

Protection for Persons in Care

Quarterly Report

January 1, 2001 – March 31, 2001



Protection for
Persons in Care

A PROGRAM OF

**ALBERTA
COMMUNITY
DEVELOPMENT**

PROTECTION FOR PERSONS IN CARE

PART I

REPORTED ALLEGATIONS

APRIL 1, 2000 – MARCH 31, 2001

PROTECTION FOR PERSONS IN CARE

BACKGROUND

For this report the facilities and agencies are reported according to the government structure prior to the reorganization that took place in mid March. Future reports will reflect the government's new structure.

REPORTED ALLEGATIONS: Fourth Quarter 2000 - 2001 (January 1-March 31, 2001)

NUMBER OF REPORTS:

- During this quarter, 163 reports were received. The number of reports this quarter has increased over the past three quarters by approximately 30%, averaging over 50 reports each month.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment.
- The majority of allegations involve persons in care in long term care facilities, which are under the responsibility of Health and Wellness (H&W).
- This quarter there were reports regarding women's shelters, which are under Children's Services (CS) and AADAC facilities, under the responsibility of H&W.

Agency/Ministry Responsibility	# of Reports					
	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Regional Health Authorities/ H&W	78	93	71	106	348	69.7%
Persons with Developmental Disabilities/H&W	26	19	19	34	98	19.6%
AADAC/H&W	1	0	0	5	6	1.2%
Alberta Mental Health Board /H&W	1	0	0	4	5	1.0%
Management Bodies/CD	8	7	12	9	36	7.2%
Children and Family Services Authorities/CS	0	1	0	5	6	1.2%
Total	114	120	102	163	499	100%

See figure 1 for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE:

Allegations of emotional and physical abuse remain the largest group. The biggest increase was in allegations of emotional abuse.

Types of abuse	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Physical	39	37	40	39	155	26.0%
Emotional	50	48	41	112	251	42.1%
Inappropriate medications	2	0	3	0	5	0.8 %
Sexual	8	11	4	10	33	5.5%
Financial	4	4	13	10	31	5.2%
Neglect	28	42	23	28	121	20.3%
Total	131	142	123	199	596	100%

*Each report can have more than one type of abuse.

See figure 2 for individual breakdown by organizational structure

ALLEGED ABUSERS:

Client to client abuse allegations have remained constant. There is an increase in the percentage of cases where the service provider has been considered as the alleged abuser.

Alleged Abuser	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Service Provider	92	86	68	137	383	76.8%
Client	15	16	16	14	61	12.2%
Other	6	12	6	4	27	5.4%
Family	1	6	12	8	28	5.6%
Total	114	120	102	163	499	100%

See figure 3 for further breakdown by organizational structure

Note: Other includes volunteer, visitors, non family guardians and trustees.

INVESTIGATORS:

In this 4th quarter, contracted investigators conducted approximately 88% of the investigations, 9% were conducted by a professional college and less than 1% by a police service.

Investigator	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Contracted Investigators	101	101	91	144	437	86.5%
Professional Colleges:	10	11	8	15	44	8.7%
-AARN (RNs)	6	8	3	7	24	
-CLPN (LPNs)	4	2	2	2	10	
-CPS (Physicians)	0	1	2	6	9	
-Other	0	0	1	0	1	
Police	2	9	7	1	19	3.8%
Other bodies (MHPAO)	1	0	1	0	2	0.4%
Not applicable ***	0	0	0	3	3	0.6%
Total	114	121*	107**	163	505	100%

* One case was investigated by an external investigator and a professional college

** Five cases were investigated by more than one type of investigator.

***Cases were previously reported and investigated or incident occurred prior to 1998.

Part I Attachments: Summary of Reported PPC cases 2000-2001
 Figure 1 – Number of reports
 Figure 2 – Types of alleged abuse
 Figure 3 – Categories of alleged abusers
 Reported Allegations by Governing Structure Prorated

Protection for Persons in Care Number of Reports

April 1 – March 31, 2001 (12 Months)

