Protection for Persons in Care

Quarterly Report

July 1, 2001 – September 30, 2001

Protection for Persons in Care

A PROGRAM OF

ALBERTA COMMUNITY DEVELOPMENT

PROTECTION FOR PERSONS IN CARE

PART I

REPORTED ALLEGATIONS

JULY 1, 2001 – SEPTEMBER 30, 2001

PROTECTION FOR PERSONS IN CARE

REPORTED ALLEGATIONS: Second Quarter 2001 - 2002 (July 1-September 30, 2001)

NUMBER OF REPORTS:

- During this quarter, 170 reports were received. This was a 36% increase from last quarter.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment.
- The majority of allegations continue to involve persons in care in long term care facilities. However, this quarter there were a marked increase in the number of reports from Persons with Developmental Disabilities (PDD) settings and seniors' lodges.

Agency/Ministry Responsibility	# of Reports			
	1st Quarter	2nd Quarter	Fiscal Year	
			Total	%
Regional Health Authorities/ H&W	83	83	166	56.2%
Persons with Developmental Disabilities/CD	27	56	83	28.1%
AADAC/H&W	4	0	4	1.4%
Alberta Mental Health Board /H&W	0	2	2	0.7%
Management Bodies/Alberta Seniors	7	29	36	12.2%
Children and Family Services Authorities/CS	4	0	4	1.4%
Total	125	170	295	100.0%

See figure 1 for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE:

Allegations of emotional and physical abuse remain the largest group. The numbers of allegations of sexual and financial abuse have tripled since last quarter.

Types of Abuse	# of Allegations			
	1st Quarter	2nd Quarter	Fiscal Year	
			Total	%
Physical	38	61	99	25.1%
Emotional	76	96	172	43.7%
Inappropriate medications	1	1	2	0.5%
Sexual	7	21	28	7.1%
Financial	5	18	23	5.8%
Neglect	41	29	70	17.8%
Total	168	226	394	100.0%

See figure 2 for individual breakdown by organizational structure

ALLEGED ABUSERS:

There were more reports this quarter of client-to-client abuse than the past quarter.

Alleged Abuser	1st Quarter	2nd Quarter	Fiscal Year Total	
			Total	%
Service Provider	96	113	209	70.8%
Client	18	41	59	20.0%
Family	9	14	23	7.8%
Other	2	2	4	1.4%
Total	125	170	295	100.0%

See figure 3 for further breakdown by organizational structure

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

INVESTIGATORS:

In this 2nd quarter of 2001-2002, contracted investigators conducted approximately 85% of the investigations, 7% were conducted by a professional college and 6% by a police service.

Investigator	1st Quarter	2nd Quarter	Fiscal Year Total	
			Total	%
Contracted Investigators	116	150	266	86.9%
Professional Colleges:	10	12	22	7.2%
-AARN (RNs)	*8*	*5*		
-CLPN (LPNs)	*2*	*2*		
-CPS (Physicians)	*0*	*1*		
-Other (CPTA, RPNA)	*0*	*4*		
Police	3	11	14	4.6%
Other bodies (MHPAO)	0	1	1	.3%
Not Investigated	0	3	3	.9%
Total	**129	***177	306	100%

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

***Seven 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 Pro-rated

Protection for Persons in Care
Number of Reports

April 1, 2001 - September 30, 2001 (6 months)

