long Term Care Facility (LTCF). This had been suggested to the family as the only way to get Mr. Sandhu out of the house and where he could get help. The form was filled out by the family doctor but with no mention of the assault on the spouse. The family doctor claimed confidentiality because the information of the violent episode was not in Mr. Sandhu's chart.

There were two documented visits to the ECCAC and the remaining forms were filled out including a functional assessment, which showed Mr. Sandhu was verbally and physically aggressive and may use objects to hit out with when he is aggressive. The intake manager at the ECCAC then passed the application on to the placement manager who assessed the case and came to the conclusion that Mr. Sandhu was eligible for admission and was a crisis admission since the primary care-giver was at risk if Mr. Sandhu was left in the home. Since the ECCAC had no beds available the placement manager contacted the North York CCAC as they had beds. The manager at the North York CCAC indicated two beds were available at Casa Verde and to help them decide on his suitability for admission that a behavioral assessment be obtained. She also thought the case would not be accepted by Casa Verde from her initial assessment of the application. The ECCAC was asked to do the assessment and it was done over the phone by another placement manager who had not seen the original functional assessment. She talked to the 20-year-old grandson as Mr. Sandhu's son felt his English was not good enough. The resulting behavioral assessment showed no evidence of physical abuse only verbal and that he did not need close observation. (A somewhat different report than the functional report originally done in an interview with Mr. Sandhu, the son and grandson.) No further assessment was done to verify the information received.

All the reports were sent to Casa Verde and reviewed by the Director of Care that afternoon who within a short time (1-2 hours) accepted the admission for either that afternoon/evening or the next day Saturday June 9th. The family were informed and took the Saturday time.

Around noon on the Saturday Mr. Sandhu, his son, grandson and the family friend arrived at Casa Verde and were met by the assistant Director of Care working that day. They all then went up to the nursing floor 2E and here the charge nurse took the patients information and was given information that he could have violent physical and verbal episodes and documented this fact in the progress notes. Mr. Sandhu was taken to his

room and underwent the usual admission examination. In general, he was described by the staff as being quiet and polite. He had a shower and was taken for lunch. His family left about this time, it was never determined if they ever had warned Mr. Sandhu where he was going and that it was meant to be permanent. After lunch Mr. Sandhu was seen to wander around the floor looking around and sitting in the lounge area. He did go to his room and slept for a while and around 1500 hrs indicated he wanted to call home. The nurses helped him to place the call as no one on the floor spoke Punjabi Mr. Sandhu's mother tongue so they relied on the family to help translate. Mr. Sandhu was escorted by one of the nurses to the dining room just before dinner was served between 1700 and 1800 hrs. The nursing staff noted he did not eat all his food. After dinner he walked to his room on his own and all appeared normal. At 1900-1915 hrs he was given his evening medications. Around 1930 hrs some unusual noises were heard to come from room 204 and as people were going towards the room Mr. Sandhu was seen to be coming out and going into room 203 and carrying a metal object. The first staff member into 2004 saw two individuals both with severe injures to the head and they saw Mr. Sandhu attacking another resident in room 203. It required two male Staff to restrain Mr. Sandhu, remove the weapon from him and hold him until the police arrived. Both the residents in 204 were deceased from severe head injuries at the scene. The third victim did survive his injuries. Mr. Sandhu was arrested and charged with double homicide soon after 2100 hrs. At his arraignment hearing he was sent to Penatanguishine Psychiatric Hospital for psychiatric assessment but died while there from a stroke while being assessed.

The jury heard the evidence from 43 witnesses and had 85 exhibits submitted during the Inquest of 34 days. The jury deliberated over 9 days.

The jury determined the following:

Name of the Deceased:	**Mr. Ezzeldine El-Roubi**
Date and time of Death:	**June 9th 2001 at 1930 hrs**
Place of Death:	**Casa Verde Health Centre 3995 Keele Street, Toronto**
Cause of Death:	**Blunt Force Crainio-Cerebral Trauma**
By what means	**Homicide**

Name of the Deceased:	**Mr. Pedro Lopez**
Date and time of Death:	**June 9th 2001 at 1930 hrs**
Place of Death:	**Casa Verde Health Centre 3995 Keele Street, Toronto**
Cause of Death:	**Blunt Force Crainio -Cerebral Trauma**
By what means	**Homicide**

Recommendations:

The following recommendations are not presented in any particular order of priority:

Need for MOHLTC to Make Long Term Care A Higher Priority

Recommendation 1:

That the Ministry of Health and Long-Term Care (MOHLTC) should give increased priority to the health care needs of the elderly and, in particular, the serious challenges faced in treating elderly cognitively impaired residents, by immediately developing and implementing a plan (or "Framework") to ensure appropriate standards, funding, tracking and accountability in Long Term Care (LTC) and other facilities treating such individuals.

Recommendation 2:

The Ontario Seniors' Secretariat, in consultation with stakeholders in the long-term care system should initiate a public education campaign to decrease the stigma attached to elderly people with dementia and other cognitive difficulties.

Recommendation 3:

The MOHLTC, in consultation with the College of Family Physicians, should design and implement an expanded and on-going education and support programme for family physicians to assist them in the early detection, diagnosis and treatment of dementia and related behavioural problems and in accessing available community resources for the client and family caregivers.

Recommendation 4:

It is recommended that the MOHLTC take immediate steps to implement the "Ten-Point Plan for Improving the Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario".

