

Protection for Persons in Care

Quarterly Report

January 1, 2002 – March 31, 2002

(includes statistics from fiscal year 2001 – 2002)



**Protection for
Persons in Care**

A PROGRAM OF

**ALBERTA
COMMUNITY
DEVELOPMENT**

PROTECTION FOR PERSONS IN CARE

PART I

REPORTED ALLEGATIONS

JANUARY 1, 2002 – MARCH 31, 2002

AND

FISCAL YEAR 2001/02

PROTECTION FOR PERSONS IN CARE

REPORTED ALLEGATIONS: Fourth Quarter 2001 - 2002 (January 1-March 31, 2002)

NUMBER OF REPORTS:

- During this quarter, 126 reports were received by the Protection for Persons in Care (PPC) reporting line. This was a similar amount to the last quarter.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment this quarter or this fiscal year.
- There were fewer reports from lodges in this quarter. However, there was a 61% increase in the number of reports from last fiscal year to this fiscal year.
- There was a 60% increase this fiscal year to last fiscal year in the number of reports from settings for Persons with Developmental Disabilities.
- In this fiscal year, there was an approximate 10% decrease in reports from hospitals and nursing homes.
- There was an increase in the number of reports in 2001/02, with 542 compared to 2000/01, when there were 499 reports.

Agency/Ministry Responsibility	# of Reports					
	1st Quarter	2nd Quarter	3rd Quarter	4 th Quarter	2001/02	
					Total	%
Regional Health Authorities/ H&W	83	83	66	74	306	56.5%
Persons with Developmental Disabilities/CD	27	56	36	39	158	29.1%
AADAC/H&W	4	0	1	1	6	1.1%
Alberta Mental Health Board /H&W	0	2	3	2	7	1.3%
Management Bodies/Alberta Seniors	7	29	15	7	58	10.7%
Children and Family Services Authorities/CS	4	0	0	3	7	1.3%
Total	125	170	121	126	542	100.0%

See Part II figure 1 for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE:

Allegations of emotional abuse remain the largest group. The number of allegations of intentionally failing to provide the basic necessities of life has remained consistently high this fiscal year compared to previous years.

Types of Abuse	# of Allegations					
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	2001/02	
					Total	%
Physical	38	61	41	47	187	25.7%
Emotional	76	96	58	71	301	41.3%
Inappropriate medications	1	1	3	3	8	1.1%
Sexual	7	21	11	8	47	6.4%
Financial	5	18	8	10	41	5.6%
Neglect	41	29	31	44	145	19.9%
Total	168	226	152	183	729	100.0%

See Part II figure 2 for individual breakdown by organizational structure

ALLEGED ABUSERS:

Service providers remain the largest category of alleged abusers. In this quarter, there is a decrease in the percentage of allegations where clients are named as alleged abusers.

Alleged Abuser	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	2001/02	
					Total	%
Service Provider	96	113	73	85	367	67.7%
Client	18	41	36	23	118	21.8%
Family	9	14	9	12	44	8.1%
Other	2	2	3	6	13	2.4%
Total	125	170	121	126	542	100.0%

See Part II figure 3 for further breakdown by organizational structure

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

INVESTIGATORS:

In this 4th quarter of 2001-2002, contracted investigators conducted approximately 87% of the investigations and 8% were conducted by a police service.

Investigator	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Fiscal Year	
					Total	%
Contracted Investigators	116	150	98	111	475	85.7%
Professional Colleges:	10	12	13	0	35	6.3%
-AARN (RNs)	8	5	8	0		
-CLPN (LPNs)	2	2	2	0		
-CPS (Physicians)	0	1	1	0		
-Other (CPTA, RPNA)	0	4	2	0		
Police	3	11	4	10	28	5.1%
Other bodies (MHPAO)	0	1	1	0	2	.4%
Not Investigated	0	3	5	6	14	2.5%
Total	*129	**177	121	***127	554	100.0%

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

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

***One case was investigated by more than one type of investigator.

PROTECTION FOR PERSONS IN CARE

PART II

SUMMARY OF REPORTED PPC CASES

FISCAL YEAR 2001/2002

GRAPHS AND CHARTS

- Figure 1 – Number of reports
- Reported Allegations by Governing Structure Pro-rated
- Figure 2 – Types of alleged abuse
- Figure 3 – Categories of alleged abusers
- Comparison 2000/01 to 2001/02

Protection for Persons in Care Number of Reports

April 1, 2001 - March 31, 2002 (12 months)