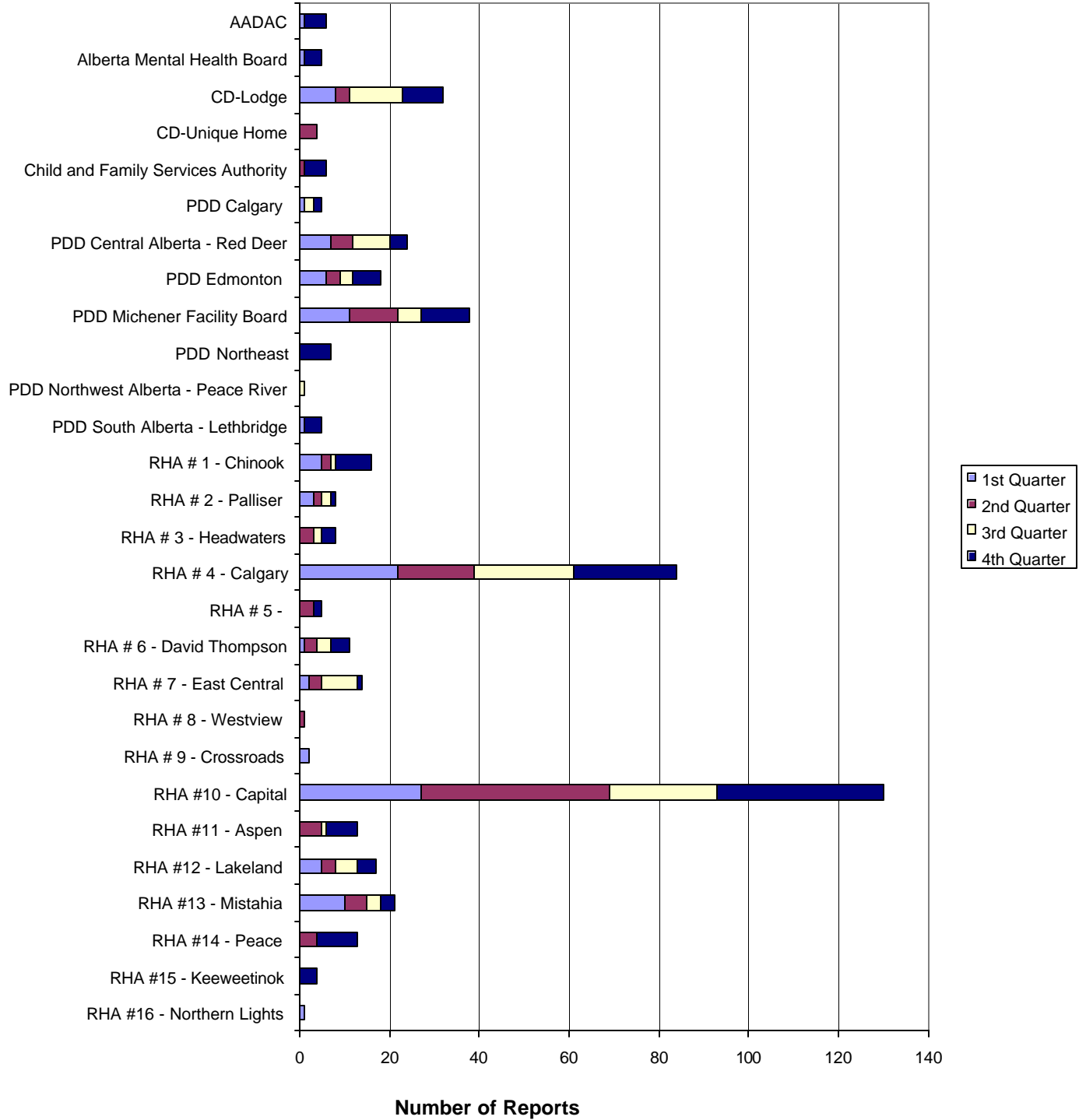
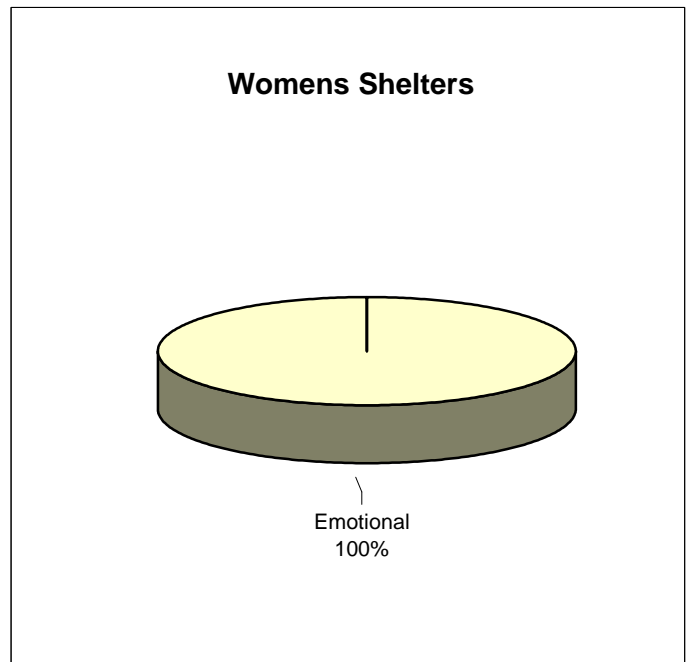
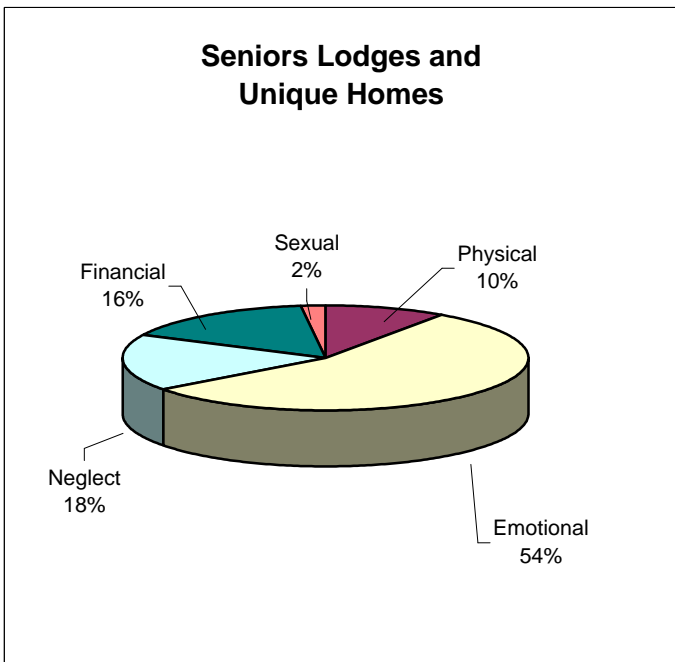