Rationale: **It is recommended that the MOHLTC recognize that due to health care restructuring LTC facilities have become "new Mental Health institutions" in Ontario, without the funding and resource necessary nor a recognition of the anticipated needs given the demographics in Ontario related to the increased aging population with cognitive impairments. (Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care in Ontario).**

Coroner's Comments: **The jury heard evidence of the downloading from acute care hospitals and anticipated increase in numbers of elderly requiring Long Term care as the population ages. With one in five of this group being aggressive and or violent, there was concern that there are no other facilities for the patients.**

Office Of The Chief Coroner

Recommendation 5:

The Office of the Chief Coroner publish these and all other inquest recommendations on its website.

Recommendation 6:

The Office of the Chief Coroner publish all Annual Reports of the Geriatric and Long-Term Care Review Committee on its website. Notification of publication should be sent annually upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.

Recommendation 7:

The Office of the Chief Coroner thoroughly investigates all suspected homicides in long-term care.

Recommendation 8:

The Office of the Chief Coroner review all other potential homicides in long-term care homes which have occurred since 1999 and publish a special report with respect to all of these deaths. This report should be published on the website of the Office of the Chief Coroner, and notification of publication should be sent upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community Care Access Centres, and resident and family advocacy groups, as well as all police forces in Ontario.

Coroner's Comments:

Jury heard evidence that all deaths in Long Term care Facilities are reported to the Office of the Chief Coroner. Every tenth death is a mandatory Coroners investigation as well as any death that falls under Section 10 of the Coroners Act. Inquest recommendations are publicly available on request but are not posted on the Office of the Chief Coroner website because of the requirement of French translation. The jury made a recommendation that this posting be done.

The College Of Physicians And Surgeons Of Ontario

Recommendation 9:

The College of Physicians and Surgeons of Ontario communicate to its members the importance of preparing discharge summaries and providing them to the family physician within 7 days from discharge.

Recommendation 10:

The College of Physicians and Surgeons of Ontario clarify the issue of confidentiality when issues of abuse arise. Specifically, the specifics of this case should be reviewed, discussed and the content published by the College in its "Members Dialogue" and on its website.

Recommendation 11:

The MOHLTC, in consultation with CCAC's should revise the Health Assessment Form to ensure the health professional completing the form has a clear understanding of the purpose of the form and the importance of including a detailed diagnosis, prognosis, specialist reports, psychiatric or psychological assessments, behavioural concerns, and all information that would have an impact on the client's ability to be cared for in a long-term care facility in a manner that ensures the safety of both the client and other residents. The structure of the form itself should also be changed in order to accommodate the above noted recommendation.

Recommendation 12:

The Health Assessment Form should be amended to include a "drug profile" which analyzes the side effects of prescribed drugs on the LTC applicant.

Recommendation 13:

The Health Assessment Form should be amended to include a separate section that seeks information about incidents of aggressive or violent behaviour of the applicant that have occurred in the applicant's past.

Rationale: Report from the Geriatric and Long Term Care Review Committee on the Deaths of Mr. El-Roubi and Mr. Lopez.

Coroner's Comments:

The admitting physician did not complete the hospital discharge summary following Mr. Sandhu's admission in March 2001, until after the deaths had occurred. That information could have been of assistance to the family doctor when he was completing the medical report for the Etobicoke Community Access Centre on Mr. Sandhu. Also the family doctor withheld significant information on Mr. Sandhu's violent behaviour believing it to be a breach of confidentiality had he done so. This violent behaviour was documented in another family member's chart.

The Ministry Of Health And Long-Term Care

Recommendation 14:

The Ministry of Health and Long-Term Care website be amended to include detailed information for physicians and families about the long-term care application process and the importance of providing detailed and up-to-date

information to the Community Care Access Centre and upon admission to the long-term care home.

Recommendation 15:

The Ministry of Health and Long-Term Care produce a monthly bulletin to be sent to all long-term care homes, Community Care Access Centres, associations, resident councils, family councils, and other interested parties, providing information regarding policies, programmes and other information of assistance. This bulletin should also be available to the public on the Ministry of Health and Long-Term Care website.

Recommendation 16:

The Ministry of Health and Long-Term Care produce and distribute information pamphlets in all major language groups. Specifically, the pamphlets should include information about long-term care and in-home care, the application process, and living in a long-term care home.

Recommendation 17:

The MOHLTC in consultation with health care professionals should take immediate steps to issue standardized monitoring forms for all LTC facilities (i.e. wanderers record, daily flow sheet, medication administration record, screening tools for placement of residents, placement criteria score sheet, residential functional profile, behavioural/aggressive behaviour checklist, etc.)

Rationale: Uniformity will ensure a "continuity of care" across all long-term care facilities throughout Ontario (Report -Commitment to Care: A Plan for Long-Term Care In Ontario - Prepared by Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care - Spring 2004).

Coroner's Comments:

There was evidence that pamphlets about long-term care facilities were not available in all languages. The forms used in each facility tended to be developed by that facility and although they had a common basis they were not interchangeable between facilities.

Placement of Individuals

Recommendation 18:

It is recommended that the MOHLTC, after appropriate consultation, review eligibility and admissions regulations and policies to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized facilities or LTC facilities with appropriate specialty units.

It is further recommended that if the decision is made to continue to place such individuals in LTC facilities, that the MOHLTC must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these

behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others. If unregulated staff are assisting the regulated health professional on these specialty units/facilities they must be U-FIRST trained.

Rationale: Report from the Geriatric/Long Term Care Review Committee on the deaths of Mr. El Roubi and Mr. Lopez.