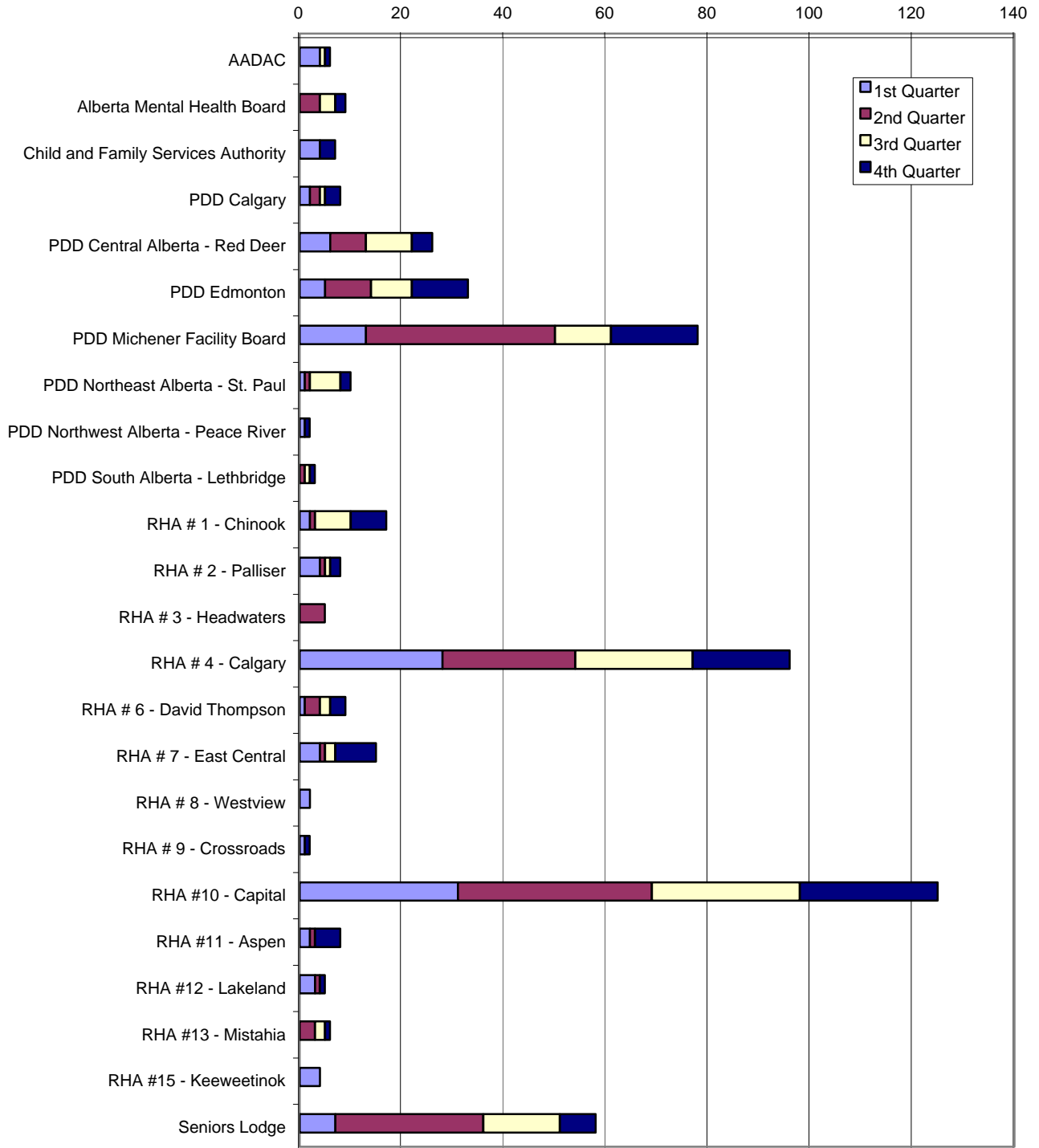


Figure 1
PPC 4th Quarterly Report 2001 - 2002

REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRO-RATED: APRIL 1, 2001 – MARCH 31, 2002

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	4
PDD Central Alberta - Red Deer	23
PDD Edmonton	13
PDD Northeast - St. Paul	22
PDD Northwest Alberta - Peace River	7
PDD South Alberta - Lethbridge	3

*Based on figures from Annual Report 2000/2001

Michener Facility Board is not included due to being facility-based rather than community-based. However, Michener Centre had 78 actual reports per 416 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	12
RHA # 3 - Headwaters	9
RHA # 4 - Calgary	14
RHA # 5 - Health Authority 5	0
RHA # 6 - David Thompson	7
RHA # 7 - East Central	20
RHA # 8 - Westview	3
RHA # 9 - Crossroads	7
RHA #10 - Capital	20
RHA #11 - Aspen	14
RHA #12 - Lakeland	7
RHA #13 - Mistahia	10
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, e.g. 15 – 19, 20 – 24, etc.

LODGE FOUNDATIONS/UNIQUE HOMES

Reports by Alberta Seniors pro-rated per 1,000 units served*

Province Wide	Reports
Units	7

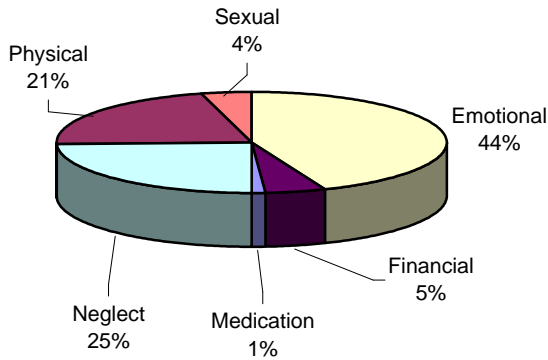
*Based on figures from Alberta Seniors, January 31, 2002

OTHER GOVERNING BODIES:

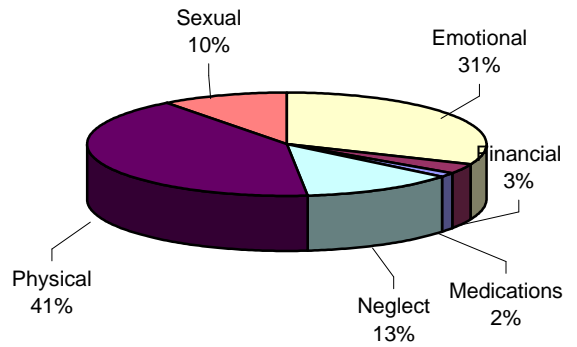
The number of reports from Children's Services and AADAC are too small to formulate any projections.

