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 ai 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 décés de:

Surname / Nom de famite	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

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**

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

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CC 010 (Rev. 02/04)

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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:

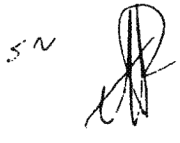
The Office of the Chief Coroner publish all Annual Reports of the Geriatric and Long-Term Care Review Committee on its website. Notification of publication should be sent annually upon release to all interested parties, including the Ministry of Health and Long-Term Care, long-term care homes, Community 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:

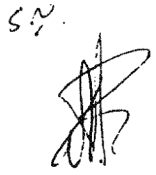
The College of Physicians and Surgeons of Ontario communicate to its members the importance of preparing discharge summaries and providing them to the family physician within 7 days from discharge.

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.



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.

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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

<u>Revision to Long Care Funding Model</u>

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

<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 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 category 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

Coroner's Comments:

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.

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 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.

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.

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 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.

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)

Section 2

Distribution List of Letter Requesting Implementation of Recommendations

DISTRIBUTION LIST OF LETTER REQUESTING IMPLEMENTATION OF RECOMMENDATIONS

LETTERS WERE SENT TO:

1. Ministry of Health and Long Term Care
2. Ministry of Citizenship and Culture
3. Ontario College of Family Physicians
4. Office of the Chief Coroner
5. College of Physicians and Surgeons of Ontario

Section 3

Summary of Responses to Recommendations

SUMMARY OF RESPONSES TO RECOMMENDATIONS
REGARDING THE INQUEST INTO THE DEATHS OF:
Ezzeldine El Roubi
Pedro Lopez
Date of Deaths: June 9, 2001.
Date of Inquest: January 31 – April 18, 2005.
Inquest number: Q2005-29
Presiding Coroner: Dr. D. Evans

Recommendation Number	Lead Agency(s)/ Ministry(s)/Organization(s)/Subject Areas Assigned Recommendation	Lead Agency(s)/ Ministry(s)/Organization(s) responding to Recommendation	No Response	Date of Response	Response Analysis
1	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
2	Ministry of Citizenship and Immigration Ministry of Health and Long Term Care	See response from MOHLTC below Ministry of Health and Long Term Care		1 Sept 2005 12 June 2006	N/A 2
3	Ministry of Health and Long Term Care Ontario College of Family Physicians	Ministry of Health and Long Term Care Ontario College of Family Physicians		12 June 2006 27 June 2006	1 1
4	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
5	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	1B
6	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	2
7	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	1
8	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	1B
9	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario		23 June 2006	1A
10	College of Physicians and Surgeons of Ontario	College of Physicians and Surgeons of Ontario		23 June 2006	1A
11	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
12	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1A
13	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1A
14	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
15	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
16	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
17	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
18	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
19	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
20	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	

LEGEND: 1 Has been implemented 1A Will be implemented 1B Alternate has been implemented 1C Alternate will be implemented
2 under consideration 3 unresolved issues 4 rejected 4A rejected due to flaws 4B rejected due to lack of resources
5 did not apply to assigned agency 6 no response 7 unable to evaluate

21	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
22	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
23	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
24	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
25	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
26	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
27	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
28	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
29	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
30	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
31	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
32	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
33	Ministry of Health and Long Term Care	MInistry of Health and Long Term Care		12 June 2006	2
34	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	3
35	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
36	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
37	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
38	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
39	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
40	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
41	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
42	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
43	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
44	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
45	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
46	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
47	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
48	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
49	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
50	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
51	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1C
52	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
53	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
54	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
55	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
56	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
57	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
58	Ministry of Health and Long Term Care				

LEGEND: 1 Has been implemented 1A Will be implemented 1B Alternate has been implemented 1C Alternate will be implemented
2 under consideration 3 unresolved issues 4 rejected 4A rejected due to flaws 4B rejected due to lack of resources
5 did not apply to assigned agency 6 no response 7 unable to evaluate

59	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
60	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4
61	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
62	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4
63	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
64	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
65	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
66	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1B
67	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
68	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
69	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
70	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4
71	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4
72	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
73	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	4A
74	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
75	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
76	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
77	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
78	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
79	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1
80	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	2
81	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1A
82	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1A
83	Ministry of Health and Long Term Care	Ministry of Health and Long Term Care		12 June 2006	1A
84	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	1B
85	Office of the Chief Coroner	Office of the Chief Coroner		12 April 2006	1

LEGEND: 1 Has been implemented 1A Will be implemented 1B Alternate has been implemented 1C Alternate will be implemented
2 under consideration 3 unresolved issues 4 rejected 4A rejected due to flaws 4B rejected due to lack of resources
5 did not apply to assigned agency 6 no response 7 unable to evaluate

Total number of Recommendations: 85

Evaluation Definition	HAS been Implemented 1	WILL BE implemented 1A	ALTERNATE HAS BEEN implemented 1B	ALTERNATE WILL BE Implemented 1C	Under Consideration 2	Unresolved Issues 3	Rejected 4	Rejected (due to flaws or impractical) 4A	Rejected (due to lack of resources) 4B	Not Applicable 5	No Response 6	Unable to Evaluate 7
# of Recommend.	15	8	15	6	29	1	4	7	0	0	0	0
Percentage of Recommend.	18%	9%	18%	7%	34%	1%	5%	8%	0%	0%	0%	0%

# of Agencies asked to Respond	5
# of Agencies Responding	5
% of Agencies Responding	100%

LEGEND: 1 Has been implemented; 1A Will be implemented; 1B Alternate has been implemented; 1C Alternate will be implemented; 2 under consideration; 3 unresolved issues; 4 rejected; 4A rejected due to flaws; 4B rejected due to lack of resources; 5 did not apply to assigned agency; 6 no response; 7 unable to evaluate

Section 4

Responses to Recommendations:

Ministry of Citizenship and Immigration
and
Ministry of Health and Long Term Care

Ministry of Citizenship and Immigration

Deputy Minister

6th Floor
400 University Avenue
Toronto ON M7A 2R9
Tel.: (416) 325-6210
Fax: (416) 325-6196

Ministère des Affaires civiques et de l'Immigration

Sous-ministre

6e étage
400, avenue University
Toronto ON M7A 2R9
Tél. : (416) 325-6210
Téléc. : (416) 325-6196

Ontario

September 1, 2005

Dr. Bonita Porter
Deputy Chief Coroner – Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto ON M7A 2G9

Dear Dr. Porter:

I am responding to Dr. McLellan's letter to my predecessor concerning the inquest into the deaths of Ezz-El-Dine El-Roubi and Pedro Lopez at the Casa Verde Health Centre, and the jury recommendations resulting from the inquest. Dr. McLellan had indicated in his letter that this Ministry might be in a position to respond to recommendation 2.

Our Ontario Seniors' Secretariat has prepared a response to this recommendation and has forwarded it to the Ministry of Health and Long-Term Care for their inclusion in that Ministry's overall response.

I trust that you will find this satisfactory.

Sincerely,

Robert Montgomery

Robert Montgomery
Deputy Minister (A)

11-244

Ministry of Health and Long-Term Care

Corporate Coordination Office
Corp. Services & Organizational Development Division
9th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 1R3
Tel: 416-327-3090
Fax: 416-327-2714

Ministère de la Santé et des Soins de longue durée

Bureau de coordination des affaires ministérielles
Division des services ministériels et du développement organisationnel
Édifice Hepburn, 9e étage
80, rue Grosvenor
Toronto ON M7A 1R3
Tél.: (416) 327-3090
Téléc.: (416) 327-2714

Ontario

June 12, 2006

Dr. B.M.B. Porter
Deputy Chief Coroner – Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto ON M7A 2G9

Dear Dr. Porter:

Re: Inquest into the death of El-Roubi & Lopez - Your file Q2005-29.

Thank you for the opportunity to review the verdict of the Coroner's Jury and the Presiding Coroner's explanation in the above inquest.

Ministry of Health and Long-Term Care staff have reviewed the jury's recommendations and our comments are attached.

If I can be of further assistance, please contact me at 416-327-3090.

Sincerely,

Dale MacDonald, A/Manager
Corporate Coordination Office

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.

Ministry Response:

The Ministry accepts this recommendation. The responses, which follow, will specifically address the care of cognitively impaired residents who are at risk of aggression or violence.

The Ministry has given priority to the health care needs of the elderly. In May 2004, Parliamentary Assistant Monique Smith, MPP, tabled a report *A Commitment to Care: A Plan for Long-Term Care in Ontario*, which is serving as a guide to the Ministry's reform of the legislation governing LTC homes. Several initiatives have been implemented to improve the quality of life and safety of residents in LTC homes, including the following:

Standards:
- New regulations are in place to improve the standard of care. For example, all homes must have a registered nurse on site and on duty 24 hours a day.
- Long-term Care Program Standards are being revised.
- Prioritization to ensure that eligible spouses/partners can remain together or be reunited expeditiously in LTC homes.
- Approval of all planned menus annually by a dietitian.

Funding:
- In 2004/2005 and 2005/2006, an additional $264 million for the hiring of an additional 2000 front-line staff including 600 nurses.
- In November 2005, the Ministry enhanced the High Intensity Needs Fund (HINF) to provide additional staffing resources and preferred accommodation (single rooms) for residents exhibiting aggressive behaviours.
- The Ministry recently provided an additional $2.4 million for PIECES/U-FIRST training sessions for the LTC sector which will be available across the province.