Recommendation 19:

It is recommended that the MOHLTC and all CCAC's change their policies to ensure that in cases of potential residents with cognitive impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.

Recommendation 20:

Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as:

i) appropriate support in their homes up to 24 hours a day to assist the family;
ii) beds available at an appropriate alternative facility (hospital, mental health facility or specialized facility)

Recommendation 21:

That the MOHLTC review the delays in obtaining Psychogeriatric assessments to ensure that such assessments are available in a timely way and to take steps to address the delays, such as increasing the numbers of Psychogeriatric assessors and resources available in every region.

Coroner's Comments:

The jury heard evidence that crisis admission applications were given short response times to remove the patient from the home environment if the patient or the family caring for the patient were at risk of physical harm. There was no consideration given to risks of the residents or staff at the receiving facility. The psychogeriatric assessors are unable to give prompt responses to urgent request for assessments of such patients. Delays of 2-6 weeks to do such assessments were common. There appears to be a need for assessment type units with appropriately trained staff to deal with these patients; or, for the family to receive more home care until the patient is assessed.

Specialized Facilities and Units

Recommendation 22:
The MOHLTC should fund specialized facilities to care for demented or cognitively impaired residents exhibiting aggressive behaviour as an alternative

to LTC facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals (RN's and RPN's) who are trained in PIECES, and in sufficient numbers to care for these complex and behaviourally difficult residents.

Recommendation 23:

The facilities, in consultation with experts in the field, should be designed using the model of the Dorothy Macham Home at Sunnybrook and Women's College Health Science Centre to meet the physical and staffing requirements of these high needs residents.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors (Exhibit 67, p.4)
Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report March, 2001 – (Exhibit 40, p.1)

Recommendation 24:

The MOHLTC should ensure that these facilities are accessible for the individuals who are not appropriate for placement in long term care facilities. This means that there should be sufficient beds for the region's needs, in all regions that there is no barriers to admission for the individuals who require this specialized care (e.g. no requirements that the resident be "stable" to be transferred there from long term care facility, no requirement to be a war veteran or only referred by institutions).

Recommendation 25:

The MOHLTC should immediately mandate and fund specialized units in sufficient numbers in each region to care for residents with behavioural problems. The MOHLTC should consult with healthcare professionals and experts working in the field in setting standards for these units. These units should be regulated by the MOHLTC rather than based on the LTC facility's definition of a "specialty unit". The units should include:

i) beds in appropriate physical spaces (i.e. Private rooms located close to nursing stations, etc.) in which residents stay for a short period of time while they are assessed and an appropriate care plan is developed.
ii) If appropriate, the resident, once they are assessed and a care plan developed may be transferred to other units where the care plan will then be implemented. Attention must be paid to ensuring that the care plan is transferred completely, and that follow-up resources are available to the unit caring for the resident.
iii) Some of these units may also be set up based on a long term residential model where residents would live in these units for the entire duration of their behavioural complications.

Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors

Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report - March, 2001
Review of Homicides in Long Term Care Facilities by the GLTCRC

Coroner's Comments:

The jury heard evidence that with the closing of psychiatric long-term care beds there are no other facilities for these violent aggressive demented patients to be placed. Their admission defaults to the remaining long term care facilities. These groups of demented patient's require specialized environment and treatment so there is need for such units in each region. At these assessment units the patient can be assessed regarding a treatment plan, which can be implemented when the patient is transferred to a suitable long-term care facility. A small group of such patients will require continuous treatment in a specialized unit for the duration of their violent/aggressive status, which usually lasts less than a year. These specialize units need to be more than a "secure area" within a long term care facility.

Revision to Long Care Funding Model

Recommendation 26:

That the MOHLTC, in consultation with stakeholders, should revise the funding system presently in place for LTC facilities within the next fiscal year. Any new system (such as the MDS (Minimum Data Set) model presently being contemplated by the MOHLTC) should be designed to ensure that the funding model is sufficient to take into account the higher skill level of staff required for residents with dementia and other mental health problems and, in particular, give sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC facilities if they are responsible to manage residents with such behaviours.

Rationale: Commitment to Care – A Plan for Long-Term Care In Ontario Prepared by Monique Smith - Spring, 2004

Recommendation 27: .

That MOHLTC report back to the Coroner's office, prior to the one year review, with a time line to ensure funding model review is given priority in fiscal year and implemented in a timely way.

Recommendation 28:

That the MOHLTC retain Price Waterhouse Coopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognitive impairment and complex care needs in LTC facilities. This would include determining the appropriate amount of direct RN care that is required, the indirect RN care and the total hours per resident per day of overall Nursing and Personal Care (RN, RPN, and HCA) on average.

Recommendation 29:

That the MOHLTC in the interim, pending the evidence-based study should fund and set standards requiring LTC facilities to increase staffing levels to, on average, no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal car for the average Ontario case mix measure. The funding formula for the Nursing and Personal Care envelope must be immediately adjusted to reflect this minimum staffing.

Recommendation 30:

That the MOHLTC, once the updated evidence based study is received, should set out standards based on this information, for all Ontario LTC facilities to ensure that Ontario LTC facility residents are given appropriate nursing and other staff hours. At a minimum the staff hours must be comparable to other similar jurisdictions and are sufficient to meet the needs of present and future Ontario LTC facility residents.

