

Protection for Persons in Care

Quarterly Report

April 1, 2001 – June 30, 2001



Protection for  
Persons in Care

**A PROGRAM OF**

**ALBERTA  
COMMUNITY  
DEVELOPMENT**

**PROTECTION FOR PERSONS IN CARE**

**PART I**

**REPORTED ALLEGATIONS**

**APRIL 1, 2001 – JUNE 30, 2001**

# PROTECTION FOR PERSONS IN CARE

## BACKGROUND

This is the first quarterly report for the 2001-2002 fiscal year. In this report the facilities and agencies are reported according to the government reorganization that took place in mid March, 2001. Alberta Health and Wellness (H&W) includes: hospitals, nursing homes, mental health approved and group homes, personal care homes and AADAC facilities; Community Development (CD) includes: Michener Centre and Persons with Developmental Disabilities agencies; Human Resources and Employment (HR&E) includes: hostels, emergency shelters and transitional homes; Children's Services (CS) includes: women's shelters, youth shelters (18 years and over) and Seniors includes: lodges, and unique homes.

## REPORTED ALLEGATIONS: First Quarter 2001 - 2002 (April 1-June 30, 2001)

### NUMBER OF REPORTS:

- During this quarter, 125 reports were received. The number of reports this quarter has decreased slightly from the last quarter.
- 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.

Agency/Ministry Responsibility	First Quarter	%
Regional Health Authorities/ H&W	83	66.4%
Persons with Developmental Disabilities/CD	27	21.6%
AADAC/H&W	4	3.2%
Alberta Mental Health Board /H&W	0	0.0%
Management Bodies/Seniors	7	5.6%
Children and Family Services Authorities/CS	4	3.2%
Total	125	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	First Quarter	%
Physical	38	22.5%
Emotional	77	45.6%
Inappropriate medications	1	0.6%
Sexual	7	4.1%
Financial	5	3.0%
Neglect	41	24.2%

See figure 2 for individual breakdown by organizational structure

## ALLEGED ABUSERS:

There is a decrease in the percentage of cases where the service provider has been considered as the alleged abuser. However, there were fewer reports this quarter than the past one. Client to client abuse allegations have remained constant.

Alleged Abuser	First Quarter	%
Service Provider	96	76.8%
Client	18	14.4%
Other	2	1.6%
Family	9	7.2%
Total	125	100%

See figure 3 for further breakdown by organizational structure

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

## INVESTIGATORS:

In this 1st quarter of 2001-2002, contracted investigators conducted approximately 90% of the investigations, 8% were conducted by a professional college and 2% by a police service.

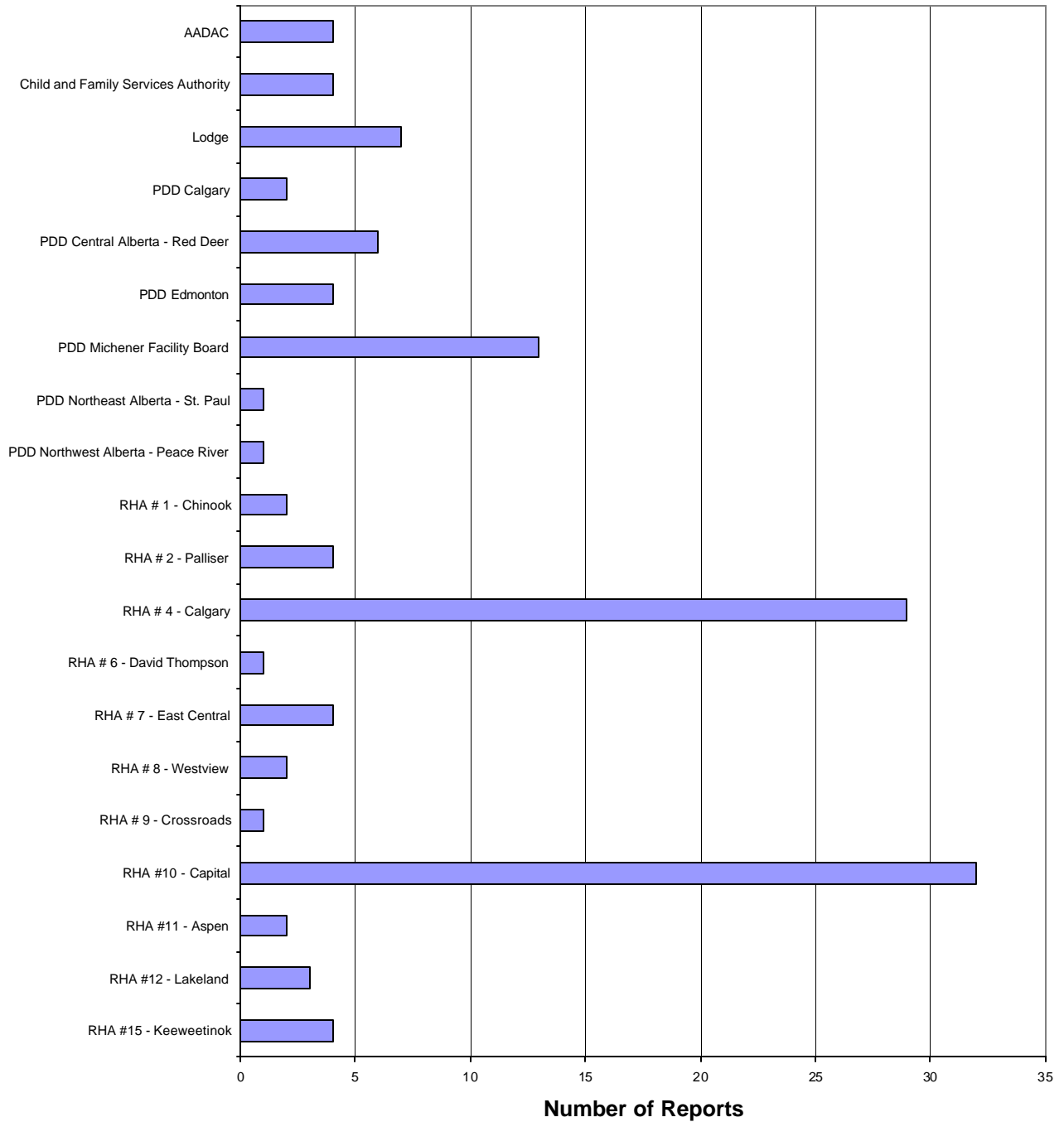
Investigator	First Quarter	%
Contracted Investigators	116	90.0%
Professional Colleges:	10	7.7%
-AARN (RNs)	8	
-CLPN (LPNs)	2	
-CPS (Physicians)	0	
-Other	0	
Police	3	2.3%
Other bodies (MHPAO)	0	0%
Total	**129	100%