Tracking:
- The Ministry is phasing in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), which places more emphasis on behavioural issues and will replace the existing Case Mix Index (CMI).
- The Ministry is reviewing and amending the current critical events reporting system to better track incidents in LTC homes.

Accountability:
- A LTC Homes quarterly staffing report process has been implemented and will enable the Ministry to monitor and ensure that the new staffing and enhanced care requirements are achieved.
- A toll-free Action line was set up in January 2004 as a way for the public to lodge a complaint about care in LTC homes. The Ministry follows up on all complaints.
- Ministry inspections of LTC homes are now unannounced.

- A public reporting website that provides information on LTC homes and their record of care is available.

Inquest Response Code: 1

Recommendation 2:

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

Ministry Response:

The Ministry will work with the Ontario Seniors' Secretariat and other stakeholders in the LTC system to consider this recommendation. A Roundtable on Future Planning for People with Alzheimer Disease and Related Dementias has been established by the Ontario Seniors' Secretariat to advise government on the future impact of dementia on our society as the population ages. The Roundtable will be asked to consider what public education efforts would best address the stigma associated with dementia.

The Roundtable brings together seniors groups, consumers, caregivers, service providers, planners, policy-makers and researchers to identify and plan for the impacts of Alzheimer Disease and related dementias. The Roundtable is comprised of 22 members from across the province and reflects the perspectives of rural, Francophone and multicultural communities.

Inquest Response Code: 2

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.

Ministry Response:

The Ontario Strategy for Alzheimer Disease and Related Dementias provided support for the design and implementation of a training program for physicians, physician educators, medical school students and residents on early and improved detection, diagnosis and treatment of Alzheimer Disease and related dementias, and the best use of regional specialty and local community support services.

During the strategy implementation, the ministry provided $500,000 per annum to develop the physician training curriculum and establish educational support mechanisms including an educational mentoring program (with mentors from Geriatric Medicine and Psychiatry, and Opinion Leaders and Peer Presenters from Family Medicine), and support for educators in all regions of the province to provide continuing education activities on dementia. The Opinion Leaders now function as knowledge brokers with their peers in their communities. In total, $2 million was provided through the Strategy to establish these supports which continue to be a

part of the education of new family physicians and as ongoing educational supports for practicing family physicians.

As part of the strategy, a Steering Committee worked with the Ontario College of Family Physicians on the design and implementation of the educational program as well as establishing a web site to post curriculum materials and continuing education programs, and support interaction of physicians participating in the various initiative activities. The steering committee and related work groups had representation from family physicians, geriatricians, geriatric psychiatrists, neurologists, each Ontario medical school, continuing medical education programs and the Alzheimer Society of Ontario.

The Ministry will continue to work with the Ontario College of Family Physicians (OCFP) and others towards supporting physicians' efforts in providing dementia care.

In December 2005, the Seniors Health Research Transfer Network (SHRTN), which is funded by the Ministry, launched a call for proposals that included the development of a continuing education module based on PIECES aimed at family physicians for detecting potential aggression in seniors living in the community as well as physicians who provide medical services to residents in LTC homes. The winning proposal was submitted by the OCFP and the Alzheimers Society of Ontario and the initiative is expected to be completed by the end of March 2007.

Inquest Response Code: 1

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.

Ministry Response:

Each of the strategies outlined in the Ten-Point Plan have been or are currently being addressed by the Ministry.

With respect to strategy 1 on PIECES (Physical, Intellectual, Emotional, Capabilities, Environment Social) training, the Ministry has provided extensive support for the training of LTC home and Community Care Access Centre (CCAC) staff in PIECES, U-FIRST (Understanding, Flagging, Interaction, Reflection, Support, Team) and ENABLER training. Please see the responses to recommendations 40-42 and 45-49.

With respect to strategies 2 and 4 related to family physicians and network support, Family Health Teams (FHTs) will improve access to primary health care through the introduction of interdisciplinary health teams, developed with the cooperation and support from community and health care providers. FHTs will also provide care coordination to link patients to other parts of the health care system, including long-term care, mental health and community programs and services.

For strategies 3, 5, 8 and 9 which relate to psychosocial resources and improving the lives of residents, there are currently 50 Psychogeriatric Resource Consultants and 41 Public Education Consultants in the province available to support front line LTC home staff. In addition, there are

five Regional Geriatric Programs (RGPs). The RGPs provide a comprehensive range of specialized geriatric assessment services, provided by interdisciplinary teams with expertise in care of the elderly, across the continuum of care. In addition, there are a range of Geriatric Psychiatry Programs throughout the province that provide specialized assessment, consultation, treatment and education. The LTC home care standards renewal, referred to in recommendation 1, contributes to improving the quality of care for residents. Please see the responses to recommendations 21, 49 and 50 for further information.

With respect to the resident classification system referred to in strategy 6, the Ministry is currently phasing in the Resident Assessment Instrument Minimum Data Set (RAI-MDS) 2.0 system, which places more emphasis on behavioural issues in the LTC home funding model than does the current resident classification system. Please see the response to recommendation 31 for further details.

For strategy 7, the Ministry is considering the issue of specialized homes or parts thereof. As well, recent changes to the High Intensity Needs Fund (HINF) will provide interim support for LTC home residents with behavioural and mental heath issues. Please see the responses to recommendations 22-24 and 38-39.

With respect to strategy 10, on education standards for front-line workers, the Community Colleges Branch of the Ministry of Training Colleges and Universities (MTCU) has upgraded their Personal Support Worker (PSW) Standard effective September 2005. This will increase the training requirement of PSWs by 200 hours. Please refer to the response to recommendation 44.

Inquest Response Code: 1/1A

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 LTC 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.

Ministry Response:

The Ministry supports this recommendation. The form will be amended to include a clear statement about the purpose of the form and the importance of including complete and accurate information. The Ministry will also include a contact name and telephone number at the local Community Care Access Centre should the professional who completes the form have any questions or wish to discuss the information with the CCAC.

Inquest Response Code: 1A

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.

Ministry Response:

The Ministry will amend the health report form to request information about any known side effects experienced by the LTC home applicant. It should be noted that the Resident Assessment Instrument – Home Care (RAI-HC), which is a mandatory part of the LTC home placement process, has a section where the applicant's medications are listed. Nurses and physicians have a professional responsibility to know the side effects of any medication being administered to their patients.

Inquest Response Code: 1C

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 has occurred in the applicants past.

Ministry Response:

The Ministry accepts this recommendation and will amend the form to include a separate section that seeks information about an applicant's aggressive or violent behaviour.

Inquest Response Code: 1A

Recommendation 14:

The MOHLTC web-site be amended to include detailed information for physicians and families about the LTC application process and the importance of providing detailed and up-to-date information to the CCAC and upon admission to the LTC home.

Ministry Response:

Ministry websites will be amended to provide detailed information to the public explaining the LTC application process and emphasizing the importance of providing accurate and up-to-date information to CCACs and LTC homes during the application and admission process.

Inquest Response Code: 1A

Recommendation 15:

The MOHLTC produce a monthly bulletin to be sent to all LTC homes, CCAC, 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 MOHLTC web-site.

Ministry Response:

Starting in October 2005, the MOHLTC began producing a quarterly bulletin that is available on the LTChomes.net website and sent to all LTC homes, CCACs, associations representing LTC

home operators, resident councils, and family councils. The bulletin provides updates and information on Ministry policies and programs.

Inquest Response Code: 1B

Recommendation 16:

The MOHLTC produce and distribute information pamphlets in all major language groups. Specifically, the pamphlets should include information about LTC and in-home care, the application process, and living in a LTC home.

Ministry Response:

CCACs, as placement co-ordinators for LTC homes, are the entry point for access to LTC home admissions and community services (home care). Many CCACs already produce information pamphlets in the major language groups served by their particular agency. The Ministry will reinforce to CCACs the importance of having information pamphlets in languages representative of the cultural groups' resident in their geographic region.

Inquest Response Code: 1B

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.)

Ministry Response:

The Ministry will consider this recommendation in consultation with LTC home operators, their associations and health care professionals. The forms referred to in this recommendation fall into two categories. The first category is comprised of forms used in the admission process (that is, when the LTC home approves or does not approve the admission). This would include forms such as the RAI-HC (Resident Assessment Instrument – Home Care), the standardized assessment tool used by CCACs. The second category is comprised of forms used to record care or treatment provided to residents and ongoing monitoring of residents. In the Ministry's view, there is a need for some flexibility for each home to determine its forms and the type of information recorded, depending on its specialized programs (for example, convalescent care) or units (for example, specialized dementia care units). The Ministry also notes that regulated health care professionals who fill out the forms must meet standards of their governing colleges with respect to documentation and record-keeping.

Inquest Response Code: 2

Recommendation: 18

(a) 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.

(b) 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.