Rationale: Report of a Study to Review Levels of Service and Responses to need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators – January 11, 2001
Price Waterhouse Coopers Report – Report of a Study to Review Levels of Service and Responses to Need in a Sample of Long-Term Care Facilities and Selected Comparators – January 11, 2001

Recommendation 31:

Pending the remodeling of the funding system, the MOHLTC immediately review and revise the present CMI system to ensure cognitive impairment and behavioural problems are sufficiently weighted in the CMI system to ensure sufficient funding for appropriate skilled staff for assessment, monitoring and management of residents prone to these behaviours.

Rationale: "Report on Individuals Who Present Challenges to Placement in a Long-Term Care Facility" – Interim Report – March 2001

Recommendation 32:

Pending the remodeling of the funding system, the MOHLTC immediately review the present CMI system to ensure that cognitive impairment and behavioural problems are properly identified and captured under the system. As the present system depends on charting of behaviours, the system should ensure that those RN's who are assessing and charting the behaviours have sufficient time to actually assess and record the behaviours. In addition, all staff that the RN's are supervising must also have the training and time to report the behaviours in order that the behaviours be appropriately picked up by the system.

Recommendation 33:

Pending the remodeling of the future system and implementation of training for all staff, additional funding must be provided and tracked to ensure that a PIECES trained Registered Nurse at each facility is designated for those residents on each shift, due to the unpredictability of behaviours and level of risk associated with these residents.

Rationale: Service Provisions Manual – Ministry of Health and Ministry of Community and Social Services – Service Provision – Objectives and Functions (1994-1997)

Coroner's Comments:

Evidence was heard that Ontario long-term care residents have the lowest direct contact time with Registered Nurses in the country. Thus lower RN/patient ratios are needed to improve direct patient RN contact. The present funding formula does not adequately take into account the increased nursing needs of the demented aggressive/violent patients. It needs to be modified to reflect this nursing requirement. This would mean the funding envelope which includes nursing care would need to be improved.

Working Conditions

Recommendation 34:

In order to attract and retain sustainable Registered Nurses' to provide the skilled continuity of care required, the MOHLTC should take immediate steps to enhance the working conditions in LTC facilities including:

i) Immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses; and
ii) Increased number of full-time RN positions and increased the total percentage of full-time RN positions significantly;
iii) Monitor and track LTC facilities use of funds in the Nursing and Personal Care Envelope to ensure that funds are used to meet the agreed upon staffing mix and RN/resident ratios;
iv) Monitor and decrease significantly the use of agency nurses and other LTC staff by LTC facilities.

Coroner's Comments:

The present pay scales for nursing staff at the long-term care facilities are slightly lower than those in general hospitals and the benefits are not always included.

Professional Standards of Regulatory Colleges to Protect the Public

Recommendation 35:

Given the College of Nurses' Ontario mandate is to protect the public and that it has set standards of practice for RN's and RPN's (including different scopes of practice between RN's and RPN's and express responsibilities for RN's in supervision and delegation to unregulated health care workers) the RN staffing levels must be sufficient to allow the RN in the LTC facility to have time to adhere to the standards set out by the Ontario College of Nurses.

Rationale: Chart – "Profile of Practice Expectations for RN's and RPN's – College of Nurses of Ontario Practice Guideline, "Utilization of Unregulated Care Providers (UCP's)

Recommendation 36:

The MOHLTC staffing standards and the implementation of the staffing standards by the LTC facilities must ensure that the RN has sufficient time to ensure that she/he has time for collaboration with physicians, RPN's and Psychogeriatric Resource Consultants and sufficient time to adequately supervise, teach and delegate to the unregulated workers.

Coroner's Comments:

The RN in a long-term care facility is expected to supervise the RPN's and HCA's as well as carry out their normal duties. The present requirement of 1 RN per facility does not appear satisfactory since there could be up to 300 patients in the facility. So the ration of RN to other health care staff should be reduced.

Accountability

Recommendation 37:

To ensure that the funding provided to long-term care facilities is sufficient to provide the level of care required by residents and that the assessed needs of the residents are being met, the MOHLTC should, in keeping with the recommendations of the Office of the Provincial Auditor:

i) Develop standards for staffing in LTC facilities including the number of RN hours of direct and indirect care per resident, the mix of registered and non-registered staff and the staff to resident ratios depending on the complexity of care needs of the residents at the facility; and
ii) Track staff to resident ratios, the number of RN hours per resident and the mix of registered and non-registered nursing staff and determine whether the level of care provided are in accordance with the standard, the specific service agreements of the facility and are meeting the assessed needs of residents; and
iii) Monitor to ensure compliance and accountability of funds given to LTC facilities.
iv) Data regarding the facilities staffing levels, including RN to resident ratios and average numbers of RN hours (direct and indirect) per resident, in addition to compliance reports in LTC homes should be public and easily accessible for review by both request and on the public website. This will ensure that all relevant individuals and entities (including the families and CCAC employees) have this information to make decisions regarding appropriate facilities. This information must be kept current.

Rationale: Price Waterhouse Coopers Report – Report of A Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators – January 11, 2001
Report - Commitment to Care: A Plan for Long-Term Care in Ontario - prepared by Monique Smith – Spring 2004

Coroner's Comments:

Funding monies given to the facilities by the Ministry of Health and Long Term care should be tracked by the Ministry, as indicated by the auditor general of the province. This is to be sure that the funding envelopes are being utilized for the appropriate aspects of the residents' total needs.

Immediate High Needs Funding for Cognitively Impaired/Aggressive Residents

Recommendation 38:

That MOHLTC immediately review and revise their "High Intensity Needs Program" to ensure that every LTC facility has access to additional funding for immediate staffing increases to care for *existing* cognitively impaired residents safely. The revised programme should ensure the funding is used by LTC facilities to provide RN care for all such residents who are prone to or assessed with potential aggressive behaviours.