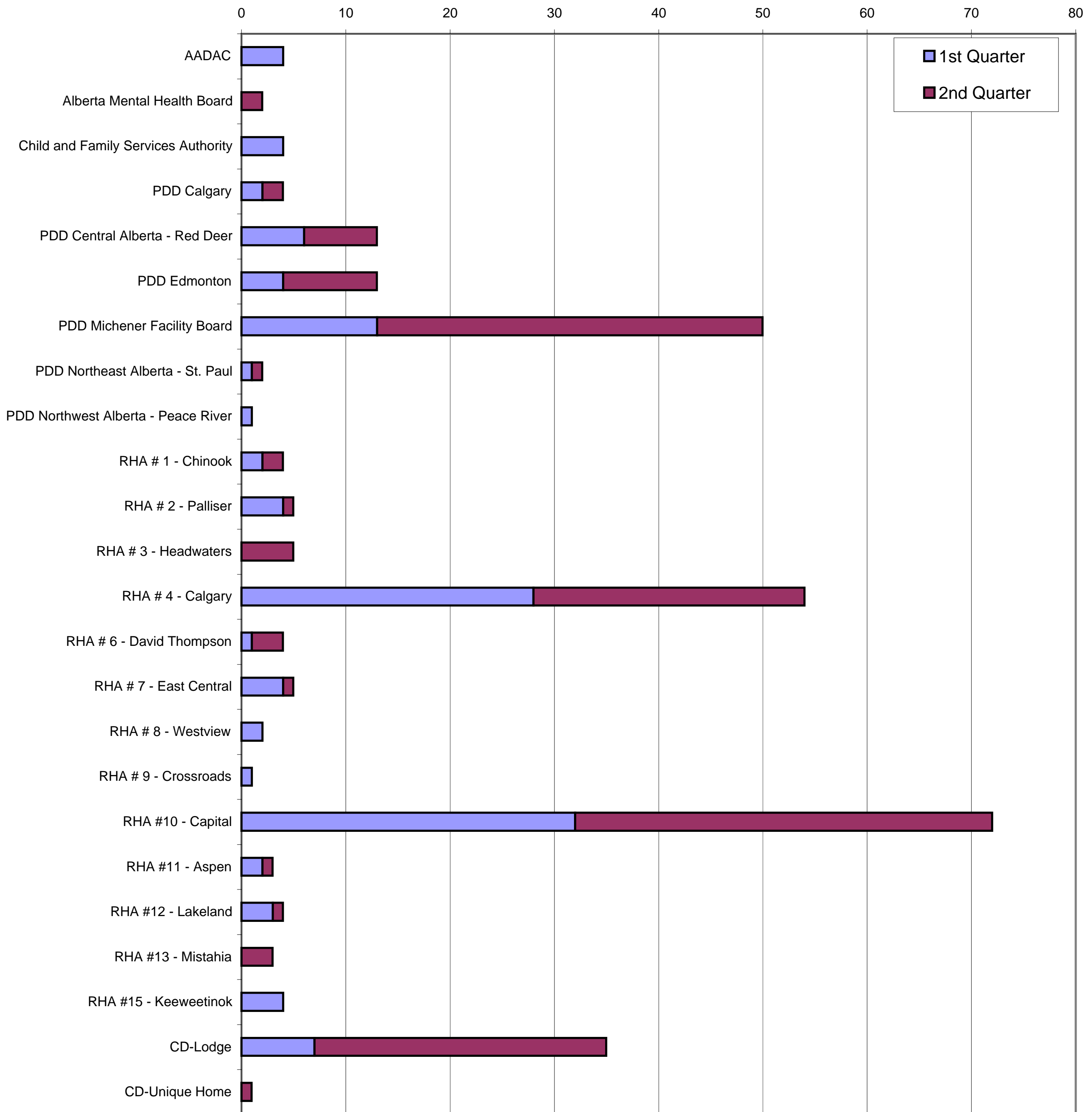
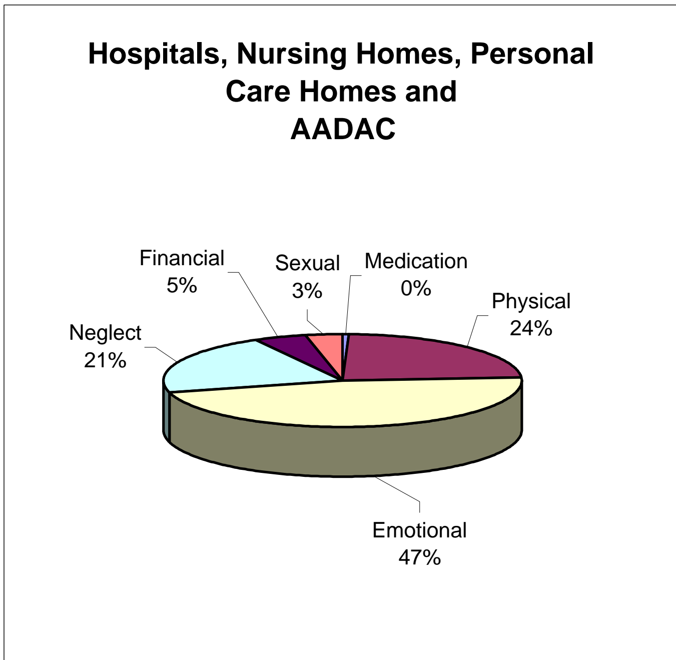
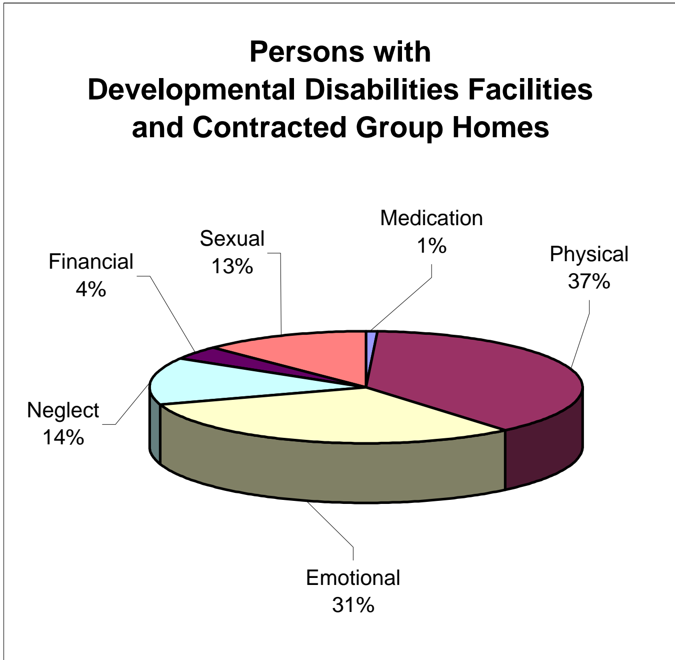