Ministry Response:

The Ministry is currently considering these recommendations. Please see recommendations 40-48 for information related to specialized training such as U-FIRST and recommendations 22-24 with respect to specialized units. Concerning the recommendation about eligibility, after the incident at the Casa Verde Health Centre in 2001, CCACs began using the Resident Assessment Instrument – Home Care (RAI-HC) tool to assess an applicant's eligibility for admission to a LTC home. Using the RAI-HC is a Ministry requirement. The RAI-HC includes a behavioural assessment component that addresses mental functioning, cognitive, mood and behavioural patterns. Concerns identified in these areas trigger the more detailed Client Assessment Protocol (CAP) which provides an in-depth assessment of behaviour, depression, anxiety and cognition. The RAI-HC assessment is then provided to LTC home operators to enable them to determine whether they have the nursing expertise and physical facilities necessary to meet the applicant's care needs.

Inquest Response Code: 2

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 behaviors, that the CCAC health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.

Ministry Response:

The Health Report Form completed by a physician, registered nurse, or a nurse practitioner provides medical information about a potential resident. In addition, CCACs have access to 50 Psychogeriatric Resource Consultants across the province for consultation and advice. As well, CCACs have access to regional geriatric programs for assessments.

The results of the RAI-HC standardized assessment tool now used by CCACs in determining eligibility for admission to LTC homes will indicate whether there is a need for additional medical information or assessment by a specialist. Should this type of assessment be indicated, the CCAC will request it. However, the availability of specialized professionals in all areas of the province may present a challenge to obtaining timely assessment. The Ministry is currently working to address the issue of health human resources in the province.

Inquest Response Code: 1B

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 LTC 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).

Ministry Response:

A range of community support services are available through Community Care Access Centres which can enable individuals to maintain their safety and independence while still living at home and provide relief for families. These services include in-home health professional services by nurses, social workers, occupational therapists and others, as well as personal care and support by personal support workers. Community services that are available include individual counseling by a health care professional, such as a psychologist, social worker or a nurse, and caregiver support groups and counseling services. Adult day programs are also available and provide social and therapeutic activities in the community. In-home and short-stay respite services and caregiver education and training are also available to provide support for families.

The majority of LTC home residents are cared for safely and without any incidents of violence. There are concerns about delaying admissions to LTC homes, as this could have a serious impact on the health and safety of persons requiring placement and could place unnecessary stress on families. The plan of care is prepared by those who will be responsible for providing care to a resident in a LTC home. As noted in the response to recommendation 19, CCACs can obtain additional appropriate behavioural and other assessments and provide this information to the LTC home. This information would inform the development of the plan of care by the LTC home.

In certain cases, individuals who are ineligible for admission to a long-term care home setting due to severe behavioural issues may be admitted to a hospital or psychiatric facility for appropriate care.

With respect to appropriate alternative facilities, please see the response to recommendations 22-24 concerning behavioural management units.

Inquest Response Code: 4A

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.

Ministry Response:

The Ministry is reviewing the time it takes to obtain psychogeriatric assessments and is considering the steps required to address delays. This review will involve consideration of

health human resources, including the availability of qualified assessors generally and as well as their availability in every region of the province.

Inquest Response Code: 2

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.

Ministry Response:

The Ministry is considering this recommendation and its implications. Extensive study and consultation with geriatric specialists and others will be required. The resource needs and appropriate funding model for specialized homes or units will also be considered.

The Ministry is also phasing in the Resident Assessment Instrument - Minimum Data Set 2.0 (MDS) in place of the current resident classification system (the Alberta Classification System) to determine funding for LTC homes. Currently, resident classifications for the purposes of determine funding are conducted on an annual basis and provide for an annual acuity increase based on the care needs of residents.

RAI-MDS provides a more in-depth analysis of behavioural needs than the current system and is conducted quarterly. RAI-MDS will provide more timely information to ensure funding meets the care needs of residents. At the end of March 2006, approximately 90 LTC homes implemented RAI-MDS.

Issues related to training are addressed under other recommendations. The Ministry supports the PIECES training program and recognizes its value in improving quality of care for residents. The Ministry also recognizes that in the future other training programs may be developed which supersede the current PIECES training. Therefore, program enhancements with respect to staff training should not be limited to PIECES.

Inquest Response Code: 2

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.

Ministry Response:

This recommendation will be considered in the Ministry's analysis under Recommendation 22. The Ministry notes the evidence given at the inquest by Dr. Heather MacDonald, who is the Medical Director at the Dorothy Macham Home and also serves on the LTC Geriatric Review Committee of the Coroner. In her evidence, Dr. MacDonald indicated that the model of Dorothy

Macham Home may not be suitable for all cases and alternative models should also be considered as part of an effective continuum of care. Therefore, the Ministry will consider existing models as they relate to the full range of resident needs, innovative best practices and available research.

Inquest Response Code: 2

Recommendation 24:

The MOHLTC should ensure that these facilities are accessible for the individuals who are not appropriate for placement in LTC 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 LTC facility, no requirement to be a war veteran or only referred by institutions).

Ministry Response:

This recommendation will be considered in the analysis and review referred to under Recommendation 22. In the Ministry's view, issues such as the complex medical needs of individuals must also be considered in any placement decision. The Ministry does not view such a consideration to be an arbitrary barrier to admission, as an individual's other health care needs should not be overlooked. It is noted that the requirement to be a war veteran in order to be admitted to the Dorothy Macham Home (funded federally and not part of the province's LTC home system) is a requirement of the Department of Veterans Affairs Canada.

Inquest Response Code: 2

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.

Ministry Response:

Please refer to the response in recommendations 22, 23 and 24. The Ministry will consider this recommendation in its exploration of specialized units.

Inquest Response Code: 2

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.

Ministry Response:

While a review of the funding system is a priority for the Ministry, an extensive revision may not be feasible within the recommended timeframe. As indicated in the response to recommendation 22, about 90 homes implemented RAI-MDS by March 2006. As part of this initiative, the Ministry has also commissioned a detailed comparison of RAI-MDS and the current CMI system to assess resident care needs for funding purposes. This data will inform future improvements to the funding system.

Inquest Response Code: 2

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.

Ministry Response:

Please see the response under recommendations 22 and 26. It should be noted that the decision about implementation of any new funding system, once approved by the government, is part of the provincial budget process and must be approved by the Legislature. As such, the Ministry may not be in a position to provide a time line for implementation. The Ministry will provide an update on this issue to the Coroner.

Inquest Response Code: 2

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 LTC Facilities and Selected Comparators, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario LTC 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.

Ministry Response:

Please see the response under Recommendation 37. In the Ministry's view, it is necessary to await the outcome of the RAI-MDS implementation, referred to in the response to recommendation 22, and the full implementation of the staffing level reporting process, which will generate useful information, prior to undertaking any study related to staffing levels in LTC homes. In 2004, new regulations were passed to require that all LTC homes have a registered nurse on site and on duty 24 hours a day, 7 days a week. The Ministry's Nursing Secretariat is in the process of developing a nursing plan for the LTC sector that will require regular reporting of staffing patterns which will also provide useful data.

The Ministry believes that these initiatives will provide evidence on which to base future policy work concerning staffing levels.

Inquest Response Code: 2

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 care 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.

Ministry Response:

This recommendation is addressed in the responses to recommendations 28 and 37. In October 2004, funding for LTC homes was increased by $264 million for the purpose of hiring 2000 new front-line LTC home staff, including 600 nurses, sector-wide. The additional funding was provided, in part, to ensure that a Registered Nurse is on-site and on duty 24 hours-a-day, 7-days-a-week in all LTC homes, as required by recent regulations. The Ministry is closely monitoring the performance of each home in meeting the hiring targets through staffing level reporting as referenced in the response to recommendations 1 and 28.

Inquest Response Code: 4A

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.

Ministry Response:

Please see the responses under Recommendations 28, 29, and 37.

Inquest Response Code: 2

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.

Ministry Response:

Please see the response under Recommendation 26.

As noted above in recommendation 22, the Ministry is currently phasing in the RAI-MDS as an alternative funding model to CMI. In the Ministry's view it is essential to consider resident care needs, including behavioural needs, in assessing the effectiveness of the funding model or potential alternatives. As an interim step, changes to the Ministry's High Intensity Needs Fund (HINF) that came into effect in November 2005 will provide enhanced access to additional staffing resources and preferred accommodation (single rooms) for residents exhibiting violent or aggressive behaviour. Please see the response to recommendation 38 for further discussion of the changes to the HINF program.

Inquest Response Code: 2

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.

Ministry Response:

Please see the response under Recommendation 22 and 31 with respect to the remodeling of the CMI funding system. Governing colleges of regulated health and social service professionals have standards about documentation, such as charting and progress notes, to which members must adhere.

Inquest Response Code: 2

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.

Ministry Response:

Please see the responses to Recommendations 40 – 48.

Inquest Response Code: 2

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:

1. *immediately change the funding system to ensure parity in wages and benefits with Ontario hospital Registered Nurses; and*
2. *increased number of full-time RN positions and increased the total percentage of full-time RN positions significantly;*
3. *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;*
4. *Monitor and decrease significantly the use of agency nurses and other LTC staff by LTC facilities.*

Ministry Response:

The Ministry values the significant role that nurses and others have in caring for LTC home residents and encourages policies that help retain a skilled and stable workforce. The Ministry is reviewing the issue of how to better ensure continuity of care.