The program should ensure that the funding is available for an appropriate period of time and, at a minimum until the resident has been appropriately assessed, an appropriate nursing care plan is developed, and in the opinion of a psychogeriatric resource person, the resident is stable enough that he/she does not provide a risk to self or others if not closely monitored.

Rationale: OANHSS, "Mental Health Issues and Long Term Care"

Recommendation 39:

The MOHLTC should review its High Intensity Needs Program to ensure that transitional beds in long-term care facilities are available for *newly assessed* high risk residents while waiting assessment and/or to ease their transition into a long-term care setting. The Ministry should expand the program to ensure:

i) It is available on admission where aggressive behaviours have been identified;
ii) It is available for residents being admitted directly from the community;
iii) It is available on an on-going basis until a psychogeriatric assessment can be completed and a safe care plan can be implemented;
iv) Funds are available to provide the resident with a private room at the basic ward rate, if necessary;
v) There are sufficient funds to provide one on one care by a PIECES trained RN.

Coroner's Comments:

This high intensity funding is presently available but not well advertised to the long term care facilities. However, it is only available for 9 shifts but could be extended beyond this number if requested. (It is unlikely to be extended for an assessment to be done on the aggressive/violent patient at the present time.)

Specialty Training

Recommendation 40:

The MOHLTC should set mandatory standards and provide designated funding to ensure that all staff interacting with cognitively impaired residents in LTC are PIECES/U-First trained. This includes those individuals who make decisions regarding admission and placement, as well as those managing the individual's care.

Rationale: **PIECES Manual**
Report - Commitment to Care: A Plan for Long-Term Care In Ontario – prepared by Monique Smith – Spring 2004

Recommendation 41:

More specifically, it is recommended, that the MOHLTC create and enforce standards requiring all RN's working in LTC to be PIECES trained as a priority. Such standards should set out timelines such as ensuring that all RN's presently on staff are PIECES trained within one year, and shall include PIECES training as part of the orientation for new staff. The MOHLTC shall ensure that there are adequate classes in each region to address the waiting lists and have all RN's trained within one year.

Recommendation 42:

That the MOHLTC create and enforce standards requiring all administrative and management staff who are involved in admission decisions and staffing decisions to be trained in either the full PIECES course or the ENABLER course.

Recommendation 43:

The Ministry of Health and Long-Term Care, in order to support PIECES trained staff, require that physicians providing services in long-term care homes be knowledgeable about the programme.

Recommendation 44:

Health Care Aids should have a college or governing body, which regulates them. As part of their education they should be trained in psycho-geriatric, aggressive behaviours.

Recommendation 45:

That the MOHLTC create and enforce similar standards requiring that all other staff (RPN's and HCA's) be PIECES/U-FIRST trained in a timely way and that there be adequate classes without waiting lists to facilitate this training.

Recommendation 46:

The MOHLTC set standards, monitor and enforce such standards, to ensure that all facilities have at least one Registered Nurses' with PIECES training on staff on all shifts and available to do PIECES assessments.

Recommendation 47:

That the MOHLTC reinstate funding for all expenses associated with PIECES/U-FIRST training, including travel expenses and wages to backfill for equivalent staff to ensure that all LTC facilities have their staff appropriately trained and continue to have new staff trained.

Recommendation 48:

That the MOHLTC immediately review and address any institutional barriers that may exist that prevent RN's and LTC facilities from accessing PIECES training (i.e. Preconditions for administrators, funding issues, waiting lists or being, under-resourced in certain regions).

Recommendation 49:

The MOHLTC, in consultation with psychogeriatric health care professionals, should ensure that Psycho-Geriatric Assessment Teams with established referral patterns are available to all Ontario communities. These teams must be accessible on an urgent basis for CCAC case managers, LTC admissions staff, and PIECES-trained Registered Nurses and other health care providers in order to ensure that all applicants with complex and/or aggressive behavioural concerns can be thoroughly assessed prior to admission to a long-term care facility.

Specific funding and legislation should be put into place by the MOHLTC to develop and maintain these Psycho-Geriatric Assessment Teams.

Rationale: **Through the inquest testimony, we the jury believe that in order to properly care for the ever increasing complex care elderly patients, all heath care professionals must be properly trained in order to care for their needs.**
Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care In Ontario

<u>Coroner's Comments:</u>

The jury heard evidence that staff who have the appropriate training (Pieces and U-first) are able to help assess and deal with aggressive/violent demented patients. The administrative staff with the enabler training can also understand what the PICES and U-First trained staff are having to deal with and they can discuss the problem patient in the same language.

<u>Psychogeriatric Assessors and Consultants: Links to the Facilities</u>

Recommendation 50:
That the MOHLTC increase the number of fully funded, full-time Psychogeriatric Resource Consultants and Psychogeriatric Assessors doing assessments through the Geriatric Outreach teams and monitor delays. MOHLTC should ensure that there are sufficient "PRC's" (Psychogeriatric Resource Consultants) and Psychogeriatric Assessors available in a timely way to assist the Psychogeriatric Resource persons and other Registered Nurses in managing cognitively impaired residents in LTC facilities (and other facilities where these residents may be placed).

Coroner's Comments:

The fifty Psychogeriatric consultants at present are used as resources for education of the staff at the Long Term Care Facilities and do not do assessments on patients. The assessment persons are often specially trained RN's but there are not enough of them to deal with the number of patients.