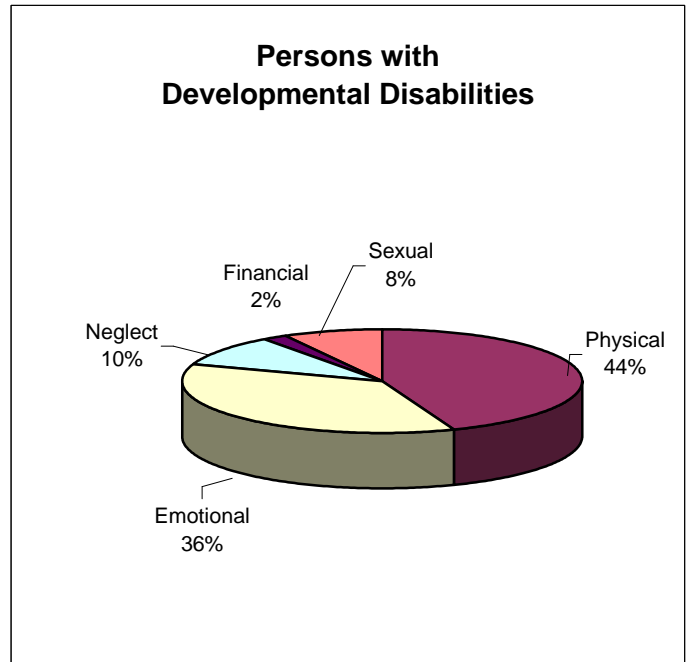
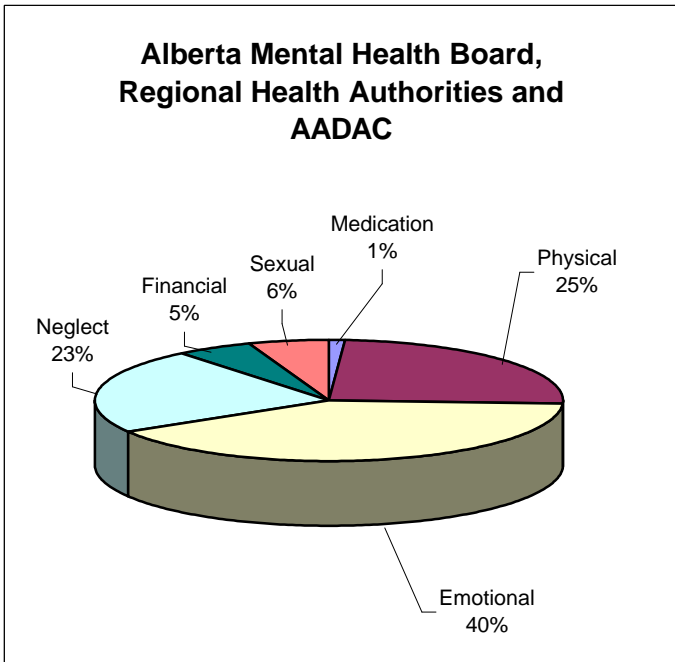