**Protection for Persons in Care
Types of Alleged Abuse by Organizational Structure
April 1, 2001 - March 31, 2002 (12 months)**

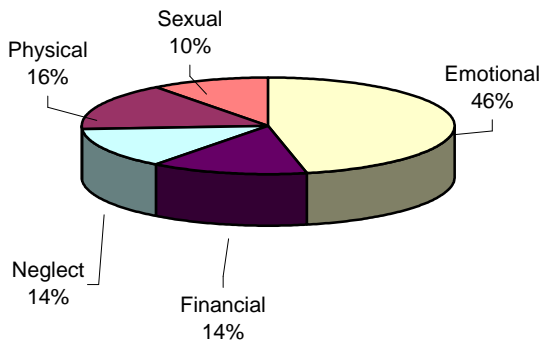
**Hospitals, Nursing Homes,
Personal Care Homes and AADAC**



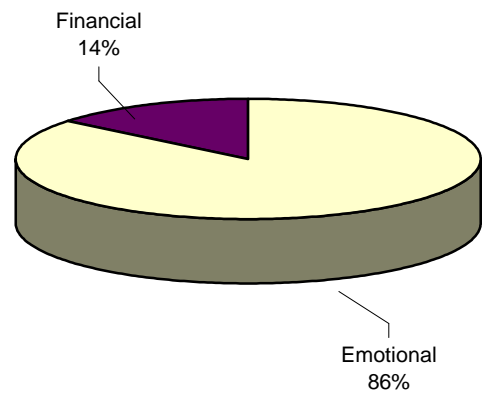
**Persons with Developmental
Disabilities Facilities and
Contracted Group Homes**



**Seniors' Lodges and
Unique Homes**



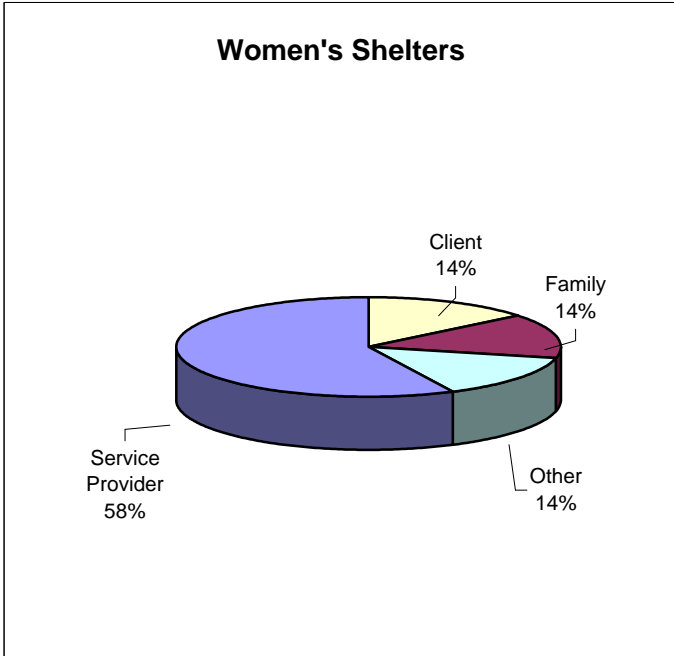
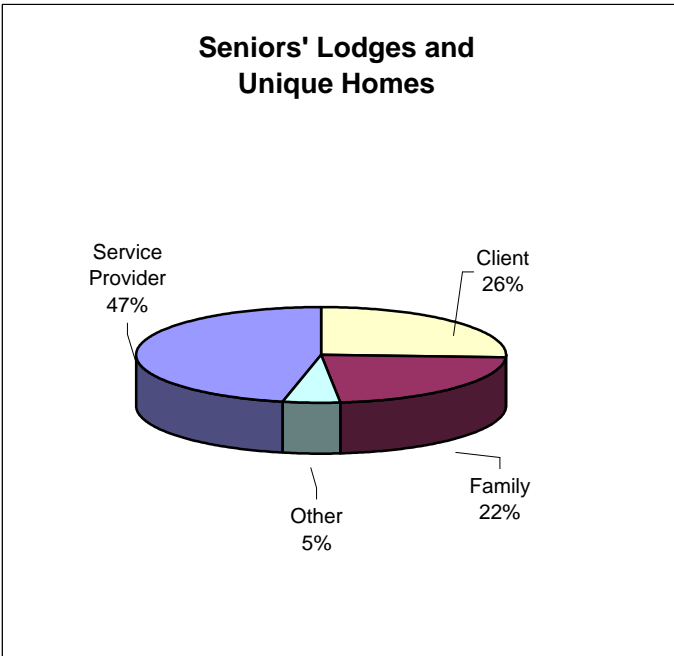
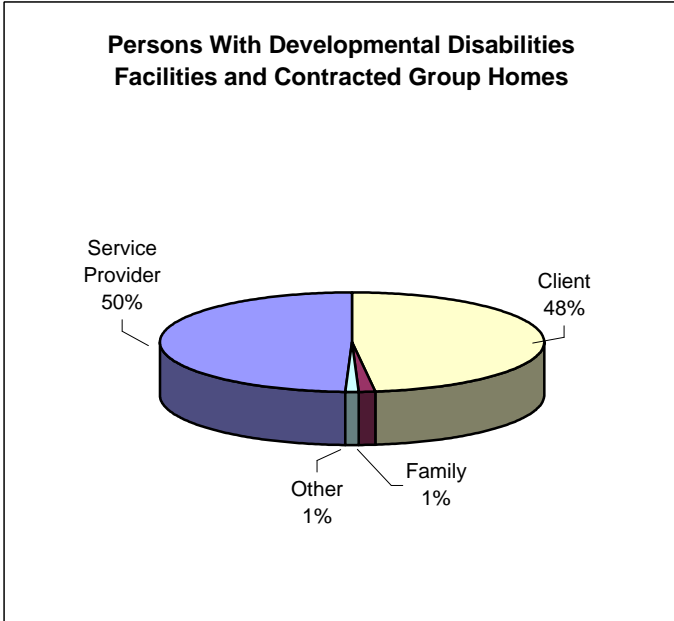
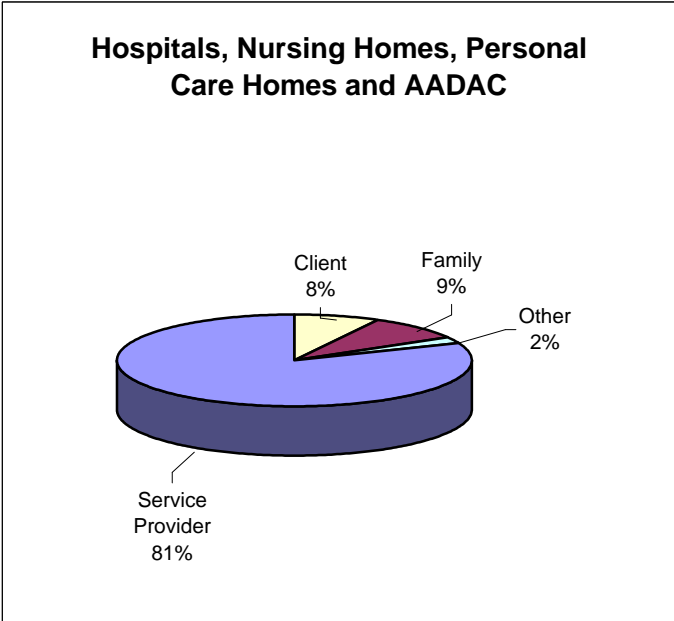
Women's Shelters