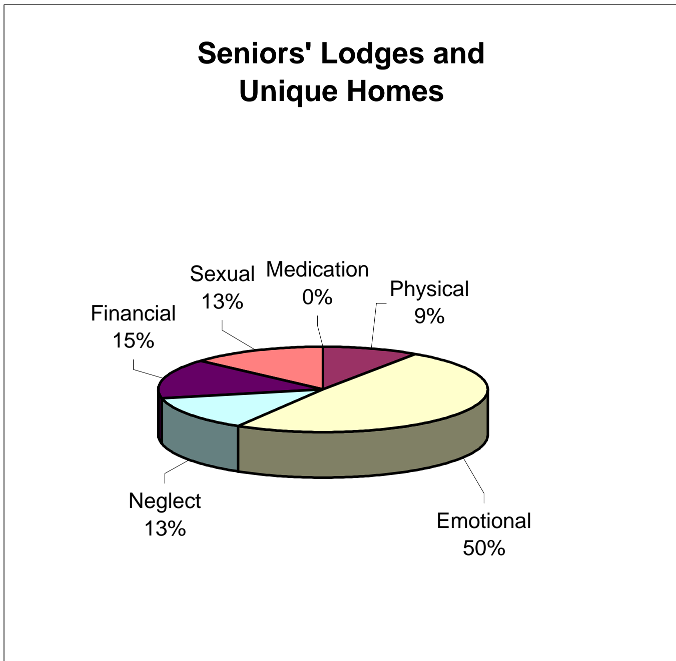
Figure 1

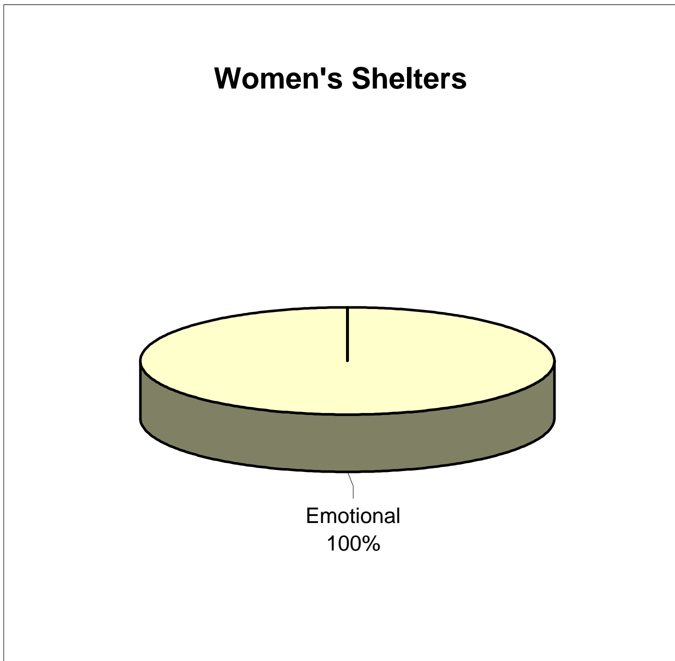
PPC 2nd Quarterly Report 2001 - 2002

Protection for Persons in Care
Types of Alleged Abuse by Organizational Structure
April 1, 2001 - September 30, 2001 (6 months)