Figure 1

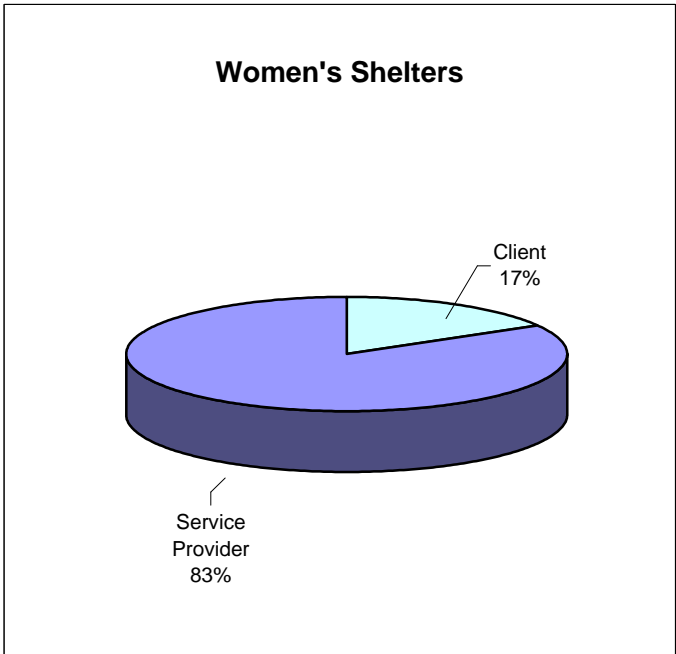
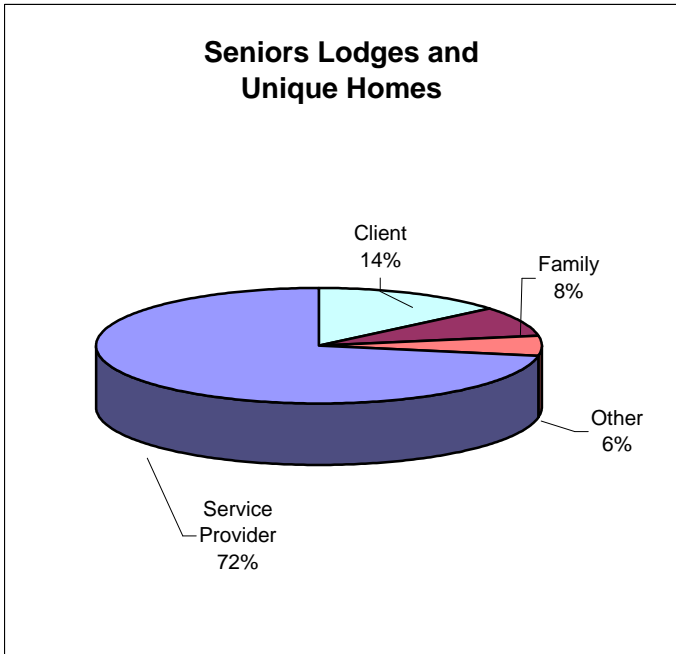
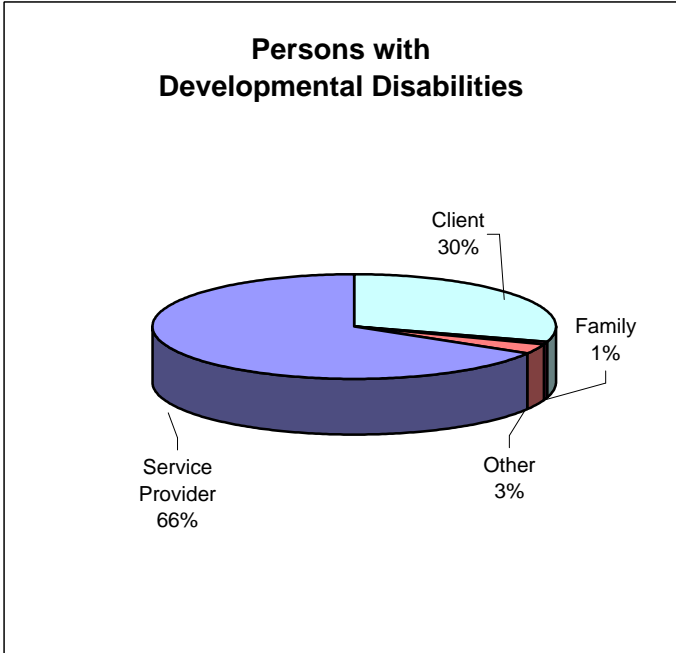
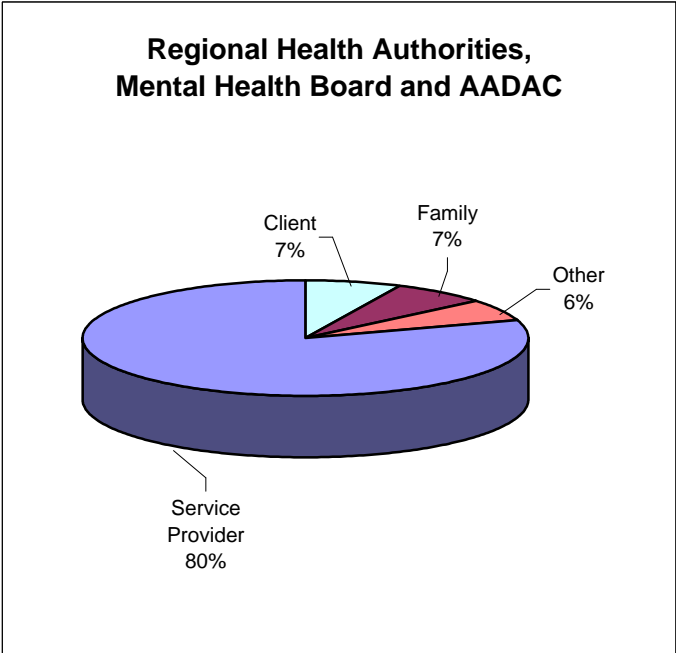
**Protection for Persons in Care
Types of Alleged Abuse by Organizational Structure
April 1, 2000 - March 31, 2001 (12 Months)**



Human Resources and Employment: 0 Reports

Figure 2

**Protection for Persons in Care
 Categories of Alleged Abusers by Organizational Structure
 April 1, 2000 - March 31, 2001 (12 Months)**



Human Resources and Employment: 0 Reports

Figure 3

REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRORATED: 2000 - 2001

To better reflect the number of reports regionally across Alberta per governing structure, the following charts have been derived based on specific adjustment factors per governing body:

PERSONS WITH DEVELOPMENTAL DISABILITIES (PDD) BOARDS

Reports by Board prorated per 1000 clients served*

PDD Community Boards	Reports
PDD Calgary	2
PDD Central Alberta - Red Deer	21
PDD Edmonton	23
PDD Northeast	17
PDD Northwest Alberta - Peace River	3
PDD South Alberta - Lethbridge	6

*Based on figures from Annual Report 1999/2000

Michener Facility Board is not included due to being facility based rather than community based. However there were 38 reports per 448 residential clients.

REGIONAL HEALTH AUTHORITIES

Reports by Region Adjusted per 100,000 population over the age of 19.