1. The Ministry is not in a position to immediately change the funding system to ensure parity as recommended.

2. In October 2004, the Ministry began providing $264 million in additional funding over two years to increase LTC home staff by 2000 new staff, including 600 nurses sector-wide. The funding also ensures that all LTC homes have a Registered Nurse on site and on duty 24-hours-a-day/7-days-a-week.

3. The use of funds in the Nursing and Personal Care Envelope is closely tracked and is also subject to audit by the Ministry to ensure that the funds are used for the designated purposes. However, the Ministry does not prescribe a staffing mix or RN/resident ratio. Please see the response to recommendation 37 for more detail. As noted above, the Ministry's Nursing Secretariat is in the process of developing a nursing plan for LTC homes to report regularly to the Ministry. The plan will be used for health human resource planning and to design strategies to continue to support nurses. The report is expected to be implemented by 2007.

4. The Ministry is considering initiatives to limit the use of agency staff by LTC homes, thereby supporting better continuity of care for residents.

Inquest Response Code: 1 - 4; 2 - 1B; 3 – 1; 4 - 2

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.

Ministry Response:

Nurses are responsible for practising in accordance with the standards of practice, guidelines and policies set out by the College of Nurses of Ontario (CNO). Although the CNO is responsible for regulating its members, staffing levels in long-term care homes are determined by each home operator subject to the requirements that LTC homes have a Registered Nurse on-site and on-duty 24-hours-a-day/7-days-a-week, and sufficient staff to meet residents' needs.

Please see the response to recommendation 34 regarding the additional $264 million in funding for new staff in LTC homes, including 600 new nurses.

Inquest Response Code: 1B

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, RPNs and Psychogeriatric Resource Consultants and sufficient time to adequately supervise, teach and delegate to the unregulated workers.

Ministry Response:

See responses to Recommendations 35 and 37.

Inquest Response Code: 1C

Recommendation 37:

To ensure that the funding provided to LTC 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 web-site. 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.

Ministry Response:

The Ministry has introduced a requirement for all LTC homes to report on staffing. This data, which is obtained on a quarterly basis, along with compliance information (annual inspection results for each home), will be used in developing changes to the funding model. The Ministry is of the view that quality of care is not guaranteed by setting minimum staffing levels or ratios. The Ministry has ensured that since August 2005, all LTC homes have a Registered Nurse on-site 24/7. The current funding model is based on levels of care or the assessed needs of each resident, rather than fixed hours of direct and indirect care per resident. For example, using only specified staffing levels and ratios could provide a disincentive to LTC homes accepting residents with heavy care needs. Other factors that affect quality of care must also be taken into consideration. This may include staff turnover and retention, leadership and management practices, clear guidelines and procedures, clear expectations regarding standards of care, the use of tools and materials to guide practice. It can also include enforcement of standards, the sharing resident information through the multi-disciplinary team, increased use of non-clinical staff and volunteers, involvement of the residents' family and improved training of non-registered staff (health care aides/PSWs).

The Ministry monitors LTC homes to ensure compliance and accountability for funding. There is an annual service agreement entered into between LTC home operators and the Ministry. This agreement sets out the program, service and financial relationship between the Ministry and the home. Under the service agreement and LTC home legislation, operators must maintain proper financial records and books of account respecting the use of Ministry funds, must permit Ministry staff to inspect and audit the books and records of home, and provide regular financial reports. Ministry staff also inspect LTC homes on an annual basis and investigate all complaints and unmet standards to ensure that resident care requirements are met.

In November 2004, the Ministry launched a public reporting website which provides the public with information on individual LTC homes and their compliance records. The results of the annual inspections of LTC homes are available on the website. The Ministry maintains its commitment to public accountability and transparency of the LTC homes program. In the Ministry's view, public reporting ensures that homes are governed in a way that reflects the public interest, promotes effective and efficient delivery of services and maintains standards of care. In addition to the website, the public may obtain information about LTC homes from Community Care Access Centres or Ministry offices. A summary of the staffing data has been made public.

Inquest Response Code: 1B

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 program 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.

Ministry Response:

The Ministry revised and enhanced the High Intensity Needs Fund (HINF) in October 2005 to provide for 72 hours of additional care per episode of aggressive behaviour by a resident, rather than 72 hours per lifetime, and preferred accommodation (private room) for residents exhibiting aggressive/violent behaviours. These changes enable LTC homes to cover the additional costs of regulated and non-regulated health care staff, and hours can be used on an as needed basis up to 72 hours. The LTC home determines the type of staff required to care for the resident. As part of these changes to the HINF, a comprehensive care plan, which includes a psychological or behavioural assessment, must be developed and implemented by the LTC home to address the needs of the resident. The assessment is to be done by a professional with the necessary expertise. The revisions to the HINF were designed to enable LTC homes to better meet the needs of both new residents and current residents of LTC homes.

Inquest Response Code: 1B

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:

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

Ministry Response:

Please see the response to recommendation 38. The Ministry has enhanced the High Intensity Needs Fund to better assist LTC homes to care for residents with severe behavioural issues who may pose a danger or threat to themselves or others. With respect to one-on-one care by a PIECES trained RN, this would depend on the availability of the RN with PIECES training and their allocation to work with the resident by the LTC home operator for the duration of the incident of aggressive behaviour. It is up the LTC home to determine the type of staff required to address the needs of the particular resident. The HINF is intended to be an interim measure targeted to the specific needs of residents. It is expected that when a person is admitted to a particular home, that home can meet his or her care needs. In addition, the Ministry expects

LTC home operators to have and implement orientation programs to ease the transition of new residents into the home.

Inquest Response Code: 1B

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.

Ministry Response:

The Ministry is very supportive of the PIECES/U-FIRST training programs for LTC home staff and is considering setting a mandatory standard for such training. Through Ontario's Strategy for Alzheimer Disease and Related Dementias, the government invested $68.4 million from 1999 to 2004 to improve the quality of life for people with Alzheimer Disease and related dementias and support the families providing care for them. The strategy outlined 10 initiatives to improve the quality of life for Ontarians affected by Alzheimers Disease and Related Dementias (ADRD). One of the staff education and training initiative activities, PIECES and U-FIRST! education, successfully laid the foundation for increased capacity to care for individuals with dementia who live in LTC homes or the community sector.

Although the strategy officially ended in 2004, training sessions in PIECES/U-FIRST for LTC home and community staff continue to be available on a request basis. As of December 2005, 2,026 regulated health professionals have been trained with participation of staff from 100% of LTC homes, another 863 LTC home management and supervisory staff have received the PIECES ENABLER training and almost 900 CCAC staff were trained.

The Ministry recently provided an additional $2.4 million for PIECES/U-FIRST training sessions for the LTC sector which will be available across the province. The funding will provide training to 4,900 Personal Support Workers (PSWs). In addition, 300 regulated health care professionals and those in a position to supervise/support the learners will be trained in the PIECES and ENABLER programs. Training sessions will be held for the 50 Psychogeriatric Resource Consultants to improve their capacity and enhance their support to LTC homes.

As with any employer, it is the responsibility of the LTC home operator to ensure that its staff has the necessary skills and training to provide appropriate care to residents. The funds that the Ministry provides LTC homes for the care of residents include an amount allocated for the training of staff. Operators are also required to provide a minimum of ten in-service education programs annually to all staff based on the assessed learning needs of staff. It is mandatory that these in-service education programs cover the topics of understanding residents with cognitive impairments and responding to disruptive behaviour.

Inquest Response Code: 2 and 1B

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 RNs trained within one year.

Ministry Response:

Please see the response to Recommendation 40. In 2004 there were 7,205 RNs in the LTC sector. Given the number of RNs working in LTC homes it is doubtful that all could be trained in a one year period. The Ministry has committed an additional $2.4 million in funding for training in PIECES and U-FIRST!

Inquest Response Code: 1C or 2

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.

Ministry Response: Please see the responses to recommendations 40 and 41.

Inquest Response Code: 2

Recommendation 43:

The MOHLTC, in order to support PIECES trained staff, require that physicians providing services in LTC homes be knowledgeable about the programme.

Ministry Response:

Residents of LTC homes are entitled to choose their own attending physician. Requiring all physicians providing services in LTC homes to be knowledgeable about the program may limit resident choice. As noted above, the Ministry is supportive of PIECES and initiatives that support PIECES. The College of Physicians and Surgeons of Ontario and the Ontario College of Family Physicians will be consulted about this recommendation, as the Colleges have an important role to play in the continuing education of physicians. The Ministry will advise the Colleges about the website of PIECES Canada (http://www.piecescanada.com/index.html) which contains descriptive material about the PIECES program. This website could provide information about PIECES to physicians who serve residents of long-term care homes.

As stated in recommendation 4, the Seniors Health Research Transfer Network (SHRTN) launched a call for proposals in December 2005 for the development of a continuing education module based on PIECES, aimed at family physicians and physicians providing services in LTC homes, which will be implemented by the Ontario College of Family Physicians and the Alzheimers Society of Ontario.

Inquest Response Code: 1C

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 behaviors.