Human Resources and Employment: 0 Reports

Figure 2
PPC 4th Quarterly Report 2001 - 2002

**Protection for Persons in Care
 Categories of Alleged Abusers by Organizational Structure
 April 1, 2001 - March 31, 2002 (12 Months)**



Human Resources and Employment: 0 Reports

Figure 3
 PPC 4th Quarterly Report 2001 - 2002

**Protection for Persons in Care Comparison
2000/2001 to 2001/2002
Reported Allegations of Abuse**

Type of Facility Involved

	2000/01	2001/02
Acute Care Hospital	42	31
Continuing Care	282	257
PDD Setting	98	158
Lodges	36	58
Women's Shelter	6	7
Other	35	31
Total	499	542

Type of Alleged Abuse

	2000/01	2001/02
Physical	155	187
Emotional	251	301
Sexual	33	47
Financial	31	41
Inappropriate Medication	5	8
Neglect	121	145

Types of Alleged Abusers

	2000/01	2001/02
Service Providers	383	367
Clients	61	118
Family	28	44
Other	27	13

PROTECTION FOR PERSONS IN CARE

PART III

INVESTIGATION RECOMMENDATIONS

OCTOBER 1, 2001 – DECEMBER 31, 2001

* Recommendations from investigations in the quarter January 1, 2002 to March 31, 2002 will be included in the next quarterly report, as the majority of the cases are not closed at this time.

INVESTIGATION RECOMMENDATIONS

Third Quarter 2001 – 2002

(October 1, 2001 – December 31, 2001)

- As of April 1, 2002, 120 cases were received during this three-month period with 109 files closed. There are 11 reports still under investigation. Of the 11 open files, 10 of the reports are investigated by the professional colleges and one report investigated by the police.
- Of the 109 closed files this third quarter, 61% were dismissed as unfounded or due to insufficient evidence and 2.8% were referred to the police.
- During the first, second and third quarters in this fiscal year, 59% of the allegations in PDD facilities were dismissed, 62% were dismissed in facilities governed by regional health authorities and 50% were dismissed in senior's lodges.
- Although the allegations of abuse may be dismissed, based on the definition of abuse in the *Act*, as unfounded or due to insufficient evidence of intent or harm, systemic recommendations are often made in an effort to assist facilities in preventing similar incidents from occurring.

INVESTIGATION RESULTS FOR FILES CLOSED THIS QUARTER:

RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:

In 32 reports involving an employee/service provider as the alleged abuser, the facility took disciplinary action before the contracted investigator started or completed the investigation. Action taken included: suspension, monitoring job performance, staff reassignments, verbal reprimands, completion of educational training, and other forms of disciplinary action. There were nine staff terminations and one staff resignation.

EXAMPLES OF RECOMMENDATIONS MADE TO AGENCIES:

Education and Training:

- Consider identifying a method to acquaint casual staff who may not be familiar with all aspects of a client's routine, to unique client care provisions including privacy during bathing and privacy in other circumstances.
- Service provider be given a follow up inservice regarding the physical handling of the "frail elderly" and demonstrate their expertise to the Education Coordinator.
- Facility periodically assess the need for staff training for handling aggressive residents or unexpected situations such as when a resident is falling.

Policies and Procedures:

- Facility discuss with the regional assessment placement office the need for patients in acute care hospitals and their families to receive education and discussion about care expectations in continuing care facilities, prior to arranging placement of a patient.
- Agency initiate the design of a behavior management program for the client who is the alleged abuser and that staff working with the client have knowledge of Fetal Alcohol Syndrome and consider the aspects of this disorder in all interventions with the client.
- Consider advising the alleged abuser verbally and provide her with written notice of her contractual obligation, as described in the "Contract for Lodging", not to create a nuisance or a danger to other residents. Remind her that management has the authority to evict her as a

potential consequence of further complaints. At the same time, the facility consider exploring other options for accommodation for the alleged abuser in advance, in the event that further steps need to be taken.