RHA	Reports
RHA # 1 - Chinook	16
RHA # 2 - Palliser	13
RHA # 3 - Headwaters	16
RHA # 4 - Calgary	11
RHA # 5 - Health Authority 5	13
RHA # 6 - David Thompson	8
RHA # 7 - East Central	19
RHA # 8 - Westview	2
RHA # 9 - Crossroads	7
RHA #10 - Capital	21
RHA #11 - Aspen	23
RHA #12 - Lakeland	23
RHA #13 - Mistahia	34
RHA #14 - Peace	95
RHA #15 - Keeweenok Lakes	25
RHA #16 - Northern Lights	4
RHA #17 - Northwestern	0

*Based on Population Projections for Year 2000 for Health Regions 2000-2003

Alberta Health and Wellness, January 2001

Note: While the PPCA is for adults >17 years of age, population projections are in increments of 5, eg. 15 – 19, 20 – 24, etc.

LODGE FOUNDATIONS AND UNIQUE HOMES

Reports by Foundation prorated per 100 units

Foundation/Unique Homes	Reports
Lodge Foundations	<1
Unique Homes	1

Reference: Alberta Seniors, March 31, 2001

Note: the number of reported cases concerning Lodges are very small

OTHERS:

The number reports from AADAC, AMHB, and Children's Services are too small to formulate any projections.

PROTECTION FOR PERSONS IN CARE

PART II

INVESTIGATION RECOMMENDATIONS

APRIL 1 – DECEMBER 31, 2000

* Recommendations from investigations in the quarter January 1-March 31, 2001 will be included in the next quarterly report, as the majority of the cases are not closed at this time.

INVESTIGATION RECOMMENDATIONS

First, Second and Third Quarter 2000 – 2001

(April 1-December 31, 2000)

- Of the 336 cases reported during this nine-month period, 316 files are closed. There are 20 reports still under investigation.
- Of the 316 closed files, 60.4% were dismissed, 33.2% were confirmed as abuse having occurred, 4.1% were referred to the police and 2.2% were determined to be not under the *Act*.

Organization	Dismissed	Confirmed	Ongoing	Not under the Act	Referred to Police	Total
RHA	134	78	17	3	10	242
PDD	38	18	3	3	2	64
AADAC	0	0	0	1	0	1
AMHB	0	1	0	0	0	1
Lodges	18	8	0	0	1	27
Children's Services	1	0	0	0	0	1
TOTAL	191	105	20	7	13	336

See figure 4 for further breakdown by organizational structure

INVESTIGATION RESULTS FOR FILES CLOSED THIS QUARTER:

COMMON RECOMMENDATIONS:

- There are consistent recommendations coming forth this quarter again regarding the need for staff training around polices, procedures and practice issues, such as:
 - provide registered nursing staff with a minimum of an annual in-service on clinical nursing assessment skills and incorporate into policy, clear guidelines for all professional staff with respect to clinical nursing assessments;
 - review with staff the definitions of abuse and their obligations to report suspected abuse;
 - provide staff with in-service education on appropriate boundaries, including sexual, in relation to patient care;
 - reinforce for all staff members, the core values of honesty, integrity and ethics.
- There were more recommendations this quarter related to the need for adequate and consistent documentation, such as:
 - staff members should document incidents automatically instead of being requested to do so;
 - review with shift supervisors the expectation that patient concerns, no matter how the concerns come to their attention, should be adequately addressed with an attached report of actions taken.
- In several reports, the need for better communication with other service providers, family members and guardians around the care plan was also noted.

RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:

- In 18 reports, involving staff as the alleged abuser, the facility took disciplinary action before the contracted investigator started or completed the investigation.
- Action taken by the facility included: staff termination (7); staff resignation (1); suspension of various lengths without pay (4); written and or verbal reprimands (4); reassignments (2); and attendance at special in-service training sessions (4) and performance monitoring (2).
- In seven reports, the contracted investigator recommended the facility carry out disciplinary action against the service provider identified as the alleged abuser.

RECOMMENDATIONS RELATED TO PROFESSIONAL COLLEGES:

- In three reports, which were investigated by a contracted investigator, the investigator recommended the professional member be referred to the member's professional college for evaluation of the members' professional practice.
- In three reports, referrals were made to the professional association because the member of the professional body would not speak to the contracted investigator.

FACILITY RESPONSES TO RECOMMENDATIONS:

- Facilities/agencies have responded to the report recommendations in a timely and positive action. Examples are:
 - Service provider attended three workshops, viewed a video and listened to a tape to improve her communication with clients.
 - Facility reviewed its communication strategies with residents and families and will continue with its "open door" policy to residents and families for their questions, concerns and suggestions. Families and residents will continue to be a valued member of the "care team."
 - The occupational therapist has reassessed the resident's wheelchair and the need for foot rests.
 - Contact has been made with the community handibus service regarding their hours of service.
 - The facility policy on outings has been revised.
 - Communication is continuing with the Office of the Public Guardian regarding guardianship for the resident.
 - Discussions with the staff at all levels have taken place to ensure that incidents are reported on a timely basis to family members.
 - A social worker has been hired to work with residents, staff and families to work through concerns and conflicts that may arise in the facility.
 - Program Manager conducts tours of the Dementia Program for other residents and their families and family of dementia patients, during the initial tour of the facilities and again during orientation so that they better understand the disease process. Family members are invited to join the Family Support Group specifically for family members of residents with a diagnosis of dementia.