Ministry Response:

The Minister of Health and Long-Term Care, in February 2005, asked the Health Professions Regulatory Advisory Council (HPRAC) to provide advice and recommendations regarding the regulation of personal support workers. HPRAC is currently organizing public consultations throughout Ontario in late May and early June 2006.

The Ministry supports improved educational programs for Personal Support Workers (PSWs) (Health Care Aides) who work in the LTC home sector. The Ministry is liaising with the Ministry of Training, Colleges and Universities (MTCU) which is enhancing the training and education requirements for PSWs.

Please also see the response to recommendation 40 with respect to the Ministry's in-service education program requirements for all LTC home staff, including PSWs.

Inquest Response Code: 2

Recommendation 45:

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

Ministry Response:

Please see responses to recommendations 40 and 41.

As noted above, the Ministry supports PIECES and U-FIRST! training programs. There may be waiting lists in some areas of the province to ensure that there are a sufficient number of people enrolled in a program to make effective use of resources. With respect to the issue of waiting lists, it should be noted that the PIECES training program is conducted for a minimum of 15 and a maximum of 30 participants.

As stated in recommendation 41, the Ministry has approved $2.4 million for training in PIECES and U-FIRST! for the LTC sector.

Inquest Response Code: 2

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.

Ministry Response:

Please see the responses to recommendations 40 and 41. The Ministry will consider this recommendation.

Inquest Response Code: 2
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.

Ministry Response:

Please see the response to recommendation 40. During the Alzheimer Strategy, the Ministry provided backfill and other costs for the purpose of ensuring extensive reach for PIECES training. The Ministry advised that at the end of the Alzheimer Strategy, these costs would be the responsibility of the employer and that backfill costs would no longer be provided.

As noted in recommendation 41, the Ministry is providing an additional $2.4 million for PIECES and U-FIRST! training. This funding will provide backfill costs for LTC staff attending U-FIRST! to ensure that PSWs receive this training as a priority. As part of the Ministry's current funding for LTC home residents, the Nursing & Personal Care envelope includes an amount of funds for staff training which LTC home operators could use for PIECES training and to cover backfill costs.

Inquest Response Code: 1C

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).

Ministry Response:

Please see comments under recommendations 40, 42 and 47. Some preconditions have the aim of ensuring the best use of PIECES training by front-line LTC home staff who care for residents on a daily basis. The evaluations of PIECES and feedback from the PIECES educators consistently indicated that the top factors facilitating the success of PIECES were support of front-line staff by senior management (such as administrators), the opportunities to integrate the learning into practice, and on-the-job reinforcement of learning. It was for these reasons that the ENABLER program was developed and introduced for administrators and other management staff, such as the Director of Care (Nursing). The ultimate goal of the ENABLER program is to benefit residents by ensuring that PIECES trained staff have support at the management level.

As noted above, any waiting lists are for the purpose of ensuring that efficient use is made of training resources. PIECES is conducted for a minimum of 15 and a maximum of 30 participants.

Inquest Response Code: 4A

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 behavioral concerns can be thoroughly assessed prior to admission to a LTC facility.

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

Ministry Response:

Please see the response to recommendation 21.

CCACs, LTC home staff, and other service providers are able to access the following programs which are funded by the Ministry: a) the Regional Geriatric Program (RGP), located in five areas of the province and which provides a comprehensive range of specialized geriatric assessment services and outreach teams with expertise in care of the elderly, b) mental health outreach teams in some hospitals, and c) Geriatric Psychiatry Programs throughout Ontario that provide specialized assessment, consultation, treatment and education to seniors, their families and service providers.

The Ministry is exploring ways to ensure that psychogeriatric assessments are accessible on a more timely basis across the province.

Inquest Response Code: 1B and 2

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).

Ministry Response:

Please see the responses to recommendations 21 and 49. Fifty psychogeriatric resource consultants (PRCs) are funded currently by the province. These PRCs are available across the province to provide consultative support and education for staff in LTC homes and CCACs. The Ministry is considering this recommendation as part of a longer-term strategy to increase the availability of assessments.

Inquest Response Code: 2

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.

Ministry Response:

The Ministry supports an integrated continuum of care and will consider this recommendation. Prior to admission, CCACs provide assessment and community support services. On admission, the LTC home must initiate the development of a plan of care to address the resident's individual needs. Current Ministry legislation supports consistency of care of cognitively impaired individuals by requiring care plans to be reviewed and updated regularly to meet the changing needs of the resident. The Local Health Integrated Networks (LHINs) have the mandate to integrate health care at a local level and consolidate planning, system integration and service coordination, funding allocation, and evaluation of performance.

Inquest Response Code: 2

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.

Ministry Response:

The Ministry will continue to work with CCACs to ensure continuity of assessment by one case manager to the extent that it is practicable and feasible in individual circumstances. The Ministry will reinforce with CCACs that where more than one case manager is involved, there are mechanisms to ensure the completeness and consistency of information gathered.

Inquest Response Code: 1C

Recommendation 53:

The CCAC 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.

Ministry Response:

This recommendation reflects current practice. As part of the RAI-HC assessment, the CCAC case manager interviews the applicant, caregivers and others with relevant information (such as family members living with the applicant) provided such persons are willing and available to be interviewed by the case manager. It is appropriate for the case manager to have discretion, on a case by case basis, about which family members to interview. Ministry policy requires that a mentally competent applicant provide consent for such interviews to occur.

The Ministry expects case managers to verify information and observations, to the extent possible, with family members and caregivers.

Inquest Response Code: 1B

Recommendation 54:

The CCAC 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.

Ministry Response:

In cases where the applicant is mentally incompetent, the case manager, as part of the existing application process, interviews the substitute decision-maker (SDM) as indicated in the RAI-HC training manual. Where the spouse is the SDM, the CCAC case manager will request to interview the spouse. Where the spouse is not the SDM, the case manager has the discretion to request to speak to the spouse. However, the case manager cannot require that the spouse co-operate in being interviewed.

Inquest Response Code: 4A

Recommendation 55:

The CCAC 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.

Ministry Response:

Legislation requires only the consent of an incapable person's substitute decision-maker (SDM) for admission to a LTC home. Under current Ministry policy, the CCAC case manager requests an interview with the substitute decision-maker. If the SDM refuses to be interviewed, the case manager seeks to obtain information from other sources such as family members, family physician or community service providers. In the majority of cases, the SDM is interviewed. However, in cases where the SDM refuses to be interviewed, the Ministry is of the view that halting the placement process is not appropriate as this could have a detrimental effect on the applicant's well being.

Inquest Response Code: 4A

Recommendation 56:

The CCAC'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.

Ministry Response:

The Ministry considers this recommendation to be consistent with current good practice. Please see the response to recommendation 76 regarding LTC home records for additional information. CCACs have documentation practices, which reflect the documentation standards of colleges governing the health and social service professions. These standards require the full names and relationships of persons interviewed and the content of discussions and all relevant information. However, recording the lengths of conversations and meetings are not required, for example, by the College of Nurses of Ontario (CNO) documentation standards.

Inquest Response Code: 1

Recommendation 57:

The CCAC 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.

Ministry Response:

The Ministry considers this recommendation to be consistent with current good practice. Please see the response to recommendation 56 for more information.

Inquest Response Code: 1

Recommendation 58:

CCACs 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.

Ministry Response:

The legislation governing LTC homes requires the CCAC as placement co-ordinator to provide LTC homes with information about the client's social and other care requirements if the placement co-ordinator has the information (see, for example, clause 20.2(2)3 of the *Nursing Homes Act*). In some instances, this information is included in the documentation that CCACs provide to LTC homes with the assessment information.

The CCAC is required, if the client wishes, to assist in selecting homes to which to apply for authorization of admission. In providing this assistance, the client's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors (see, for example, subsections 20.1(7) and (8) of the *Nursing Homes Act*) are considered. When an applicant is prioritized for a religious/ethno-cultural home, this information is always provided to the home.

Inquest Response Code: 1

Recommendation 59:

The MOHLTC, in consultation with the CCAC sector, should consider including a provision in legislation and MOHLTC policy that limits the choice of clients who have been assessed as

posing a risk to others due to physically aggressive or violent behavior. 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.

Ministry Response:

The Ministry will examine this recommendation in its considerations with respect to specialized behavioural management units as outlined under the responses to recommendations 22-25. Consultation is required with the LTC sector, geriatric specialists, CCACs, and others to ensure that all relevant considerations are taken into account.

It should be noted that one of the eligibility criteria for admission to a LTC home is that the applicant's care requirements, including behaviour management needs, can be met in the home. Some applicants may not be approved for placement in a particular LTC home on the basis that the home lacks the physical facilities or nursing expertise necessary to meet their needs. Other applicants can be cared for safely in a LTC home that has the physical facilities and nursing expertise necessary to meet the person's care requirements with a comprehensive care plan that identifies strategies to address aggressive behaviours. Some applicants would be ineligible for admission to a LTC home and may require care in an acute care setting.

Inquest Response Code: 2

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.

Ministry Response:

a) The RAI-HC which CCACs are required to conduct as part of the eligibility and placement process addresses mental functioning, cognitive and mood and behavioural patterns. Concerns identified in these areas trigger the more detailed Client Assessment Protocol (CAP) which provides an in-depth assessment of behaviour, depression, anxiety and cognition.