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

Part I Attachments:      Summary of Reported PPC cases 2001-2002  
                                    Figure 1 – Number of reports  
                                    Figure 2 – Types of alleged abuse  
                                    Figure 3 – Categories of alleged abusers  
                                    Reported Allegations by Governing Structure Prorated

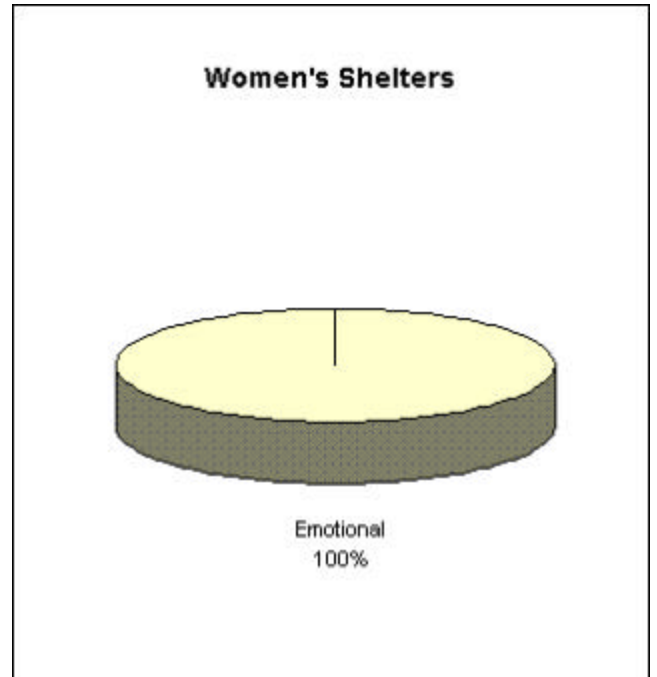
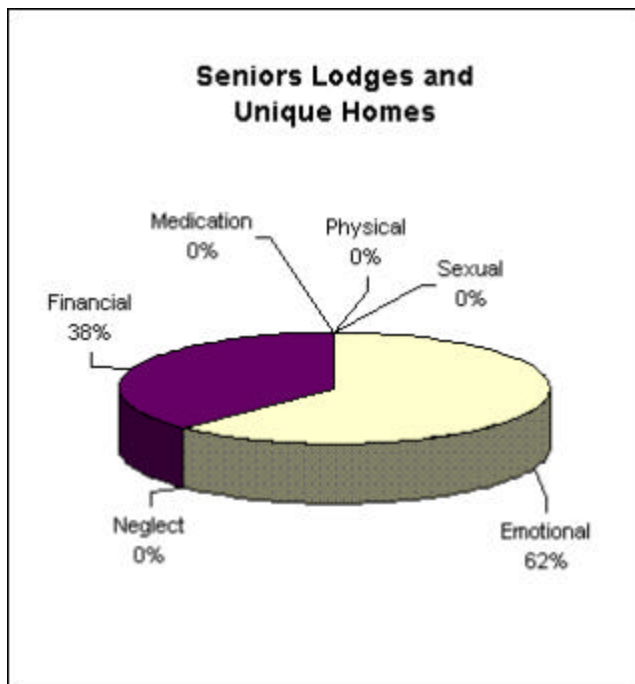
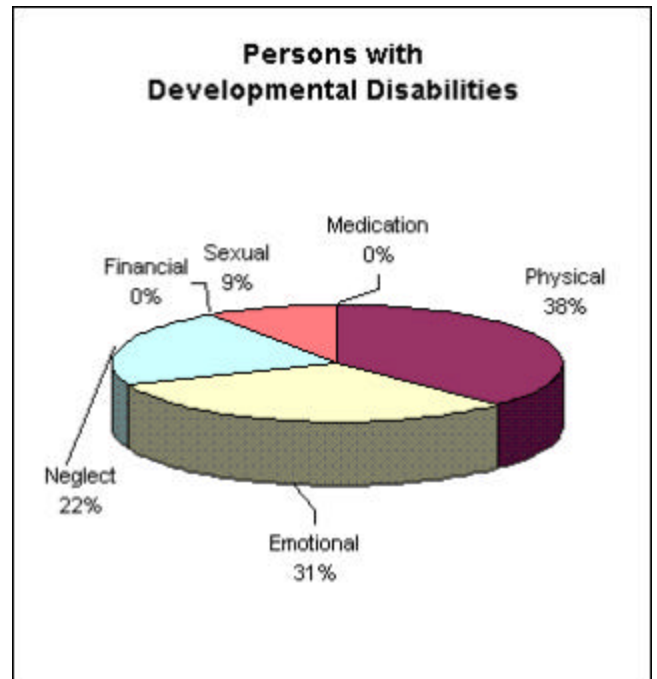
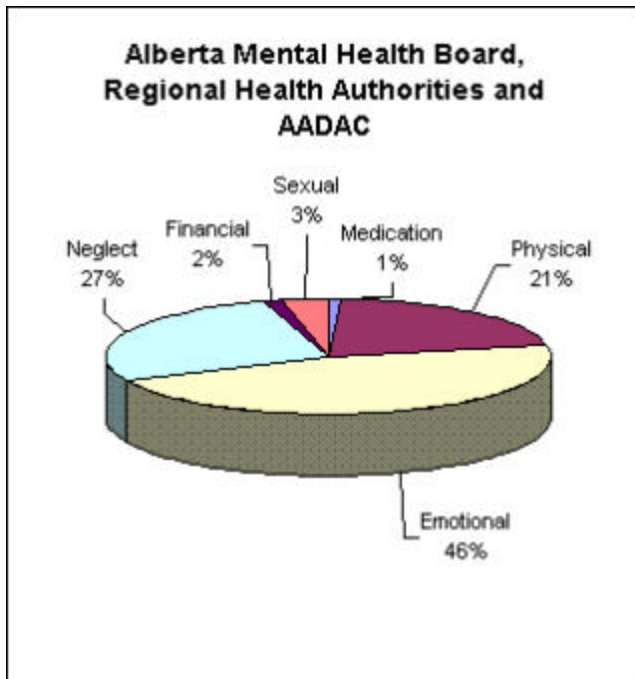
# Protection for Persons in Care Number of Reports