Protection for Persons in Care Report Outcomes April 1, 2000 - December 31, 2000 (9 months)

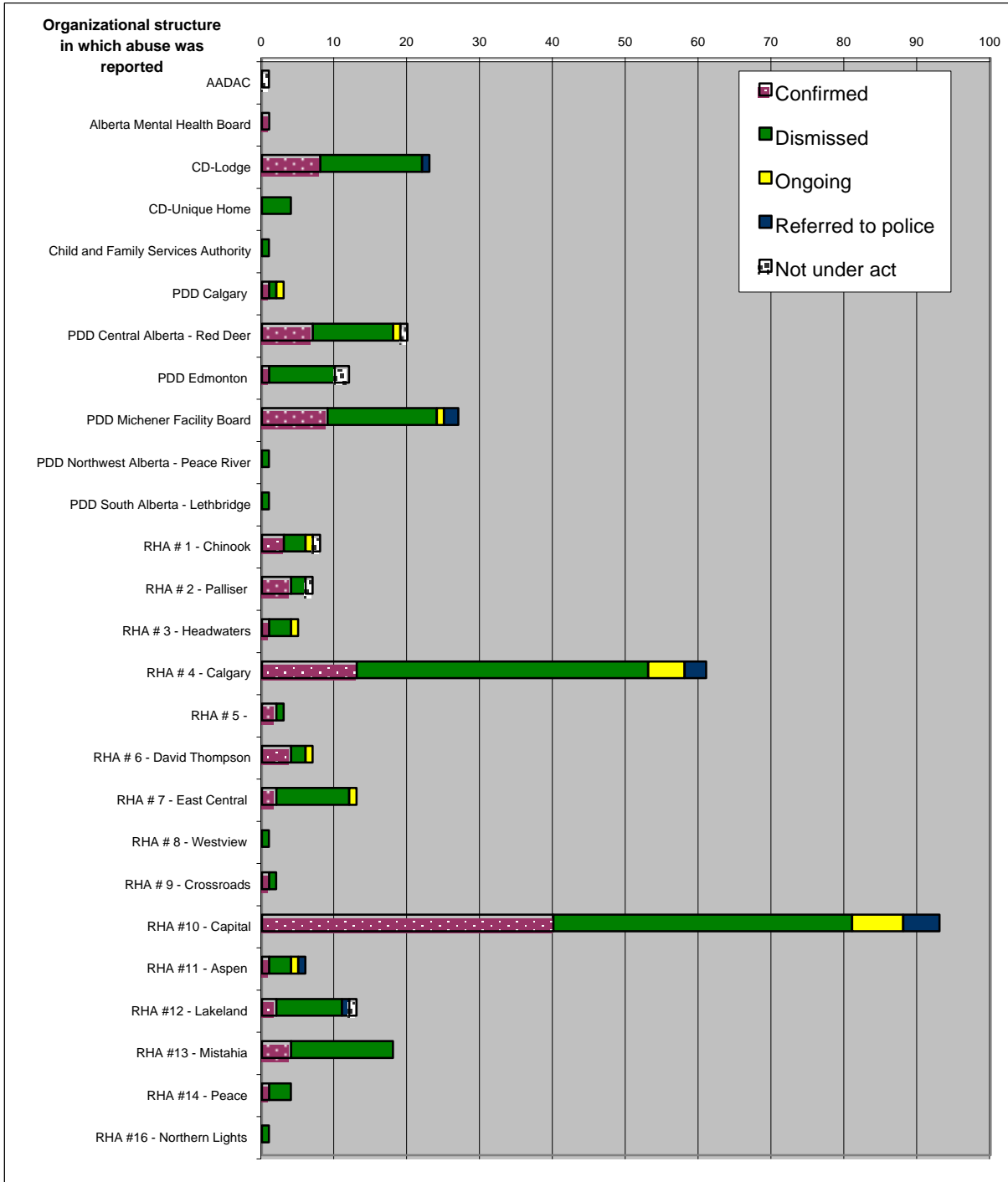


Figure 4

PERCENTAGE OF INVESTIGATIONS BY GOVERNING STRUCTURE

(Based on the number of reports received for the specific governing structure per regional area in 2000 – 2001)

PERSONS WITH DEVELOPMENTAL DISABILITIES BOARDS

Organizational Structure	# of Reports	Abuse confirmed	Dismissed	Ongoing
PDD Calgary	5	20.0%	20.0%	60.0%
PDD Central Alberta	24	29.2%	54.2%	12.5%
PDD Edmonton	18	5.6%	62.2%	16.7%
PDD Michener Facility Board	38	23.7%	44.7%	26.3%
PDD Northeast Alberta*	1	0.0%	0.0%	100.0%
PDD Northwest Alberta	5	0.0%	100.0%	0.0%
PDD South Alberta	7	0.0%	20.0%	80.0%
PDD Provincially	98	20.2%	45.9%	30.6%

The sum of the percentages do not add to 100% as some files have been referred to the police or are not under the Act