   Persons conducting these assessments are skilled in identifying potential for behavioural problems. Case managers who conduct the RAI-HC currently use the Notes Section of the RAI-HC for documenting behavioural issues that involve potential harm to self or others (e.g. noting what aggravates such behaviours and what relieves these behaviours). If the applicant is found to be ineligible for admission due to severe behavioural problems, other options, such as acute care, are considered.

b) The Ministry does not support the recommended new role for CCACs in the placement process. The operator of the LTC home is in the best position to assess the expertise and capabilities of its staff, facilities and capacity in relation to the care needs of the home's population at any given time. It is important to the placement process that there be strengthened communications between CCACs and homes. The Ministry will continue to work with CCACs and homes to facilitate this.

Inquest Response Code: a) 1; b) 4

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.

Ministry Response:

Complete assessments, which include the RAI-HC assessment and completion of the health report form, are required for all admissions, including crisis admissions. The current regulations and policies regarding the placement process require that complete and accurate information be obtained before a person's admission to a home is authorized. For persons who are placed on a waiting list for admission to their selected home(s), regulations require the CCAC to ensure that existing assessments are current within 6 months of authorizing admission. Where assessments are updated, they are required to be provided to the LTC home operator who may then withdraw approval for the admission if the home lacks the physical facilities or nursing expertise to meet the person's care requirements. Obtaining information from police may raise privacy issues. In cases when the placement process is halted due to inadequate information, alternate options, such as home care services, are presented to applicants and their families. However, applicants are not obligated to accept these options. The Ministry has clarified with CCACs the requirement to conduct the RAI-HC for all admissions, including crisis admissions.

Inquest Response Code: 1B

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.

Ministry Response:

The Ministry does not support the concept of conditional placements. In the Ministry's view, such placements may not be in the interests of residents and could undermine continuity of care. Changing a resident's environment a number of times may trigger further aggressive behaviour and could be detrimental to the individual's health and well-being.

The discharge regulations provide that the LTC home operator may discharge a resident if it is informed by the inter-disciplinary team that the home cannot provide a sufficiently secure environment to ensure the safety of the resident or other persons and other arrangements are made to provide the accommodation, care and secure environment required by the resident. Currently, if a transfer of the resident to another LTC home is sought, the CCAC is involved as the placement co-ordinator for all LTC home admissions. In cases where the resident requires care in an acute care setting, such as a hospital or psychiatric facility, the LTC home operator is responsible for making the referral. The Ministry is of the view that this is appropriate because the LTC home is providing care to the resident and would have direct knowledge of the resident's behaviours and conditions. The CCAC is not involved in securing admissions to acute care facilities.

The Ministry does not support the recommendation to change the role of the CCAC.

Inquest Response Code: 4

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.

Ministry Response:

The legislation governing LTC homes provides the operator of the LTC home with up to 5 business days to authorize or withhold approval for a person's admission to the home. CCACs provide LTC homes with information and assessments about applicants, including the results from the RAI-HC and more detailed assessments on behaviours if triggered. The operator may withhold approval of an admission based on the lack of the physical facilities or nursing expertise necessary to meet the person's care requirements. It is the responsibility of the operator to determine how to best organize its staff and resources to ensure that this decision is made appropriately. The LTC home can also contact the CCAC case manager for additional information about the applicant.

Applicants, their substitute decision-makers (SDMs) and families, are encouraged by the CCAC to visit the LTC homes to which placement will be sought. Some applicants, SDMs or families may not be able to or wish to make such a visit prior to admission. The Ministry does not support the recommendation that LTC home staff meet with the resident and family prior to

making the decision to approve the admission to the home. Such a proposal raises the potential of introducing additional assessments or interviews which applicants must undergo and additional criteria for admission. Having an independent and centralized placement co-ordination system for all LTC homes ensures that criteria are consistently applied in the admission process. In the Ministry's view it is crucial that the placement co-ordination function be conducted by an agency independent of LTC homes and at arm's length from the Ministry, such as the Community Care Access Centres. The current process promotes fair and equitable access to LTC homes based on applicant preferences and assessed care requirements.

As noted in the response to recommendation 62, the Ministry does not support the concept of conditional admissions to LTC homes.

Inquest Response Code: 1

Recommendation 64

The MOHLTC 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 CCAC 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.

Ministry Response:

The Ministry will consider clarifying that LTC home operators have a duty to review all assessment information and documentation provided by the CCAC. Intrinsic in the operator's approval of an admission to the home is that the operator understands the care needs of the individual and is able to meet his or her care requirements.

Inquest Response Code: 2

Recommendation 65

The MOHLTC amend the RAI-HC tool to include elements that 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".

Ministry Response:

The developer of the RAI-HC, Inter*RAI,* is a collaborative network of experts and researchers from a variety of gerentological specialties working in a large number of jurisdictions. As such, the Ministry is not able to amend the RAI-HC. However, the Ministry will consult with InterRAI's representative in Waterloo, Ontario to discuss this recommendation.

Geriatric mental health specialists were involved in developing the RAI-HC tool. It is the Ministry's understanding that inter*RAI* took into account extensive literature reviews related to geriatric mental health in the development of the current version of the instrument.

The training of CCAC case managers on the use of the RAI-HC includes asking questions related to suspicion and paranoia. The RAI-HC includes a number of elements or sections that

address the risk of violence or aggression. These sections include questions directed to assessing cognitive patterns (with questions relating to indicators of delirium, delusions or hallucinations), mood and behaviour patterns (which include wandering, verbally abusive behaviour, physically abusive behaviour, socially inappropriate or disruptive behaviour and resistance to care). As noted above in the response to recommendation 60, the RAI-HC form has a Notes Section for elaborating on the conditions or behaviours identified by the assessment. The Notes Section is where additional information related to behaviours, including triggers for the behaviour and methods for relieving the behaviour, would be noted. Progress notes would not be included as the RAI-HC is intended to provide a comprehensive assessment of the person's condition at a point in time, that is when seeking placement in a LTC home. Any changes in the person's condition or status would be noted elsewhere in the person's plan of care and other documentation once admitted to a LTC home.

Inquest Response Code: 2 and 4A

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.

Ministry Response:

The Ministry is supportive of appropriate training, including PIECES, for CCAC case managers (placement co-ordinators). As noted in the comments under recommendation 40, many CCAC staff have received PIECES training. However, this training is not universal for all CCAC case managers, nor is it an ongoing requirement.

While most CCAC case managers are registered nurses, some are other regulated health professionals or social workers and bring a wide range of skills and expertise to the position. There are still some CCACs that have small numbers of placement co-ordinators who are not regulated health or social service professionals but these individuals have backgrounds in gerontology or years of experience with placement. Within a CCAC, case managers do consult their colleagues on multiple issues, including medical and pharmaceutical matters.

The Ontario Association of Community Care Access Centres (OACCAC) has developed an online learning tool for CCAC case managers on "The Art of Case Management" which advocates a "whole person" approach to the management of a person's care. The focus of CCAC case management is holistic in its approach.

Inquest Response Code: 1B

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.

Ministry Response:

This recommendation is consistent with existing Ministry policy. The Ministry has clarified to CCACs the requirement that determinations of eligibility for admission be made solely on the basis of the applicants needs and preferences and the criteria set out in the legislation.

Inquest Response Code: 1

Recommendation 68:

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

Ministry's Response:

The Ministry will consult with LTC homes about this recommendation with respect to those residents who exhibit aggression or violence. Many LTC homes only admit new residents from Monday to Friday during business hours. In the Ministry's view, it is not appropriate to end all weekend and evening admissions. Some persons admitted on weekend or evening may pose no risk for aggression or violence, for example, persons who are discharged from hospital to a Convalescent Care Program in a LTC home. In addition, weekend or evening admissions support the resident and family. Family members, particularly those who reside out-of-town or work during the week, may prefer weekend admissions so that they may accompany and support their loved one's transition into a LTC home. If a LTC home is appropriately staffed to admit residents on an evening or weekend, it would be unreasonable to delay admission.

The LTC Short-Term Sustainability Grant Program was cancelled as of March 31, 2005.

Inquest Response Code: 2

Recommendation 69:

The MOHLTC, in consultation with health care professionals working in the long term care industry, should develop an 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.

Ministry Response:

The Ministry considers this recommendation to be a high priority and will consult with *interRAI*, the consortium that developed the RAI-HC. The development of an aggression risk assessment tool requires significant consultation with mental health experts, particularly those that specialize in the geriatric population.

Through financial support from the Ministry, the Seniors' Health Research Transfer Network (SHRTN) was established to connect professionals who care for seniors in long-term care homes and in the community in order to share and acquire new knowledge. As part of this

initiative, proposals were selected in March 2006 to develop a continuing education module for physicians for detecting potential aggression in seniors, and for the establishment of an Aggressive Behaviours Community of Practice (CoP) for caregivers, researchers and others.

Inquest Response Code: 2

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.