Placement and Admissions

Recommendation 51:

That the regulations and policies regarding long term care should be reviewed by the MOHLTC to ensure that there is an integrated continuum of care. The MOHLTC policies should ensure consistency in managing these cognitively impaired individuals so the risk is managed appropriately both before and after admission to a LTC or other facility.

Recommendation 52:

The regulations, policies and structure of all Ontario CCACs should be reviewed to ensure an integrated continuum of care. Each CCAC should be structured for continuity of care by the case managers to ensure completeness and consistency of information.

Coroner's Comments:

The jury heard evidence that there was no continuity of the application process with different people doing different parts of the admission process. This may have been a contributing factor in the admission of Mr. Sandhu to Casa Verde as there was contradicting information about his behviour that was not recognised.

Community Care Access Centres

Recommendation 53:

The Community Care Access Centre ensure that when completing the long-term care application, case managers make every effort to interview all family members living with the applicant. Where the applicant is mentally competent, consent must be obtained from the applicant first.

Recommendation 54:

The Community Care Access Centre ensure that where the applicant for long-term care is mentally incompetent, the spouse, if mentally competent and available, must be interviewed as part of the application process.

Recommendation 55:

The Community Care Access Centre ensure that where the applicant for long-term care is mentally incompetent, the substitute decision-maker is interviewed as part of the application process. No application may be allowed to go forward without such an interview-taking place.

Recommendation 56:

The Community Care Access Centres' policies be amended to require proper documentation in all client files. Included in this documentation must be: (a) the full names and relationship of all persons that they speak to about an applicant, including during telephone conversations and face-to-face meetings; (b) time, date and length of conversations and meetings; (c) content of discussions and all relevant information.

Recommendation 57:

The Community Care Access Centre require that all documentation must be completed at the time of the conversation or meeting, or as soon as possible thereafter. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 58:

CCAC's should include with the assessment package sent to long-term care facilities a social assessment that would include the client's interests, wishes, family dynamics, and ethnic, cultural and religious considerations.

Recommendation 59:

The MOHLTC, in consultation with the CCAC sector, should consider including a provision in legislation and Ministry policy that limits the choice of clients who have been assessed as posing a risk to others due to physically aggressive or violent behaviour. Clients, who are assessed as posing this risk, should be required to choose a LTC home with a specialized behavioural unit designed to deal with the clients behavioural concerns.

Recommendation 60:

That the Regulations, including the PCS Manual be revised by the MOHLTC to ensure that there is a requirement that an assessment of risk to self and others is done by the CCAC *prior* to placing the individual in any LTC facility. This revised regulation and the accompanying policy, would require the CCAC to consider a full assessment of the applicant's mental health status and behavioral problems prior to the determination of eligibility. It would also require the CCAC to consider the particular LTC facility and assess its resident population (the frailty of other residents, the competing high needs of other residents, the level of staffing, the numbers of Registered Nurses available, the presence of an appropriate specialty unit etc.) as part of the CCAC process and the determination of whether the resident is eligible for admission to LTC and should be placed in that particular LTC facility.

Rationale: Placement Coordination Service Manual

Recommendation 61:

That the MOHLTC review their regulations and policies to clarify the crisis admission process. At a minimum, standards must be set to ensure that complete and accurate information is obtained prior to decision making about an

applicant's eligibility and admission, despite the fact that the family is in crisis. The policy should ensure that no decisions regarding eligibility and placement are made without all relevant information. This information must include, but is not necessarily limited to, information from the entire health care team such as, information from all relevant family members, family physicians, and specialists. Information from other community resources such as psychogeriatric assessments and, where appropriate the police, should also be obtained. If the information is inadequate at the time of the application, the family should be notified and the CCAC should not make the placement arrangements until all relevant information is obtained and should ensure alternative resources are made available to the family in the interim.

Recommendation 62:

That the legislation, regulations and policies be reviewed to ensure that there is a mechanism for the conditional placement of residents in LTC facilities. If, after admission, a resident is found to have a complexity of care such as aggressive behaviors that cannot be safely managed, or to have requirements beyond the staffing ratios and staff expertise of the LTC facility, the CCAC shall be responsible for overseeing the immediate removal of the resident and their placement in a more appropriate setting. The LTC facility should not be left with the responsibility of finding alternative services, such as an acute care hospital, a specialized Centre or another LTC facility with a more appropriate unit.

Recommendation 63:

That the LTC facility, through its Director of Care or delegate, when reviewing the CCAC materials to determine if the facility has the physical and nursing expertise to safely admit the individual, should be given sufficient time, resources and mechanisms to make this determination. This may include the LTC facility meeting with the resident and family prior to the decision to admit being made, and the facility having the means to accept the resident on a conditional basis.

Recommendation 64:

The Ministry of Health and Long-Term Care long-term care home policies be amended to include requirements for the review of applications for long-term care. Specifically, all documentation received from the Community Care Access Centre must be reviewed by the long-term care home, and there must be written documentation stating that all care requirements have been considered and are able to be met within that facility.

Recommendation 65:

The Ministry of Health and Long-Term Care amend the RAI-HC tool to include elements, which have been identified as predictors for violence, such as suspicion and paranoia. It is further suggested that a geriatric psychiatrist or other geriatric mental health specialist review the form to ensure that all appropriate mental health issues are captured therein. The form should also be changed to accommodate "progress notes".

Rationale: The RAI-HC was introduced by the Community Care Access Centre to replace the initial client assessment forms. This tool

needs to be amended to provide a more "holistic" view on the patient, which would include behavioural issues.