April 1, 2001 - June 30, 2001 (3 months)



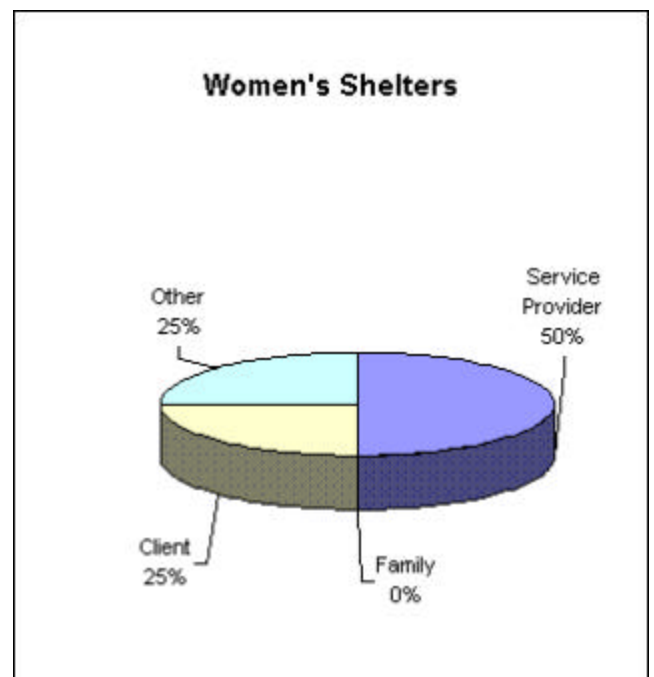
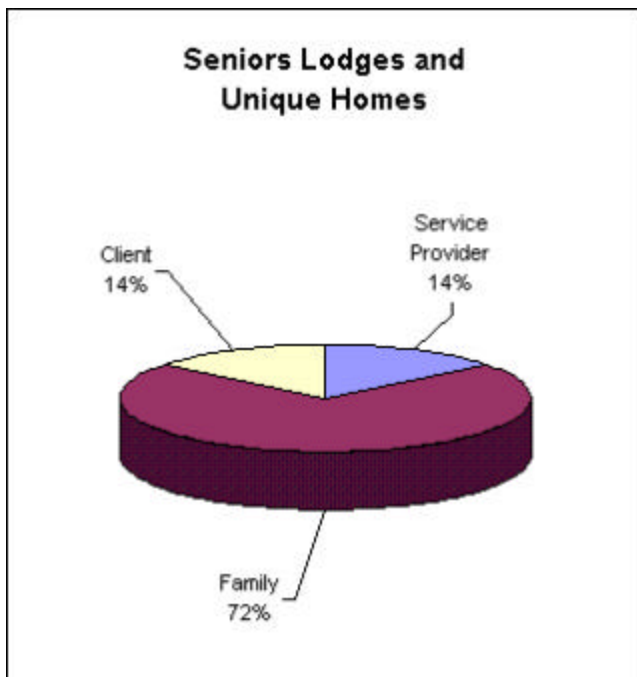
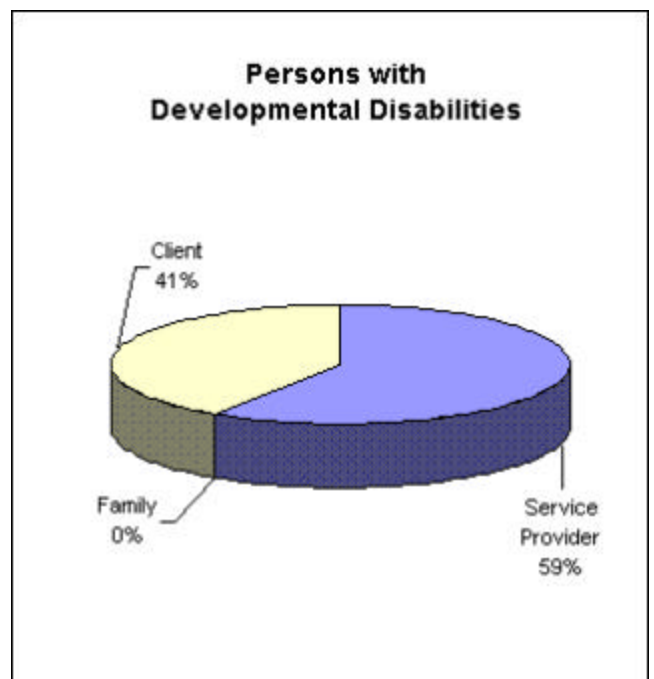
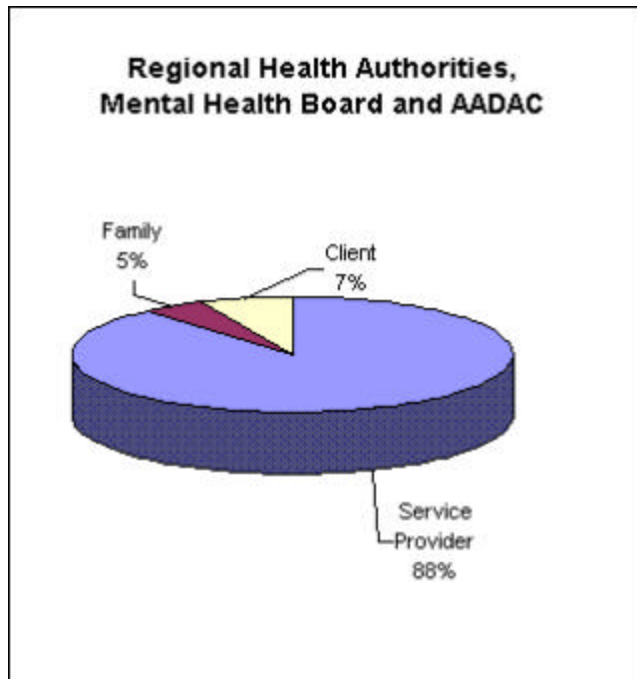
## Protection for Persons in Care

**Types of Alleged Abuse by Organizational Structure**  
**April 1, 2001 - June 30, 2001 (3 months)**



**Human Resources and Employment: 0 Reports**

**Protection for Persons in Care  
 Categories of Alleged Abusers by Organizational Structure  
 April 1, 2001 - June 30, 2001 (3 Months)**



**Human Resources and Employment: 0 Reports**

## **REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRO-RATED: APRIL 1, 2001 – June 30, 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 Community Board pro-rated per 1,000 clients served\*

PDD Community Boards	Reports
PDD Calgary	1
PDD Central Alberta - Red Deer	5
PDD Edmonton	2
PDD Northeast - St. Paul	2
PDD Northwest Alberta - Peace River	2
PDD South Alberta - Lethbridge	0

\*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 13 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	2
RHA # 2 - Palliser	6
RHA # 3 - Headwaters	0
RHA # 4 - Calgary	4
RHA # 5 - Health Authority 5	0
RHA # 6 - David Thompson	1
RHA # 7 - East Central	5
RHA # 8 - Westview	3
RHA # 9 - Crossroads	4
RHA #10 - Capital	5
RHA #11 - Aspen	4
RHA #12 - Lakeland	4
RHA #13 - Mistahia	0
RHA #14 - Peace	0
RHA #15 – Keeweenok Lakes	25
RHA #16 - Northern Lights	0
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**

The number of reports from lodge foundations and unique homes are too small to formulate any projections.

## **OTHERS:**

The number of 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, 2000 – MARCH 31, 2001**

\* Recommendations from investigations in the quarter April 1, 2001-June 30, 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, Third and Fourth Quarter 2000 – 2001**  
**(April 1, 2000 - March 31, 2001)**

- Of the 499 cases reported during this twelve-month period, 479 files are closed. There are 20 reports still under investigation. The contracted investigators are investigating nine of the reports, the police five of the reports and the Alberta Association of Registered Nurses six of the reports.
- Of the 479 closed files, 65.5% were dismissed, 28.1% were confirmed as abuse having occurred, 4.1% were referred to the police and 2.0% were determined to be not under the *Act*.