Ministry Response:

The Ministry expects employers, whether a CCAC or a LTC home operator, to ensure that their employees are appropriately trained and kept current in their training in order to fulfill their professional responsibilities. Employers have the responsibility to ensure that the processes and policies of their organizations enable their staff to have sufficient time to carry out their duties in relation to assessments and admissions decisions. In addition, the governing bodies for some regulated professions have standards and requirements, which members must meet in terms of continuing education and competence for practice. All health profession regulatory colleges (under the *Regulated Health Professions Act*) are required to have in place a quality assurance program that ensures ongoing competence of its members.

Inquest Response Code: 4

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.

Ministry Response:

i. Currently, all CCAC staff involved in the assessment and placement process must obtain the relevant information about an applicant. With respect to obtaining criminal record information, there are potential issues regarding an individual's right to privacy. It should be noted that other regulated professionals such as social workers are involved in assessment and placement. Social workers are trained in a holistic and probing approach to assessment and interviewing.

ii. Please see the comments under Recommendation 52, above. The Ministry agrees that CCACs must ensure that the information obtained with respect to persons seeking placement in a LTC home is consistent and comprehensive. In some smaller CCACs, clients are usually followed by a single case manager for both in-home (community) services and placement in a LTC home. Due to volume of clients, some larger CCACs have a specialized placement unit or branch, which occasionally necessitates the transfer of a client from an in-home services case manager to a placement case manager. The Ministry supports a degree of flexibility in terms of how a CCAC delivers services in order to allow for local needs and interests to be served.

iii. The *Personal Health Information Protection Act, 2004*, which came into force on November 1, 2004, establishes rules about the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care. Governing bodies of self-regulated professions have an important role to play in educating and supporting their members about these issues as well.

Inquest Response Code: i 1; ii 4; iii 7

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 CCAC 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 CCAC by the MOHLTC. 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."

Ministry Response:

In the Ministry's view, the CCAC case manager is in the best position to determine whether an "independent" translator is required and would serve the interests of the individual. For many individuals and their families, placement in a LTC home may be a time when they may prefer that a family member or friend translate for them. Persons may be more forthcoming with information if they feel comfortable during this process. Case managers must be responsive to the wishes and needs of the individual, balanced with the necessity to ensure that relevant information is obtained. In those areas of the province where this is an issue, some CCACs already hire translators or draw on internal staff resources for assistance with translation.

Where a LTC home accepts a resident for whom language could be a barrier, the home is expected to address that issue in the plan of care that is developed for the resident. There are a number of considerations with respect to language issues that a home may take into account in developing the care plan. These include how often family and friends are able to visit the resident and the availability of volunteers or other community resources that provide activities or services that are linguistically and cultural appropriate for an individual.

It is the Ministry's expectation that CCAC staff have received cultural sensitivity training in order to serve their local communities. The College of Nurses of Ontario has a standard entitled, "Culturally sensitive care" that all nurses are expected to meet. In addition, the Registered Nurses Association of Ontario (with funding from the MOHLTC) is developing a best practice Guideline on Cultural Competence, which is expected to be ready mid- 2006.

In the Ministry's view, it is not appropriate to delay admissions until a plan of care is in place. The plan of care for a resident is not prepared by the CCAC, but rather by LTC home staff once the individual has moved into the home. As noted earlier, LTC home operators are in the best position to determine their ability to meet both the care requirements and social/cultural needs of a resident.

Inquest Response Code: 4A

Recommendation 73:

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

- *LTC facility's Administrator,*
- *The LTC facility's Director of Care,*
- *The LTC facility's Chief Medical Administrator, and*
- *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.

Ministry Response:

The Ministry expects operators of LTC homes to determine who are the appropriate members of staff to be on the admissions team. It may not be appropriate or necessary for all members of

the team to be present on the day of admission. Additionally, it may not be feasible, for instance in a small home, for a team comprised of four persons to be present on the day of admission. There may be competing demands on the time of staff.

Inquest Response Code: 4A

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.

Ministry Response:

This recommendation is generally consistent with current practice for LTC home staff who provide direct care to the residents. All staff who may have 'direct contact' may not require detailed information about residents.

Inquest Response Code: 1

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.

Ministry Response:

The Ministry supports the recommendation that shift change reports be available in different formats, that direct care staff review any new information in residents' charts at the start of each shift, and that reports must place particular emphasis on new admissions and instructions for monitoring residents. The Ministry will continue to consult with LTC home operators with respect to practices. With respect to hand-over, it is generally accepted sector practice to ensure coverage during shift change.

Inquest Response Code: 2

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.

Ministry Response:

This recommendation is consistent with good practice. Governing colleges of regulated health and social service professionals have standards about documentation, such as charting and progress notes, to which members must adhere. For example, the College of Nurses of Ontario has documentation standards that clearly require the date and time to be noted, and type of documentation required. The Long-Term Care Homes Program Manual also outlines standards for documentation. It must also be noted that LTC home staff are not expected to document "casual" or informal conversations with family that are not relevant to care.

Inquest Response Code: 1

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.

Ministry Response:

MOHLTC recognizes the need for effective responses to aggressive behaviours in order to protect a resident who is exhibiting the behaviour as well as other persons. The Long-Term Care Homes Program Manual sets out requirements for operators to ensure that there are 10 mandatory in-service training sessions annually for staff. Of these, training in the following topics are mandatory: facility and resident emergency procedures, understanding residents with cognitive impairment, responding to disruptive behaviour and quality of life issues. The Ministry is considering the frequency with which such training must be provided.

In addition to the mandatory topics for in-service training, in-service education programs vary from home to home based on the assessed learning needs of staff. LTC home operators are required to provide training to respond to assessed learning needs of their staff.

Inquest Response Code: 1 and 2

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.

Ministry Response:

Please see the response to recommendation 77. The Long-Term Care Home Program Manual sets out requirements for operators to ensure that there are 10 mandatory in-service training sessions annually for staff as well as training based on assessed learning needs. The Ministry currently provides funds to LTC home operators through the Nursing and Personal Care funding envelope for training of LTC staff, which can also be used to cover backfill costs while LTC home staff are on training.

Inquest Response Code: 1

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 shoelaces) for differing patients who are suffering from cognitive, behavioural or physical issues.

Ministry Response:

The LTC Homes Program Manual requires LTC home operators to have a system to readily identify each resident in the home such as photo identification or identification bracelets. Many LTC homes place photographs of residents on the front of the medical charts. The Ministry encourages the implementation of this practice across all LTC homes.

LTC home staff are expected to know the needs of the residents of the home, including those who are known or assessed to have behavioural response issues. The safety and security precautions to be taken with respect to a resident are required to be described in the resident's plan of care. The plan of care must be easily accessible to persons providing the resident's care.

As a result, the Ministry does not believe it is necessary to require additional identifiers. Residents and their family members may view "identifiers" as disrespectful of the dignity and privacy of residents.

Inquest Response Code: 1 and 4

Recommendation 80:

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

Ministry Response:

The Ministry is supportive of LTC homes having medical directors with specialized geriatric training. Medical directors generally have a strong knowledge of geriatrics and psychogeriatrics and have considerable experience in the field. For purposes of clarification, LTC homes are required to have a medical director, but are not "headed" by a doctor.

There are challenges inherent in this recommendation based on the number of available professionals with such specialized training. The Ministry will continue to encourage operators to have formal links or consultations with geriatric specialists available through the Regional Geriatric Program. In addition, the Ministry will continue its work to address health human resource issues surrounding the supply of professionals in this specialty.

Inquest Response Code: 2

Recommendation 81

Where the police investigate an incident in a long-term care home or an incident involving a CCAC, the MOHLTC shall complete their own, thorough investigation as soon thereafter as possible, to determine whether there have been any breaches of the legislation or policies.

Ministry Response:

The Ministry accepts this recommendation. In the case where a Ministry investigation runs parallel to a police investigation, the two investigations are conducted separately and independently. The purpose of each investigation is different. The police investigate suspected criminal activity while the ministry's inspectors inspect for the purpose of determining whether the LTC home operator is in compliance with the applicable LTC home legislation, regulations, the LTC home program manual and service agreement. Ministry staff cannot interfere with any police investigation.

In order to conduct a thorough inspection, the Ministry requires the records of residents for review and the ability to interview witnesses. In some situations, the Ministry has been advised that witnesses (LTC home staff, others) have been instructed by police not to speak to anyone about the matter. In addition, relevant records may have been seized by police and the Ministry has been unable to obtain copies in order to complete its inspection. The Ministry is working with police forces to ensure that there is a better understanding of the Ministry's role in inspecting LTC homes.

Inquest Response Code: 1A

Recommendation 82:

The MOHLTC 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.

Ministry Response:

The Ministry accepts this recommendation. Under the legislation, LTC home operators are required to submit reports to the Ministry about certain occurrences that take place within the home, including violent incidents. The Ministry is reviewing and amending the current reporting system to better track incidents and intends to implement it by mid-2006.

Inquest Response Code: 1A

Recommendation 83:

The MOHLTC 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.

Ministry Response:
The Ministry accepts this recommendation and intends to implement it by mid-2006. Please see the response to recommendation 82 for more information.