Recommendation 66:

That the MOHLTC and the CCACs should review the requirements for all employees who are applying the RAI-HC tool or who are making eligibility decisions to ensure that they are the appropriate PIECES-trained health professional such as an RN. They should have the appropriate education and qualifications to holistically make assessments, including the abilities and skills to understand underlying medical causes of cognitive impairment, multiple medical diagnosis and treatments, the impact interaction of multiple medications and all assessment tools.

Recommendation 67:

That the CCAC should ensure that there are no inappropriate admissions because LTC facilities are funded based on occupancy levels. At no time should residents be admitted to fill empty beds if that facility is not appropriate for the resident.

Recommendation 68:

The Ministry of Health and Long-Term Care take immediate steps to end weekend and evening admissions to long-term care homes. Implicit in this recommendation is that the Ministry's "Sustainability Program" be cancelled.

Coroner's Comments:

Evidence was heard that the interview process in Mr Sandhu's case was only done with the son and grandson. The wife who was the main caregiver was not consulted and an independent translator was not used so the information received may have been biased. The criteria for a crisis admission includes the possibility of harm to the patient or care giver but no consideration of such risk is given to the other residents and staff of a long term care facility when considering such an admission.

There was no indication on the application forms as to who provided the information about the applicant and no real verification of the information received even if it was contradictory. The new assessment tool used by the Community Access Care Centres does not appear to have sufficient information about behaviour to make a thorough assessment of the applicant. The form does not indicate who provided the information on the applicant.

The fact that a crisis admission can be sent to a facility with incomplete documentation to speed up the process of such an admission does not seem to be appropriate in view of what happened in this case. Also the case was referred to Casa Verde because it had beds available, not that it was the best facility to take Mr. Sandhu. There was concern that he was admitted to the facility "to keep the numbers up" (at or above 97%) for consistent funding for a "for profit institution."

Assessment Tools

Recommendation 69:

The Ministry of Health and Long-Term Care, in consultation with health care professionals working in the long term care industry, should develop a aggression risk assessment tool for cognitively impaired residents with abnormal behaviours to assist in predicting future aggressive behaviours. The risk assessment tool should address an individual's military history, alcohol and drug addiction.

All assessment tools should be kept current and new tools should be incorporated into mandatory training.

Recommendation 70:

The MOHLTC, in consultation with health care professions working in the industry, should ensure that regulated staff (all regulated health care professions, social workers or other professionals who may be given responsibilities for assessments and admission decisions) are kept current in their training and that appropriate time is designated for these professionals to be able to implement the tools into the assessments and admission decisions.

Coroner's Comments:

The need to provide the appropriate assessment tool to identify the "at risk" individual for aggressive/violent behaviour is obvious. The appropriately trained staff to take the information and to be able to assess the patient as well during the interview will be helpful.

Communication

Recommendation 71:

Given that families, family physicians and others with relevant information necessary for placement and admission may not readily provide all relevant information, either unintentionally or intentionally, the MOHLTC, CCACs and Long Term Care facilities should review the applicable legislation, regulations, policies to ensure that:

i) **The appropriate regulated health professionals, who are trained in both a holistic approach and have probing assessment skills and interview techniques, are responsible for obtaining the information from all relevant members of the families, physicians, hospitals, other health and community sources, and criminal information where appropriate;**

ii) **The CCACs structure is reviewed to ensure an integrated model to ensure the resident is being followed by a single case manager who has responsibility to ensure the information is consistent, comprehensive thorough; and**

iii) **Any issues, real or perceived, regarding consent to releasing relevant information is addressed systemically to ensure that all relevant medical, social, cultural, criminal, and environmental information is available to the health care team both making decisions regarding eligibility, placement and providing management of care of cognitively impaired residents with aggressive behaviors.**

Recommendation 72:

Given Ontario's ever increasing multicultural population, it should be recognized that language and cultural values may be a barrier to obtaining all relevant information. In light of this reality, the MOHLTC, CCACs and LTC facilities should:

i) **Where the applicant for long-term care is unable to communicate with the case manager due to a language barriers, the Community Care Access Centre utilize a translator independent of the family or substitute decision-maker: (a) to ensure that the person is aware of the process, (b) if they are capable they are, in fact, agreeing to placement and, (c) if incapable, they are able to voice their opinions and concerns with respect to any placement. Funding for interpreters must be made available to the Community Care Access Centres by the Ministry of Health and Long-Term Care. These translation services should also be made available to all LTC facilities.**

ii) **Ensure that policies and training reflect the heightened need for clear communications in cases of potential aggression, including cultural sensitivity to the issue of domestic assault or placement of elderly in institutions;**

iii) **Ensure that language issues do not increase alienation or trigger aggressive behaviors when individuals become residents of facilities where staff do not speak their language or that language issues not be a barrier to staff adequately assessing and managing such behaviors; and,**

v) **That if placement must be to a facility that does not provide services in the language and with the cultural sensitivity required, that admission be delayed until there are assurances that there is all relevant information obtained, that the treatment plan is in place to address the short and long term needs of the individual in being moved to an institution that does not speak their language.**

Coroner's Comments:

The Community Care Access Centres should have translators to make sure the applicant is fully aware of the application process and to what facility they are being sent for admission. The use of translators in the long-term care facilities is most important as they cannot always rely on the family for assistance. The use of staff is the most likely source of such translators, but where there are no in house staff who speak the patients' native tongue the facility should have reasonable access to such translators. The problem of a language barrier may well be a trigger for a violent demented person.