Organization	Dismissed	Confirmed	Ongoing	Not under the Act	Referred to Police	Total
RHA	219	96	17	6	12	350
PDD	60	26	1	3	6	96
AADAC	2	3	0	1	0	6
AMHB	2	1	2	0	0	5
Lodges	26	8	0	0	2	36
Children's Services	5	1	0	0	0	6
<b>TOTAL</b>	<b>314</b>	<b>135</b>	<b>20</b>	<b>10</b>	<b>20</b>	<b>499</b>

See figure 4 for further breakdown by organizational structure

**INVESTIGATION RESULTS FOR FILES CLOSED THIS QUARTER:**

**COMMON RECOMMENDATIONS:**

- There were consistent recommendations this past quarter regarding the need for staff training around policies, procedures and practice issues, such as:
  - Provide inservice to all staff on the care of a resident with behaviours that are considered difficult and demanding. Information about palliative care and relieving resident anxiety should also be included.
  - Review with all staff on what constitutes abuse and the policy on abuse, which is in place in the facility. It is imperative that staff clearly understands that abuse in any form will not be tolerated.
  - Provide inservice training on the *Act* to all staff once a year and include this training as a part of the orientation for new staff and volunteers. Staff should be comfortable with their ability to recognize abuse and with their reporting responsibilities to the reporting line.
  - Owner/operator considers providing critical incident debriefing exercises for staff and residents where appropriate following the occurrence of emotionally and physically aggressive incidents.
  - Training for all those involved with residents, including volunteers, to enhance their understanding of the disease process regarding dementias and related conditions and to assist them in the performance of their duties.
- There were more recommendations this quarter related to the need for adequate and consistent documentation, such as:
  - Staff read client files on a consistent basis to familiarize themselves with the needs of the client including any mechanical supports used to ensure safety.

- Consider notifying families in writing of any warnings given to a resident regarding the possibility of eviction as families are usually responsible for finding new accommodations.

Other recommendations to facilities have been:

- Review the overall process for determining suitability and compatibility of roommates.
- Proceed with its behavior mapping of the resident.
- Continue to assess the resident to determine when care needs change in the future and a higher level of care is required.
- Review the placement of the alleged abuser and consider the feasibility of scheduling additional staff, monitoring the client activities in the home, monitoring client interaction between these two clients, complete a Risk Assessment in consultation with the Public Guardian, medical personnel and facility staff.
- Closely monitor the practice of the alleged abuser until satisfied that his/her interpersonal communication difficulties have been addressed to their satisfaction. This monitoring could include periodic interviews with current clients. Process should be documented.

### **RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:**

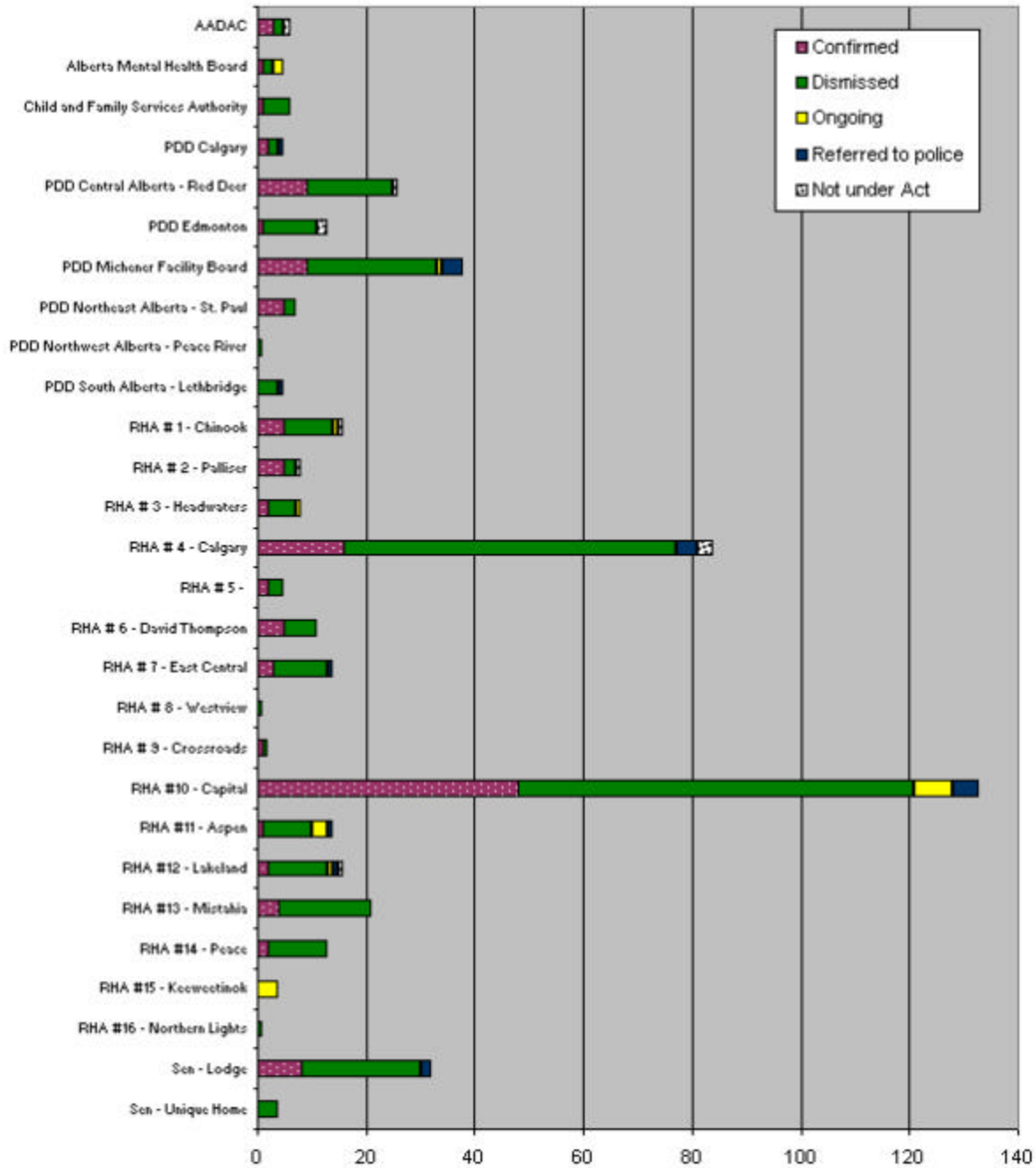
In 28 reports, involving staff as the alleged abuser, the facility took disciplinary action before the contracted investigator started or completed the investigation. Action taken included: staff resignations, suspensions of various lengths without and with pay, written and or verbal reprimands and reassignments. There were 10 staff terminations.