*Percentages based on 1-2 reports only

REGIONAL HEALTH AUTHORITIES

	# of Reports	Abuse confirmed	Dismissed	Ongoing
RHA # 1 - Chinook	16	18.8%	31.3%	43.8%
RHA # 2 - Palliser	8	50.0%	25.0%	12.8%
RHA # 3 - Headwaters	8	37.5%	37.5%	25.0%
RHA # 4 - Calgary	84	15.5%	48.8%	29.8%
RHA # 5 - Health Authority 5	5	40.0%	40.0%	20.0%
RHA # 6 - David Thompson	11	36.4%	18.2%	45.5%
RHA # 7 - East Central	14	14.3%	71.4%	14.3%
RHA # 8 – Westview*	1	0.0%	100.0%	0.0%
RHA # 9 – Crossroads*	2	50.0%	50.0%	0.0%
RHA #10 - Capital	130	30.8%	32.3%	33.1%
RHA #11 - Aspen	13	7.7%	23.1%	61.5%
RHA #12 - Lakeland	17	11.8%	52.9%	23.5%
RHA #13 - Mistahia	21	19.1%	66.7%	14.3%
RHA #14 - Peace	13	7.7%	23.1%	69.2%
RHA #15 – Keeweenok Lakes	4	0.0%	0.0%	100.0%
RHA #16 - Northern Lights*	1	0.0%	100.0%	0.0%
RHA #17 - Northwestern	0	N/A	N/A	N/A
RHA Provincially	348	23.0%	39.9%	31.6%

The sum of the percentages do not add to 100% as some files have been referred to the police or are not under the Act

*Percentages based on 1-2 reports only

LODGES FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Abuse Confirmed	Dismissed	Ongoing
Lodge Foundations	32	25.0%	53.1%	15.6%
Unique Homes	4	0.0%	100.0%	0.0%
Provincially	36	22.2%	58.5%	13.9%

The sum of the percentages do not add to 100% as some files have been referred to the police or are not under the Act

OTHERS:

Organizational Structure	# of Reports	Abuse Confirmed	Dismissed	Ongoing
AADAC	6	33.3%	33.3%	16.7%
AMHB	5	20.0%	20.0%	60.0%
CFSA's	6	0.0%	16.7%	83.3%

The sum of the percentages do not add to 100% as some files have been referred to the police or are not under the Act

PROTECTION FOR PERSONS IN CARE

PART III

CASE SUMMARIES

CASE SUMMARIES:

The following are four reports, which were investigated by contracted investigators:

Case A: Type of alleged abuse: intentionally causing bodily harm
Agency: continuing care centre
Alleged abuser: service provider (Nursing Attendant)

The alleged incident occurred during evening rounds. The nursing attendant (NA) was required to change incontinent residents who are heavy wetters and require changes during the night. During the incident, the NA was turning the resident, who grabbed and scratched the NA's arm and swore at him. The NA slapped the resident's hand. The resident sustained a small skin laceration from the incident.

The findings were that the incident was witnessed and evidence confirmed that the resident was startled at being awakened and began waving her arms in the air. The NA said that he had slapped the resident hard, due to being tired as he worked an extra shift and the day-to-day frustrations that he faced in his role as a NA. In any other job, he would not have to put up with daily abuse from residents. He was remorseful about the incident and realizes the incident should never have happened.

The Investigator did not dismiss the allegation as the NA has the knowledge and experience to know the incident should never have happened and that the resident would have been harmed by his actions. The NA's actions were purposeful. There were no scratch marks or any observable sign of injury to the NA's arm following the incident. As the NA is a casual employee, the Supervisor responsible for supervising and evaluating him is not necessarily the one on the unit where he is scheduled to work. The NA was disciplined and was required to attend an educational session on dementia.

The incident was not reported directly to the reporting line by the person who had reasonable and probable grounds to believe abuse had happened.

The Investigator recommended that the facility:

- Continue to be committed to facilitating undisturbed sleep for each resident and ensure staff are aware and are implementing their newly developed guidelines.
- Review how they can reduce nighttime waking of severely impaired residents by exploring the use of incontinent products that provide overnight protection and relief to residents who have been identified as "heavy wetters".
- Review the supervision of casual employees, as this casual employee had not received a performance appraisal since his start date many years earlier.
- Provide a leadership role and provide initiatives to staff to participate in workshops that would provide a supportive structure and increases staff's knowledge of working with dementia patients.
- Review the *PPC Act* and its mandatory reporting with all staff.

The facility response to the recommendations included the use of new absorbent products to eliminate the nighttime practice of changing the clients and in-service training to the NA.

Case B: Type of alleged abuse: intentionally causing bodily harm
Agency: PDD facility
Alleged abuser: another client

All of the clients in the group home were having supper. Client 1, the alleged abuser, was the first to finish supper and took his dishes from the dining room table into the kitchen to put them in the dishwasher. Client 1 then turned on the television in the living room (open area at the end of the dining area). Witness 1 stated that Client 1 sauntered back to the dining area and without warning “grabbed Client 2’s (alleged victim) left arm, lifted it in a twisted manner...then scratched Client 2’s left inside of his arm leaving it reddened and with open scratch areas”. Client 2 complained of his arm being sore for 2 to 3 hours.

While the client did experience physical harm, there was no evidence of intent to cause physical harm as Client 2 put his hand out for a “high five” from Client 1 as he passed. Client 1 would sometimes say ‘no’ to the high five, but this time he grabbed and pinched the arm of Client 2, which resulted in scratches and soreness. Client 1 has no previous history of violent behaviour towards other clients or staff. Client 1 has difficulty in expressing himself verbally when frustrated or angry and usually his injurious behaviour is directed towards himself.