Other:

- Facility continue its discussions with the family member regarding assessment of the resident for appropriate placement in order to provide a safe environment for other residents and a safe and supportive work environment for the staff.
- Facility review the resident's care plan, considering the incorporation of culturally specific community support with respect to the resident and ensure that staff are apprised and provided with adequate training including cultural sensitivity training, to understand and follow the direction and rationale of the care plan.
- Continue with the provision of weekly counseling to the female client ensuring issues related to sexual abuse are addressed. If it is determined that she may respond better to a female counselor, explore options in the community. Provide the female client with sexuality/relationship education including appropriate sexual behavior, boundaries and risk reduction amongst others.

EXAMPLES OF SPECIFIC RECOMMENDATIONS TO FACILITIES:

Acute Care Hospital Recommendation:

- That the facility ensure that information given by family members is recorded and followed up.

Long Term Care Recommendations:

- That the facility review with staff the importance of accurate, sequential notations on resident records, following a change in medication and behaviour.
- That the facility review all levels of staff job descriptions and expectations, especially those that relate to staff communication and supervisory responsibilities.
- That the facility review its policies and procedures for documenting and maintaining copies of relevant legal documents.

AADAC Recommendation:

- That the facility consider ensuring that the Orientation Guidelines and the Resident Admission Agreement clearly outline all "zero tolerance" rules and the consequences for breach of same, including specifying the duration of time away from the facility that is required.

PDD Setting Recommendation:

- That the agency establish a policy as to how often a client is to be checked when awake, when not visible to staff and when alone and unattended in a closed room, taking into consideration the unique needs and circumstances of the client, existing and potential risks to the client, and do so in consultation with the client's legal guardian and other appropriate and relevant resources.

Lodge Recommendation:

- That the facility continue to provide regular educational sessions to enhance resident to staff interactions, continue to recognize that staff members who respond to traumatized victims can also have adverse reactions themselves and continue to encourage staff debriefing after stressful critical incidents as outlined in the "Workplace Practices' Manual".

PERCENTAGE OF INVESTIGATIONS BY GOVERNING STRUCTURE

(Based on the number of reports received for the specific governing structure per regional area from April 1, 2001 – December 31, 2001, as of April 1, 2002)

Please note: Only two columns, dismissed and ongoing, are presented here. 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 abuse was confirmed as having occurred, or already reported to a professional association or the police.

PERSONS WITH DEVELOPMENTAL DISABILITIES BOARDS

Organizational Structure	# of Reports	Dismissed*	Ongoing
PDD Calgary	5	2	0
PDD Central Alberta	22	10	0
PDD Edmonton	21	11	0
PDD Michener Facility Board	60	40	1
PDD Northeast Alberta	8	5	0
PDD Northwest Alberta	1	1	0
PDD South Alberta	1	1	0
PDD Provincially	119	70	1

* Allegations of abuse are dismissed, based on the definition of abuse in the Act.

REGIONAL HEALTH AUTHORITIES

	# of Reports	Dismissed*	Ongoing
RHA # 1 – Chinook	11	6	2
RHA # 2 - Palliser	6	5	1
RHA # 3 - Headwaters	5	4	0
RHA # 4 - Calgary	77	48	7
RHA # 5 - Health Authority 5	0	0	0
RHA # 6 - David Thompson	6	5	0
RHA # 7 - East Central	7	2	0
RHA # 8 – Westview	2	0	0
RHA # 9 – Crossroads	1	1	0
RHA #10 - Capital	101	48	5
RHA #11 – Aspen	3	3	0
RHA #12 - Lakeland	4	3	0
RHA #13 - Mistahia	5	4	1
RHA #14 - Peace	0	0	0
RHA #15 – Keeweenok Lakes	4	4	0
RHA #16 - Northern Lights	0	0	0
RHA #17 - Northwestern	0	0	0
RHA Provincially	232	133	16

* Allegations of abuse are dismissed, based on the definition of abuse in the Act.

LODGES FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Dismissed*	Ongoing
Lodge Foundations	51	24	3
Unique Homes	0	0	0
Provincially	51	24	3

* Allegations of abuse are dismissed, based on the definition of abuse in the *Act*.

OTHERS:

Organizational Structure	# of Reports	Dismissed*	Ongoing
AADAC	5	4	0
AMHB	5	5	0
CFSA's	4	4	0

* Allegations of abuse are dismissed, based on the definition of abuse in the *Act*.

PROTECTION FOR PERSONS IN CARE

PART IV

CASE SUMMARIES

CASE SUMMARIES

The following are four 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* and were selected for their possible relevance to other facilities.

Case A: **Type of alleged abuse: intentionally causing emotional harm; intentionally causing physical harm**
 Agency: an Acute Care Hospital
 Alleged abusers: service provider (Special Hospital Constables)

The allegation was that three special hospital constables grabbed the patient by the neck, wrestled her to the ground and handcuffed her when she attempted to leave the facility resulting in the patient having difficulty breathing and sustaining two marks on her lower right leg from the struggle. It was alleged that the constables put the client in an isolation room and strapped her to a stretcher. It was also alleged that one special constable, when seeing the patient, stated, “oh it’s you”, causing her to feel unwelcome at the hospital.