### **EXAMPLES OF FACILITY RESPONSES TO RECOMMENDATIONS:**

- “An educational program for our staff that will assist them with understanding caregiver stress, and to help them deal with relationship issues when elder abuse is suspected. In addition we have incorporated a process for staff to openly share their feelings when these types of situations arise.”
- “Clinical educator for psychiatry gave an inservice on sexually disinhibited behaviors of patients and how to provide care and safety for these individuals. Reference articles were provided to the manager to help develop an individualized plan of care in the event that another patient with similar needs were to be admitted to the unit.”
- “All companions hired by the family will now have to go through a screening process on entering the facility as outlined in the previous policy. Follow-up with other team leaders, team members and the family to assess the companion care and the emotional and physical safely needs of the resident is continued throughout the time the companion is in the facility.”
- “The Region has implemented an expanded orientation/education session for all new personnel and annually thereafter for all staff to include Protection for Persons in Care, Resident Abuse Policy/Procedure and the resident’s right to choose and to be treated with respect and dignity.”
- “The Region has a policy that annual performance appraisals will be completed on all staff members. The manager has been encouraged to complete these on a timely basis, particularly for the personal support aides.”
- “The agency is in the process of revising the policies and procedures manual including the abuse policy. The intent is to ensure all policies reflect the most up to date policy and will make this revision.”

## Protection for Persons in Care Report Outcomes April 1, 2000 - March 31, 2001 (12 months)

### Organizational structure in which abuse was reported



## PERCENTAGE OF INVESTIGATIONS BY GOVERNING STRUCTURE

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

*Please note: The sum of the percentages do not add to 100% as some files have been referred to the police or upon preliminary review, it was determined that the complaint was not within the jurisdiction of the Act for such reasons as the facility is not under the Act, the same reporter has already reported the incident and it was previously investigated, or already reported to a professional association or the police.*

## PERSONS WITH DEVELOPMENTAL DISABILITIES BOARDS

Organizational Structure	# of Reports	Abuse confirmed	Dismissed	Ongoing
PDD Calgary	5	40.0%	40.0%	0.0%
PDD Central Alberta	26	34.7%	62.0%	0.0%
PDD Edmonton	14	7.1%	79.0%	0.0%
PDD Michener Facility Board	38	24.0%	63.2%	2.6%
PDD Northeast Alberta	7	71.4%	29.0%	0.0%
PDD Northwest Alberta	1	0.0%	100.0%	0.0%
PDD South Alberta	5	0.0%	80.0%	0.0%
PDD Provincially	96	27.13%	62.5%	1.0%

## REGIONAL HEALTH AUTHORITIES

	# of Reports	Abuse confirmed	Dismissed	Ongoing
RHA # 1 - Chinook	16	31.3%	56.3%	6.3%
RHA # 2 - Palliser	8	62.5%	25.0%	0.0%
RHA # 3 - Headwaters	8	25.0%	62.5%	12.5%
RHA # 4 - Calgary	84	19.1%	72.6%	0.0%
RHA # 5 - Health Authority 5	5	40.0%	60.0%	0.0%
RHA # 6 - David Thompson	11	45.5%	54.5%	0.0%
RHA # 7 - East Central	14	21.4%	71.4%	0.0%
RHA # 8 – Westview*	1	0.0%	100.0%	0.0%
RHA # 9 – Crossroads*	2	50.0%	50.0%	0.0%
RHA #10 - Capital	132	36.1%	54.9%	5.26%
RHA #11 - Aspen	14	7.1%	64.3%	21.4%
RHA #12 - Lakeland	16	12.5%	68.6%	6.3%
RHA #13 - Mistahia	21	19.0%	81.0%	0.0%
RHA #14 - Peace	13	15.4%	85.0%	0.0%
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	350	27.4%	63.0%	4.84%