The following recommendations were made to the agency:

- Be commended for taking steps to assist Client 1 to identify stressors and learn more appropriate ways of expressing himself and managing his frustration and anger.
- Have Client 1’s legal guardian and foster family be more involved with this process and be encouraged to provide input that will enable them to be more a part of the “team”.
- Have the PDD Community Board consultant continue to be involved in supporting this client and staff through ongoing communication with the agency staff.
- Have the PDD Community Board provide an in-service to assist staff in understanding and managing a client with limited communication, and who is self-injurious as a way of expressing himself.

To date the facility has not provided their 90-day response to the recommendations.

Case C: Type of alleged abuse: intentionally causing emotional harm
Agency: Lodge
Alleged abuser: Lodge service providers

The alleged incident related to husband and wife clients, who recently moved into a lodge, regarding the management of the facility intruding into the private lives of the clients. It was alleged that on several occasions, staff had entered their room “without permission”. The clients felt this was an “invasion of privacy” and suffered emotional upset on each occasion.

The incident stemmed from the clients being away all day from the facility. They did not sign out nor upon their return to the facility, sign in. The facility policy requires staff to check on clients if they are not heard from. These policies are in effect in case of emergencies and the need to know where clients are. This information is part of the terms of the tenancy agreement signed by clients.

The complaint was dismissed as there was no evidence of intentionally causing emotional harm. The clients had not kept the Lodge personnel aware of their whereabouts as required by the Lodge rules.

They did not understand the importance of the Lodge staff knowing where residents are in case of an emergency, and the importance of signing in and out of the facility.

The Lodge has an advanced communication system that is used between staff and clients. It also has a television channel to promote activities and to relay information. The communication system was adapted to the television programming to remind clients of the importance of signing in and out of the facility.

Although the report was dismissed, the following recommendations were made to the facility:

- Ensure all new clients fully understand the terms of the tenancy agreement and the reasons why it is important to sign in and out of the facility.
- Have emergency numbers available for reaching the supervisor after hours.

The agency's response to this investigation is that it now makes available an easy to follow handbook for clients that is reviewed upon move in with new clients.

Case D: Type of alleged abuse: intentionally failing to provide the basic necessities of life
Agency: PDD setting
Alleged abuser: service provider (Rehabilitation Care Worker)

The alleged incident was that while on an outing to a recreation facility in an unfamiliar city, the RCW left the client unattended at the entrance of the recreation facility for approximately 40 minutes. The client has poor eyesight and was in completely unfamiliar environment. The possibility was great that the client could wander away from the recreation facility and become disoriented, lost or could have come to harm. The RCW provider did not adequately ensure that another trained staff person was prepared to supervise the client in her absence.

The findings were that the client was uncomfortable being inside the recreation facility and wanted to stay by the buses in the parking lot; however, due to the rain, she could not. The service provider wanted to partake in the activities within the facility and did not want to stay with the client. The service provider admitted to leaving the client unattended at the recreation facility for a significant period of time, and did not adequately ensure that another trained staff person was prepared to supervise the client in her absence.

The agency took disciplinary action against the RCW. The RCW remains the client's key worker.

There were no recommendations to the facility.

PROTECTION FOR PERSONS IN CARE

PART IV

ADMINISTRATION

ADMINISTRATION

STATUS OF FILES:

- There are 20 files from the first, second and third quarters that remain ongoing.
- From the first quarter, one file remains open and is under investigation by the Alberta Association of Registered Nurses.
- From the second quarter, seven files remain open, of which six are under investigation by the professional colleges and one file by the police.
- From the third quarter, three files are under investigation by the professional colleges, two files by police and seven files under investigation by a contracted investigator.

ADMINISTRATIVE CHANGES:

- The Protection for Persons in Care remains a program of Alberta Community Development after the government reorganization in mid March. The Honourable Gene Zwozdesky is the Minister and the Deputy Minister is William Byrne. The PPC Branch is part of the Community Support Systems Division with David Steeves as Assistant Deputy Minister.
- Sandra Plupek has joined the PPC Branch as a Senior Investigation Coordinator on April 1, 2001. Sandra was previously with Alberta Human Resources and Employment, Office of the Public Guardian. Her responsibilities include coordinating investigations for reports from PDD facilities, women shelters, mental health group and approved homes and AADAC and the review of the *Protection for Persons in Care Act*.

OTHER:

- Several reporters this quarter chose to submit reports by faxing in the completed form. The alleged abuse reporting form is now available on Community Development's new web site at www.cd.gov.ab.ca. The form can be printed, completed and returned to Protection for Persons in Care by faxing to **(780) 415-8611 (New Number)** or by mailing to Box 3100, Edmonton, Alberta, T5J 4W3. The form was made available in an effort to decrease the amount of time it takes individuals to report an allegation of abuse. Upon receipt of the report, the reporter will be contacted by phone to confirm that the report has been received and to provide the reporter with a file number and the name of the investigator. Anonymous reports will not be accepted.
- More brochures and a new smaller poster can be ordered free of charge by calling the reporting line at 1-888-357-9339. First, Second and Third Quarterly Reports and PPC Bulletins #s 1 - 6 are available through the website listed above.
- Copies of the *Act* or videos can be obtained through the Queen's Printer, telephone 310-0000 and ask for 427-4952, Edmonton or 297-6251, Calgary.
- Of interest, Manitoba's *Protection for Persons in Care Act*, similar to Alberta's legislation, has come into force on May 1, 2001.

Contact: Edith Baraniecki, Director, Protection for Persons in Care

Phone (780) 427-0552 or **Fax (780) 415-8611** or email at edith.baraniecki@gov.ab.ca