Investigation Facts:

- The patient was transported to the acute care facility on an apprehension order under the *Mental Health Act*. The patient was physically escorted from the ambulance but refused to go into the hospital.
- When interviewed the patient stated that three special constables grabbed her by the neck and pushed her to the ground, causing her to have difficulty breathing and scratching her leg.
- Documentation indicated that one constable was attempting to talk the patient into the hospital when the patient hit another constable in the stomach. A third constable stated that the patient was swearing a lot and when she hit the constable in the stomach so he immobilized her by using a headlock. Evidence supports that only two constables restrained the patient not three.
- The constable stated that the headlock was applied, with minimal pressure, for approximately 30 seconds and at no time did the patient complain of pain or discomfort. Another constable took her left arm, the headlock was released and the patient was escorted into the hospital by two constables.
- The patient stated she felt bad being physically escorted through the emergency room where all other patients could see her. The constables stated that there was an alternate route available, in which no patients would have observed the action, however, the patient was being taken the shortest route. The constables did state that the patient was being cooperative at this time.
- Evidence showed that the patient was then placed into a holding room where she continued banging on the door and screaming. Evidence supported that the patient was then restrained to the stretcher, for approximately 45 minutes. When her behaviour improved, the restraints were released.
- The patient stated that she received many bruises from the altercation. As no nursing assessment was completed, there was no documented evidence of physical injury or bruising sustained by the patient.

Case A: (Cont)

- The constables, in restraining the patient, were acting in accordance with the facility security policy as well as *Section 30 of the Mental Health Act*.
- The constables stated that first approach to a patient certified under the *Mental Health Act* is to introduce themselves and indicate that he/she has been “arrested under the *Mental Health Act*”. One constable stated that he did make the, “oh it’s you” comment to remind himself that the patient has a tendency to become violent. Another constable referred to mental health clients as “violent psychs”.

Investigator’s Recommendations to the Facility

- That the allegations involving the constables intentionally causing physical harm be dismissed as unfounded and the allegation of intentionally causing emotional harm be dismissed due to insufficient evidence of intent to cause harm.
- That the term “apprehended” rather than “arrested” be used for patients conveyed to the hospital under the *Mental Health Act*. The term “arrested” denotes wrongdoing and implies to the patient that they have committed an offense and are about to be incarcerated for that offence.
- That the facility makes every attempt to preserve the privacy and dignity of the individual in a mental health crisis by using the alternate entrance to the hospital. This may also provide some physical safety for the patient as well as others sitting in the emergency waiting room.
- That the facility provide inservice for security personnel on mental health illnesses to distinguish between individuals who become violent and those that do not.

Facility’s Responses to the Recommendations

- “We agree completely that “apprehend” is the correct terminology when dealing with patients under the *Mental Health Act*. Special constables have been instructed on the terms and staff are, and will continue, to be given feedback accordingly if the incorrect words are used. In follow up to this incident, the need for correct terminology was addressed at a staff meeting on the ...and via e-mail sent on Education on correct wording is also part of the training course for new constables and will be included in the training manuals.”
- “The Security Department agrees with supporting the privacy and dignity of the individual wherever possible. Using the alternate entry in the Emergency Department (ambulance bay) would be attempted in cases where the safety of the patient and the constable can be accommodated when taking a longer route into the Emergency, i.e. the patient is exhibiting passive resistance. In cases where the certified patient is physically combative using assaulting behavior, security personnel may elect to use the most direct route to lessen the likelihood of injury to the patient or to the constable.”
- “The Security Manager is in the process of arranging additional training in the area of mental illness. Continuing education programs are being designed for home study and available via hospital intranet for access at work. These programs are being developed with assistance from the managers and clinical educators of the ... Psychiatry Departments and will be mandatory for security personnel completion.”

Case A: (Cont'd)

- “These programs will provide information on specific mental health conditions with details of applicability for special constable intervention. Training in the identification of potentially violent patients is part of the existing security control tactics course and the non violent crisis intervention course (NCI). Two special constables have been trained to be instructors of NCI. Training sessions for all constables to partake in NCI training will be scheduled starting April 2002.”
- “...The Medical Aid policy will be amended to include that at any time security service personnel are required to use physical force beyond guidance/soft empty handed control level, they will request the nursing/medical staff to examine the patient for any potential injury from the apprehension ...[and charted accordingly].”

Case B: Type of alleged abuse: intentionally misappropriating or improperly or illegally converting money or other valuable possessions and intentionally failing to provide the basic necessities of life
Agency: a seniors lodge
Alleged abuser: family (daughter)

The allegations were that a daughter and son-in-law of a resident a) used the resident’s money for their own personal needs and did not pay the resident’s room and board payments to the lodge, resulting in accumulated arrears owing to the lodge, b) sold the resident’s vehicle and used the money from this sale for their own personal use, and c) did not supply the resident with her prescription medications.

Investigation Facts:

A) Allegations concerning misappropriation of funds:

- The resident stated that the financial arrangements she had made with her daughter were that the daughter was to look after her financial affairs and pay her bills. She confirmed her daughter opened a joint bank account with her.
- The resident was unaware that the bills from the lodge were not being paid. The lodge had notified the daughter numerous times of the unpaid bills for room and board charges. One cheque submitted by the daughter was returned NSF.
- By not having the bills paid at the lodge, the resident’s stay at the lodge was at risk and she could have been faced with possible eviction.
- By not providing her mother with any spending money, the resident had to go without buying personal items, was not able to obtain a telephone in her room, could not purchase new clothing and could not get her hair done.
- With the intervention of a witness, the resident now has her bank account solely in her name, arrangements were made to have her bills handled by the bank, one cheque is forwarded to the resident at her lodge address (not the daughter’s address), and she now has sufficient funds to meet her financial obligations with a small amount for personal spending. The unpaid bill at the lodge will be discharged in a regular payment schedule arranged between the lodge and the resident.