\*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%	69.0%	0.0%
Unique Homes	4	0.0%	100.0%	0.0%
Provincially	36	22.2%	72.2%	0.0%

## OTHERS:

Organizational Structure	# of Reports	Abuse Confirmed	Dismissed	Ongoing
AADAC	6	50.0%	33.3%	0.0%
AMHB	5	20.0%	40.0%	40.0%
CFSA's	6	16.7%	83.3%	0.0%

**PROTECTION FOR PERSONS IN CARE**

**PART III**

**CASE SUMMARIES**

## CASE SUMMARIES

The following are three reports, which were investigated by contracted investigators. These reports are representative of the types of reports and facilities investigated under the *Protection for Persons in Care Act*:

**Case A:**        **Type of alleged abuse: intentionally administrating or prescribing medication for an inappropriate purpose and intentionally causing emotional harm**  
**Agency: a continuing care centre**  
**Alleged abuser: service provider (Agency)**

The alleged victim was moved from a continuing care center located in one municipality to another continuing care center in another municipality. A witness reported that since relocating to the new location the alleged victim's health had deteriorated because she was socially isolated from some of her family and because she was being overmedicated.

### **Investigator's Findings**

The move to the new location has limited the visits by the family and her pastor in the former location but the new location has allowed other family members to visit more often. In addition, the pastor from the facility is visiting the alleged victim.

The alleged victim is able to move around independently when her wheelchair brakes are not applied. She is not able to apply or remove the brakes herself. Therefore when the brakes are applied, this is a form of restraint. This method of restraint has the potential to limit her social interaction with others. The alleged victim, however, often expresses the desire to be in her room.

The witness was concerned that the alleged victim is over medicated but based the concern on incomplete and somewhat incorrect information. The resident was receiving more medication at the former location than the witness knew about. The alleged victim has some chronic, ongoing health problems that require medication. On admission to the new facility, the physician and the facility have done a complete review of the medications prescribed for the alleged victim and in fact, have reduced the number of medications she is receiving.

The investigator was not able to find sufficient evidence to support the abuse of emotional harm related to the resident being socially isolated. The report of abuse regarding administration and prescription of medication for an inappropriate purpose was unfounded.

### **Investigator Recommendations to the Facility:**

- Advise the resident's family of any assistance they can provide to help them in resolving differences regarding the resident's care.
- Arrange a resident and family conference to discuss the resident's care needs and to include both the resident and her family in making care decisions in the best interests of the resident. The resident's difficult adjustment in moving to the facility should be considered when deciding whether or not to move her again.
- Advise staff that the application of the resident's wheelchair brakes constitutes a form of restraint if she is unable to adjust the brakes independently.

- Have a physio or occupational therapist assess the resident's wheelchair to determine if it could be modified to allow the resident to apply and remove the brakes by herself.
- Work together, with the resident's family, to ensure that the resident has a representative who can make legal decisions on her behalf.

The facility response to the recommendations included information on the "family conference being held and the discussion of care needs of the resident, adjustments to relocation, family discussions and counseling and guardianship. The facility has done an assessment of the resident's ability to use the brakes of the wheelchair and the wheelchair was modified. The facility staff have been reminded that having the wheelchair brakes on does constitute a type of restriction and should be used as safety devices for safety reasons-not restraint."

**Case B:           Type of alleged abuse: subjecting to non-consensual sexual contact, activity or behavior**  
**Agency: a PDD contracted facility**  
**Alleged abuser: another client**

The alleged incident occurred when two clients from the facility were working at an off site job. During the course of completing the janitorial tasks assigned to the workforce, the alleged abuser made sexual comments to the alleged victim. The alleged victim stated "No". Later the alleged abuser continued to make sexual comments to the alleged victim. The victim also said a previous incident happened the week before when the alleged abuser made inappropriate sexual actions towards her.

Currently the alleged victim is not working with the alleged abuser. She is working in the food services area of the facility. She had requested that she work there before the incidents occurred.

### **Investigator's Findings**

During the investigation it was found that the alleged abuser has a history of making inappropriate comments of a sexual nature to female staff members, female clients and female workers at the job site. There have been many strategies developed during the past four years to try and curtail or eliminate the behavior of the alleged abuser. They have not been successful.

The alleged abuser admitted that he recognized his comments were inappropriate and that they upset the alleged victim, but indicated that he was just joking when he made the comments and action.

The investigator concluded that the alleged victim was subjected to unwanted sexual comments, harassment, and non-consensual sexual contact by the abuser as stated by the alleged victim and admitted by the alleged abuser. It is unclear whether the alleged abuser is cognitively aware of the offensive nature of his behavior; however, the alleged abuser is aware that staff members and peers asked him to cease the offensive behavior, but he chose to continue against their wishes.

### **Investigator Recommendations to the Facility**

- Consider referring the male client for an in-depth evaluation which might provide insight into his level of understanding, self-awareness and retention that could be reasonably expected of him and to determine possible organic causes for this behavior.
- Consider referring the male client for an assessment to determine if he would benefit from the appointment of a guardian.