Inquest Response Code: 1A

Section 5

Responses to Recommendations:

Ontario College of Family Physicians

THE ONTARIO COLLEGE OF FAMILY PHYSICIANS

A CHAPTER OF THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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OFFICE OF THE EXECUTIVE DIRECTOR & CEO

June 27, 2006

Dr. Barry McLellan
Chief Coroner for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto ON M7A 2G9

Re: Inquest into the deaths of Ezz-El-Dine El-Roubi and Pedro Lopez deceased June 9, 2001. File # Q2005-29

Dear Dr. McLellan,

Recommendation #3 has been implemented. The OCFP was provided with funding from the MOHLTC to develop an extensive family physician education program on Alzheimers Disease and Related Dementias. The program is available for medical students/family medicine residents and practicing family physicians with Mainpro C small group interactive educational modules, self-learning modules and extensive web-based information educational materials. The program is receiving excellent evaluations from participants and should reassure the jury that their recommendation #3 has been addressed.

If further information is required, please do not hesitate to contact me.

Yours truly,

M. Janet Kasperski, RN, MHSc, CHE
Chief Executive Officer

Section 6

Responses to Recommendations:

Office of the Chief Coroner

Office of the Chief Coroner **B :au du coroner en chef**

26 Grenville Street
Toronto ON M7A 2G9
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Facsimile: (416) 314-4030

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April 12, 2006

MEMORANDUM TO: Dr. Barry A. McLellan
Chief Coroner

FROM: Dr. B. Porter
Deputy Chief Coroner – Inquests

RE: Inquest into the deaths of Ezz-El-Dine El-Roubi and Pedro Lopez, deceased June 9, 2001. Our file Q2005-29

Recommendation 5 from the above inquest states:

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

In response to this recommendation, the Office of the Chief Coroner is in the process of making all verdicts and recommendations available electronically. Once these items are converted into electronic format, they will be incorporated into the website for the Office of the Chief Coroner.

Response Code: 1B

Recommendation 6 from the above inquest states:

> The Office of the Chief Coroner publish all Annual Reports of the Geriatric and Long-Term Care Review Committees 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.

In response to this recommendation, the Office of the Chief Coroner will include the Geriatric and Long Term Care Review Committee Report, on the Office of the Chief Coroner web site. Key stakeholders will be informed through various newsletters and publications that the report is available.

Implementation code: 2

Recommendation 7 from the above inquest states:

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

Section 10 a) of the Coroners Act requires that the Office of the Chief Coroner investigate all deaths resulting from violence, misadventure, negligence, misconduct or malpractice, occurring within the Province of Ontario. Pursuant to this Section 10, the Office of the Chief Coroner investigates all suspected homicides, regardless of where they occur within the province.

Implementation code: 1

Recommendation 8 from the above inquest states:

> 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 the 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 police forces in Ontario.

In response to this recommendation, the Office of the Chief Coroner has directed the Geriatric and Long Term Care Review Committee to review ALL homicides of residents of licensed long term care facilities in the Province of Ontario as they occur. It is routine procedure for the Office of the Chief Coroner to keep key stakeholders informed through correspondence, newsletters and other communication means regarding information that may be of mutual interest.

Response Code: 1B

Recommendation 84 from the above inquest states:

> 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 CCAC's , all educational institutions for both regulated and unregulated health care professionals and all Colleges regulating health care professionals and Social Workers in the Province of Ontario and the professional association and Unions representing staff at long-term care facilities and CCACs.

In response to this recommendation, the Office of the Chief Coroner distributed the verdicts, recommendations and coroner's explanation directly to the five organizations and agencies who were in a position to affect implementation, as well as to an extensive list of other parties who might have had an interest in the findings. It is expected that the recipients of the materials from the Office of the Chief Coroner will disseminate the information accordingly throughout their organizations and agencies and to key stakeholder groups.

Response Code: 1B

Recommendation 85 from the above inquest states:

> The Office of the Chief 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 response to this recommendation, the Office of the Chief Coroner shall publish a report on the status of implementation of recommendations arising from this inquest. This report will be produced in July 2006, one year after the recommendations were distributed to relevant parties.

Response Code: 1

Dr. B. Porter
Deputy Chief Coroner - Inquests

Section 7

Responses to Recommendations:

College of Physicians and Surgeons of Ontario

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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June 23, 2006

Dr. Bonita Porter
Deputy Chief Coroner – Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto, ON M7A 2G9

Dear Dr. Porter:

Thank you for your letter regarding the inquest into the death of Ezz-El-Dine El-Roubi and Pedro Lopez, File Q2005-29.

I am enclosing, for your information, a copy of an article that will be published in the July issue of our journal Dialogue, and sent the medical profession on July 11, 2006.

The recommendation from the inquest was that we provide specific information to the membership about their responsibilities regarding preparing and providing discharge summaries within 7 days of discharge and to clarify the issue of confidentiality when issues of abuse arise.

I think that you can see from the attached article, that this will be done effective the dates above. Using the criteria identified in your letter, I would classify this as 1A, as this will be published in three weeks.

If you require any further information, please don't hesitate to contact me.

Yours truly,

Rocco Gerace, MD
Registrar

Enclosure

Summaries of selected cases investigated by the Coroner's Office are published where the recommendations of the Coroner's Jury may be of interest to the profession. All information is taken from the Inquest Report provided by the Office of the Chief Coroner.

The duty of confidentiality in situations of abuse

Background

In June 2001, two residents of a nursing home were killed by a third resident who suffered from dementia, and was prone to aggressive outbursts.

The third resident – MG - had been hospitalized in March 2001 for stroke, and had become aggressive and confused during his stay in hospital. The facts suggest that MG was discharged from hospital as a result of this behaviour, and was released into the care of his family with no arrangements for home care.

MG's family physician did not receive MG's discharge summary until June 2001, after the deaths occurred. The family physician was aware that MG had physically assaulted his wife just prior to his admission to the nursing home, but the family physician did not include information relating to the assault in the medical assessment form required for admission. The family physician felt that since information regarding the assault was relayed by the wife, and was only contained in the wife's medical record, the information had to remain confidential.

Functional and behavioural assessments of MG conducted by Community Care Access Centres, and the nursing home staff resulted in conflicting reports. Some identified MG as being physically and verbally aggressive and in need of a specific plan of management, while others indicated that MG was only verbally abusive and that such a plan was not required.

A few hours after MG was admitted into a nursing home, he killed two residents, and injured a third.

Coroner's Inquest & Recommendations

A Coroner's Inquest into the deaths was held in which the Jury considered the process through which MG was assessed and admitted into the nursing home, and the immediate events leading up to the deaths of the two residents. As a result of this inquest, the Jury made 85 recommendations, two of which were directed at the CPSO.

The Jury requested that the CPSO communicate information to its members about discharge summaries, and the duty of confidentiality in situations of abuse.

Discharge Summaries

The Jury felt that the facts and evidence leading to these deaths served to highlight the importance

of sharing patient information amongst health-care professionals involved in a patient's care.

The Jury asked that the CPSO communicate to its members the importance of preparing discharge summaries and providing them to the family physician within seven days from discharge.

The Jury asked that the CPSO communicate to its members the importance of preparing discharge summaries and providing them to the family physician within seven days from discharge.

In response to this recommendation, the CPSO reminds all physicians that detailed discharge summaries are an important part of the provision of quality health care. Physicians are encouraged to prepare discharge summaries on a routine basis, and to forward discharge summaries to family physicians and other relevant health-care professionals involved in patient care in a timely manner.

Physicians who wish to obtain further guidance regarding the form and content of discharge summaries are advised to contact the health care facility with which they hold privileges.

Duty of Confidentiality in Situations of Abuse

The Jury heard evidence that although MG's family physician was aware that MG was verbally and physically aggressive towards his spouse, the family physician did not include this information on MG's assessment form for the nursing home. The family physician felt that since the information regarding MG's aggression was obtained from his spouse, the duty of confidentiality to the spouse prevented the physician from disclosing this information to others.

The Jury asked that the CPSO clarify the issue of confidentiality when issues of abuse arise.

In response to this recommendation, the CPSO reminds all physicians that while they are required to keep patient information confidential, there are certain instances in which physicians will be permitted to disclose this information.

One such instance that is of particular relevance here relates to situations where an individual or group is at risk of serious harm. In these circumstances, if a physician believes on reasonable grounds that disclosing patient information is necessary to either eliminate or reduce a risk of serious bodily harm to a person or group, the physician is permitted to disclose the information, despite obligations of confidentiality or privacy.[1]

Whether disclosure is necessary is a matter that the physician needs to determine in his or her clinical judgment, in relation to the facts of each situation. The CPSO encourages physicians to consult legal counsel or the CMPA, for guidance specific to each situation. For general information on issues related to the duty of confidentiality, and permitted disclosures, physicians may wish to consult CPSO policies on Confidentiality of Personal Health Information, and Mandatory Reporting, along with the Information and Privacy Commissioner of Ontario's Fact Sheet, Disclosure in Emergency or Urgent Circumstances.

The CPSO advises physicians to document all discussions concerning requests and consents for patient information. Written requests and consents to release information should be kept in the patient record.

[1] This passage refers to a provision in Ontario's privacy legislation: the Personal Health Information Protection Act, 2004. The specific provision is s.40(1), and the statute is available on line at the following address: http://www.e-aws.gov.on.ca/DBLaws/Statutes/English/04p03_e.htm

This paragraph refers to section 40(1) of the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.