Case B: (Cont)

B) Allegation involving the sale of the resident's vehicle:

- The resident stated that “they” had sold the van.
- The daughter stated that her deceased father had wanted her to have the van, and that she sold what was rightfully hers. The sale of the van yielded the amount of \$1,000.

C) Allegation regarding not supplying the resident with her medications:

- There is evidence that the resident's physician prescribed an antibiotic medication. The Home Care Nurse (nurse) telephoned the daughter and left a message for her to deliver the medication to her mother immediately as it was important. Six days later, the daughter left a message for the nurse advising that she did not receive the prescription for her mother and that apparently it had been “lost”. The nurse again contacted the pharmacist who confirmed the prescription was filled and had been picked up. Arrangements were subsequently made with the physician to re-issue the prescription.
- The information provided by the daughter was inconsistent with that of other evidence. The daughter alluded to an incident whereby the physician did not phone in a prescription for an increase in one of the resident's diabetic medications. Then when the prescription was called in, the daughter said she had to delay picking it up because she had no money.
- Arrangements have since been made with a local drug store to deliver the resident's medication to the lodge.

Investigator Recommendations to the Facility

- That the facility assist the resident to explore other resources and/or mechanisms that she can consider or access, now and/or in the future, to safeguard her personal and financial affairs. Consider contact with the Office of the Public Trustee and the Office of the Public Guardian to obtain information about what options exist for the resident to plan for her future.
- That the facility consider notifying a police service of any concerns of a criminal nature or if the immediate safety of a resident is in question.
- The lodge manager should be commended for taking action and for making arrangements to assist the resident with setting up her finances in a secure arrangement with the bank, and for arranging delivery and payment of prescription medications.

Facility's Responses to the Recommendations

- “Prior to this, she [alleged victim] lived with her daughter in The *Act* does not apply to this client's situation prior to her move to the lodge. The client is competent and the client chose to involve her daughter by giving her signing authority on the client's bank account. This is not unusual, and is not something in which Home Care would become involved. There was no evidence of financial abuse when the client lived in”

Case B: (Cont)

- “... To the benefit of the client the Case Coordinator was concerned that the Client’s condition had not resolved so she followed up, thus finding out the prescription was never delivered by the daughter.”
- “ The Lodge manager approached the Home Care Nurse to request advise on how to get the client to pay her rent. It is not Home Care’s responsibility to intervene in the contractual obligations between a housing operator and the tenant. This is a matter to be dealt with by the housing operator. The Home Care Nurse, however, suggested to the Lodge Manager that she contact the Protection for Persons in Care office as the Lodge Manager was the person with actual proof that bills were not being paid.”

Case C: Type of alleged abuse: intentionally causing bodily harm
Agency: a Persons with Developmental Disabilities Agency
Alleged abuser: service provider (Rehabilitation Care Worker)

The alleged incident was that a service provider had purposefully restricted the movements of a client by inserting his feet between a footrest and the seat of a recliner chair, causing the client to struggle to get out, which resulted in cuts and abrasions to his feet that bled.

Investigation Facts:

- Two witnesses observed the client struggling to get out of a recliner chair that is described as a brown electric chair, with his feet between the chair and the footrest. Blood was observed to be on the client’s feet and on the floor. Another witness noticed bloody footprints along the floor where the client walked from the chair once he was extricated and a fair pool of blood around the chair.
- The service provider was alone with the client in the living room and then voluntarily left the client alone to assist another staff. The service provider stated that he left the client with his feet up on the footrest. There is conflicting information as to whether the service provider was asked by the staff to assist with another client or whether he was told by the other staff that his assistance was not necessary.
- Witnesses indicated that there was a previous practice of placing the client’s feet between the chair seat and footrest as a form of restraint, which contravenes policy related to restrictive procedures at the facility.
- The brown electric chair has controls that are stiff and difficult to manipulate. There is a metal box under the footrest that has very sharp metal edges. The facility has since removed this chair and a review of other electric chairs was completed.
- It was the accepted custom to place the client in a blue recliner chair and sit next to him while he calmed down. The service provider was aware of this practice as a method to attempt to have the client relax. The blue recliner chair is also viewed as potentially hazardous and a witness has observed this client pull this chair over onto himself. The minor modifications were not professionally done and may not protect this client from harm if he flails around.

Case C: (Cont)

- There were no written instructions on appropriate methods of managing this client before the incident. After the incident, target behaviors and positive interventions were prepared for this client.

Investigator's Recommendations to the Facility

- That the facility arrange for close supervision of the service provider, and that the Home Coordinator provide coaching to the service provider on safe procedures when caring for an individual with behavioral challenges.
- That the facility consider conducting a review of all client's information to ensure there are written positive practices for each client to guide staff when intervention is necessary.
- That the facility consider having the blue recliner chair examined to ensure it is safe for this client and consider undertaking a review of all furniture that clients have access to with a view to safety.
- That the facility discuss with parents/guardians and visitors the risks associated with using this procedure as a restrictive measure and advise them that this practice is in conflict with the facility restrictive procedures policy and does not conform to acceptable standards of care at the facility.
- When conducting refresher course for staff on abuse prevention and reporting, emphasize that this type of practice could constitute abuse.

Facility's Responses to the Recommendations

- "All employees in the home have been cautioned in the importance of following safety procedures. It will continue to be addressed at monthly home staff meetings and through the home support division."
- "A written positive practice has been updated for each person in the home and made available to all staff to read, understand and follow."
- "Rehabilitation Services has been checking all recliner chairs that have an open space between the chair's seat and footrest. They are exploring ways to cover the opening with a durable material. In this home, both chairs have since been removed."
- "The parents/guardians have been informed that the alleged victim prefers to sit in the chesterfield versus a recliner chair. All restrictive procedures must be reviewed and approved by the Restrictive Procedures Committee before implementation. Any proposed restrictive procedure that is deemed harmful to an individual would not be approved."
- "Home orientation is provided when staff are new to, or transferred to, a new location, and reviewed every three years. The home orientation is currently under review and change, and will address client health and safety."