- All staff who work with the male client should be advised that his behavior should not be tolerated as it is abusive to females, could potentially be dangerous to himself, and that staff need to be vigilant to ensure that all clients are protected.
- Consider developing routine, consistent responses to the behavior of the male client, which may include teaching him to stop when directed to do so.
- If, after further interventions, the behavior persists, the facility should consider consulting with a male member of the police service to impress upon the male client the seriousness of his behavior and potential consequences of his actions.
- Over time, if there is no change in the behavior of the male client, the facility should consider changing his daily routine to limit his contact with female clients. If his behavior continues unabated, review the necessity of exploring an alternate placement for the male client.

The 90-day response to the recommendations is not yet due.

**Case C:           Type of alleged abuse: intentionally causing emotional harm**  
**Agency: a Women’s Shelter**  
**Alleged abuser: Women’s Shelter service provider**

### **Investigator’s Findings**

The alleged incident involves three reports of intentionally causing emotional abuse over a period of approximately three weeks. The alleged victim, who was accepted to the facility the evening before, went to the designated smoking room.

The alleged abuser, a casual crisis worker, was in the room. The two had never met before. Over the next two hours the alleged abuser talked continuously to the alleged victim, disclosing her own personal circumstance and those of others she had worked with in the past.

A few days later the same casual crisis worker allegedly told the alleged victim, who had just returned from a meeting with her husband, that she had made a bet that the alleged victim was going to remain with her husband and not come back to the shelter.

The third allegation of emotional abuse revolved around the casual crisis worker telling the alleged victim she was a lousy, greasy cook, questioned why the alleged victim would want to work in the place she was working at and used inappropriate language with the alleged client.

The investigator found the first incident of emotional abuse to be founded, the second incident to be unfounded and third incident to be unfounded because the evidence was insufficient.

### **Investigator Recommendations the Facility**

- Take disciplinary action against the employee.
- Consider establishing guidelines that define an acceptable level of personal disclosure by employees, outline circumstances in which minimal personal disclosure may be warranted and

supportive, and outline circumstances when personal disclosures may be detrimental or counterproductive to the client.

- Consider developing policy related to the use of personal disclosures by employees and potential disciplinary action if an employee exceeds the level that has been defined as acceptable in the guidelines.
- Consider amending the job description of casual employees to reflect a passive supportive and encouraging role with clients to minimize conflicting or counterproductive advice arising from lack of knowledge of the client and lack of possible follow up. Promote that it is the role of full-time employees who have established relationships and have knowledge of the client's needs and problems, provided direction, support and consistent follow-up to clients.
- That all staff receive on-going education and training to ensure that their skills and competencies are of a professional level.
- All staff should conduct themselves professionally and limit personal conversations and discussions while in the presence of clients.

The 90-day response to the recommendations is not yet due.

**PROTECTION FOR PERSONS IN CARE**

**PART IV**

**ADMINISTRATION**

## **ADMINISTRATION OF THE ACT**

### **STATUS OF FILES (2000-2001):**

- There are 20 files that remain ongoing from the first four quarters.
- From the second quarter, one file remains open and under the investigation by the Alberta Association of Registered Nurses and two files by the police.
- From the third quarter, three files remain open and under the investigation of the police.
- From the fourth quarter, nine files remain open and under the investigation by a contracted investigator and five files by the Alberta Association of Registered Nurses.

### **REPORTERS:**

For the first quarter of the new fiscal year 2001-2002, the 125 reports were made by: service providers-management (41), service providers-non-management (45), alleged victim (9), family members (21) and others (9).

### **ADMINISTRATION:**

- The Protection for Persons in Care Quarterly Reports will continue to be printed on a quarterly basis. The report is distributed to provincial government MLAs, Ministries of Health and Wellness, Seniors, Children's Services, Human Resources and Employment and Justice, operators of care facilities such as Provincial Boards, Regional Health Authorities, Persons with Developmental Disabilities Community Boards, the Alberta Alcohol and Drug Abuse Commission, Child and Family Services Authority Boards, Housing Foundations, health professional associations, all hospitals and nursing homes and others who have expressed an interest in the area. Other interested groups can be placed on the mailing list by calling the reporting line at 1-888-357-9339. The reports are also posted on the Department web site at <http://www.cd.gov.ab.ca>.
- If you would like to see an area of information that is not printed in the quarterly reports, feel free to make suggestions to the Branch. We try to provide information to assist service providers and the general public in promoting the respect and dignity of vulnerable adults in care facilities in the province.
- The Protection for Persons in Care Branch is continuing to plan for the legislation review. A discussion paper is being drafted and it is anticipated that public consultation will occur with the various stakeholders by the fall of 2002.

### **OTHER:**

- Again, this quarter, several reporters 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](http://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, the abuse reporting form and a new smaller poster can be ordered free of charge by calling the reporting line at 1-888-357-9339.
- All Quarterly Reports for 2000-2001 and PPC Bulletins #s 1 - 6 are available through the Web site listed above.
- Copies of the *Act* or videos can be obtained through the Queen's Printer by phoning the Government Rite number 310-0000 and asking for (780) 427-4952 in Edmonton or by calling (403) 297-6251 in Calgary or shop On-line at <http://www.gov.ab.ca/qp>.

Contact: Edith Baraniecki, Director, Protection for Persons in Care  
Phone (780) 427-0552, Fax (780) 415-8611 or email to [edith.baraniecki@gov.ab.ca](mailto:edith.baraniecki@gov.ab.ca)