<u>Long-Term Care Homes</u>

Recommendation 73:

All LTC facilities must have a set "admissions team" which consist of: (i) LTC facility's Administrator, (ii) the LTC facility's Director of Care, (iii) the LCT facility's Chief Medical Administrator, and (iv) one PIECES-trained staff RN. All

members of this "admissions team" must be present on the day the patient is admitted into their respective LTC facility.

Recommendation 74:

Long-term care homes ensure that when a resident is admitted to a long-term care home, all staff who may have direct contact with a resident are provided with all necessary information about that resident.

Recommendation 75:

Long-term care homes have a method (taped or written) of ensuring that staff are provided with all updated patient information if they are unable to attend the shift report, whether due to being on a short shift, being late for work, or having to attend other duties during the report. The resident's chart must be read and reviewed at the start of each shift. All reports whether written or on tape, must place particular emphasis on new admissions and on instructions for monitoring residents who require additional observation. The MOHLTC should establish a half-hour paid "hand-over" to accommodate this recommendation.

Recommendation 76:

Long-term care homes require that their staff document in their progress notes all details of conversations and meetings, include the names of the persons they speak or meet with, the relationship of the person to the resident, and the contents of the conversation. All documents must be signed and date stamped in order to ensure authenticity.

Recommendation 77:

Long-term care homes be required to train their staff at least semi-annually on the different type of emergency codes and the responses expected from them. Included should be training for staff on how to deal with physically aggressive patients. All LTC homes should also be required to set out a contingency plan to deal with patients who exhibit aggressive behaviours.

Recommendation 78:

The MOHLTC must make mandatory all core in-service training sessions for HCA's and must ensure that their positions are backfilled if they are on duty, or are remunerated if required to attend courses on their time off or scheduled off day.

Recommendation 79:

All LTC facilities must ensure that pictures of all LTC patients be placed on the front of their respective medical records for easy identification. In addition, LTC facilities should implement identifiers (i.e. colour coded shoe laces) for differing patients who are suffering from cognitive, behavioural or physical issues.

Recommendation 80:

The MOHLTC should ensure that doctors who head LTC facilities should either have a degree in geriatrics or should have geriatric training.

Coroner's Comments:

The jury heard evidence that the handover report at the change of shift did not always include all staff coming on shift as some could be involved in patient care. The staff did not usually refer to the patients chart to assess any progress notes made by other staff about the patient, even on new admissions. In 2001 there were no PIECES trained staff at Casa Verde Health Centre to help in the assessment of patients. Since then one administrative staff member has done the enabler course but no other nurses have been trained.

In this case there was no evidence of any documentation as to who provided the RN with information on the patient. This information was signed and dated but not timed.

The attendance at an "in service" education session is not mandatory and the staff not due to work that day would not attend. Those who were going off shift would not always stay for the session. Some incentives have been tried with minimal response. If the staff was required to attend and their time compensated, more staff should attend.

The identifying items relate to facility staff being able to identify problem patients easily but with out compromising the patients status with the rest of the residents and visitors. The use of photographs is to be used to confirm new patients identity to staff and help with distributing medications.

Investigations

Recommendation 81:

Where the police investigate an incident in a long-term care home or an incident involving a Community Care Access Centre, the Ministry of Health and Long-Term Care shall complete their own, thorough investigation as soon thereafter as possible, to determine whether there have been any breaches of the legislation or policies.

Recommendation 82:

The Ministry of Health and Long-Term Care track violent incidents in long-term care homes using the FMIS system. A specific report of violent incidents should be produced on a monthly basis.

Recommendation 83:

The Ministry of Health and Long-Term Care adapt the FMIS system to include homicides as a specific category of unusual/accidental deaths in its "Accidental Deaths" database or, alternatively, create a specific database to track homicides.

Coroner's Comments:

Evidence was heard that the Ministry of Health and Long Term Care conducted a brief investigation without the patient chart, which had been seized by the police. The compliance advisor indicated that no infractions could be identified based on incomplete information (no chart) so the

investigation was concluded two days after the event. No further attempts were made by the Ministry compliance inspectors to contact the police about the patients chart even after Mr. Sandhu died to do a more detailed investigation. The Ministry of Health and Long Term care had been keeping the unusual incidents reports for some time but had only recently, 1999 started a database on the information, the FMIS programme. The deaths in this programme are classed as natural or accidental. No classification of homicide exists in the programme. No reports from this data have been published about the violent incidents of resident on resident, resident on staff or staff on resident. The resident on resident events had increased by 8 fold in 2000 to 2004 data.

Publication of Circumstances of the Deaths of P. Lopez and E. El-Roubi

Recommendation 84:

It is recommended that the Office of the Chief Coroner for the Province of Ontario should request that the Geriatric and Long Term Care Review Committee publish a comprehensive account of the circumstances surrounding and leadi to the deaths of Pedro Lopez and Ezzeldine El-Roubi, including t recommendations arising from this Inquest. This report and t recommendations of this jury should also be distributed to all LTC facilities, CCACs, all educational institutions for both regulated and unregulated heal care professionals and all Colleges regulating health care professions and Soci Workers in the Province of Ontario and the professional association and Unio representing staff at long term care facilities and CCACs.

Recommendation 85:

That the office of the Coroner within one year of this inquest follow up on the implementation of the jury's recommendations and provide a report to be made public and directed to all relevant parties working in the long term care sector in Ontario.

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention and I will gladly correct the error.

Presiding Coroner

April 27th 2005
(date)