Case D: Type of alleged abuse: intentionally causing bodily and emotional harm
Agency: a long term care centre
Alleged abuser: service provider (unknown staff)

The alleged incident was that an unknown staff tossed the resident on the bed and squeezed her chin causing her to sustain a laceration under her chin.

Investigation Facts

- When the resident's daughter attempted to wash her face the resident called out telling her daughter the staff were rough with her and squeezed her chin. The resident's daughter noted a red mark under the resident's chin.
- Staff stated that during morning care they found the resident had a rash and scratches on her hips and groin area, prescribed cream was applied. One staff member stated that the resident's daughter showed her the scratch under the resident's chin and she made the registered nurse aware of it.
- Staff stated that up to a year ago they used to get the resident up in the chair but she became tired when she was up for more than an hour so the resident's daughter wanted her kept in bed 24 hours. Two staff turn the resident frequently from side to side.
- Staff indicated that they position the resident in bed by pulling her forward up towards their chest, straightening her upper clothing and then laying her down. Staff stated that this action placed the resident very close to their nametag and this could have caused the scratch on the resident's chin.
- Staff related that the resident likes to clasp the call bell in her hands just under her chin. The call bell has a metal clasp, which could cause scratching. Staff also expressed concern with the safety issue of the call bell as staff has found the resident with the call bell cord wrapped around her neck.
- The resident's daughter insists that she be fully dressed when in bed with lots of blankets, wool undershirt, and flannel pyjamas. Staff stated the resident appears very hot and sweaty and has what appears to be a heat rash over her body.
- Staff stated that this manner of dressing and type of clothing makes it difficult to change the resident's incontinent pad and staff find they have to move the resident from side to side to get the pad off and to get the flannel pyjamas back up. The resident could interpret this method of dressing her as her being "tossed around in bed".
- Staff also stated the resident scratches herself all over. The scratches are often deep enough to cause bleeding. The resident's daughter cuts the resident's fingernails but staff did not feel they were cut short enough, allowing the resident to scratch herself.
- Documentation confirmed that the resident's skin is in good condition, except for the scratch marks and rash in the groin area. The chart review and the resident's appearance indicated that the staff gives the resident good care.

Case D: (Cont'd)

Investigator's Recommendation to the Facility

- That the facility arranges a resident care conference and include the resident's family and all staff involved in providing care to the resident. The resident's care plan should be reviewed to address identified potential health risks such as access to the call bell, and develop an appropriate care plan that meets the needs of the resident.
- That the facility consults with the resident's family to find a style of pyjamas that would be lightweight and easier to put on the resident.
- That the facility considers a different form of nametag for staff that does not have sharp corners/edges.

Facility's Responses to the Recommendations

- "A Resident Care Conference was held, which included representatives from ...[the various care units]. Subsequent to the Conference the Social Worker and Nursing Services Manager have been meeting with the daughter on a regular basis to assist the family in dealing with care, expectations and family behaviors. Various strategies have been implemented to meet the resident care needs and family requests. It is recognized and acknowledged by the majority of staff that culture and beliefs play a strong role in the care of this resident and that a complete resolution to these issues may not in reality be possible."
- "Resident's clothing and dressing were reviewed as a component of the care plan and in the treatment of an ongoing medical condition at the Resident Care Conference. At this time it was determined that open backed hospital style nightgowns would be utilized. The social worker volunteered to assist the family in their selection of clothing and subsequently, the physician has written orders regarding clothing. Ongoing medical intervention is occurring in attempt to manage the medical conditions."
- "We have conducted a review of nametags used within the Region. This review has demonstrated that our nametags are consistent with those in other continuing care facilities. The facility currently has a clip on, plastic, flexible nametag. Since the nametags used at [this facility] are consistent with those used in the industry no further action is identified at this time. We understand that nametags, jewellery, etc. may possess a risk to safety and will therefore continue in their commitment to periodically review our policies in this regard."

PROTECTION FOR PERSONS IN CARE

PART V

ADMINISTRATION

ADMINISTRATION

- During this fiscal year, the 542 reports of alleged abuse were reported by non management service providers in 41% of the incidents, management service providers in 32% of the incidents, family members in 13.5% of the incidents, self in 8.5% of the incidents and other in 5% of the incidents.
- From the fiscal year April 1, 2000 to March 31, 2001 there is one file that remains open. It is being investigated by a professional organization.
- The Protection for Persons in Care office is surveying those on the quarterly report mailing list to evaluate the general services received from the office. Individuals are encouraged to complete the survey and return it to Protection for Persons in Care, Box 3100, Edmonton, Alberta T5J 4W3 or by fax to (780) 415-8611 by July 12, 2002.
- Stakeholders are encouraged to obtain further copies of the quarterly report for distribution within their agencies from the Community Development web site at <http://www.cd.gov.ab.ca> under “Helping Albertans”. Currently only one copy is provided to most facilities with the exception of large hospitals and nursing homes where a copy is provided for the site administrator and director of care.
- The Protection for Persons in Care Bulletin #1 Duty to Report has been updated. The bulletin is also available on the Community Development web site.
- A paper of Frequently Asked Questions about the *Act* has been developed to assist individuals in understanding the *Act* better. The Q&As may be useful for agency inservice training or updating of abuse policies.

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
PPC Reporting Line (toll free) 1-888-357-9339