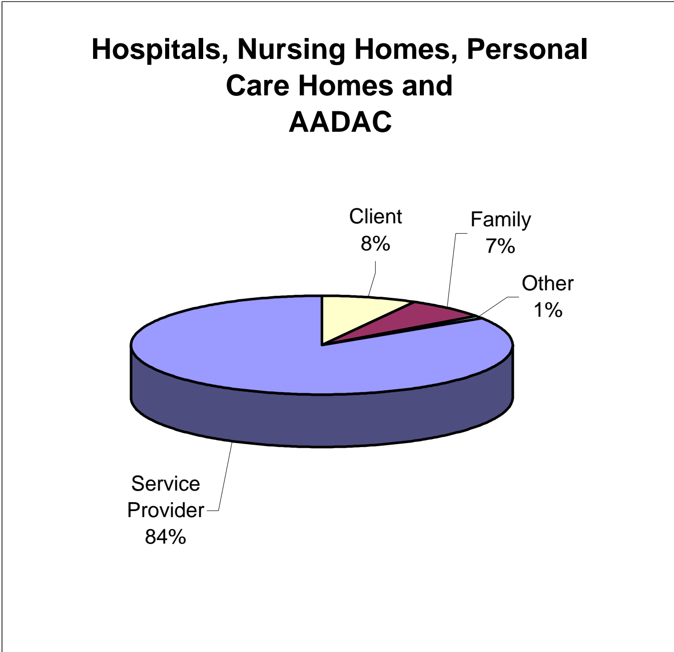


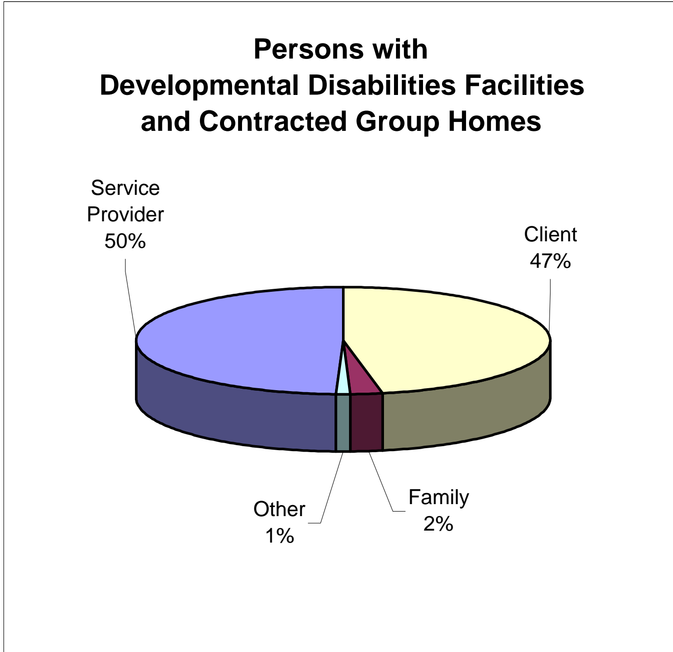


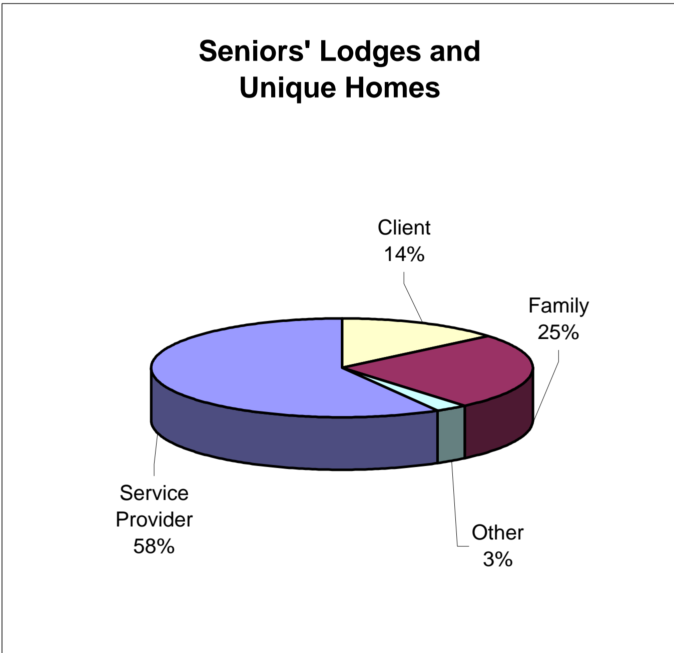
Human Resources and Employment Facilities: 0 Reports

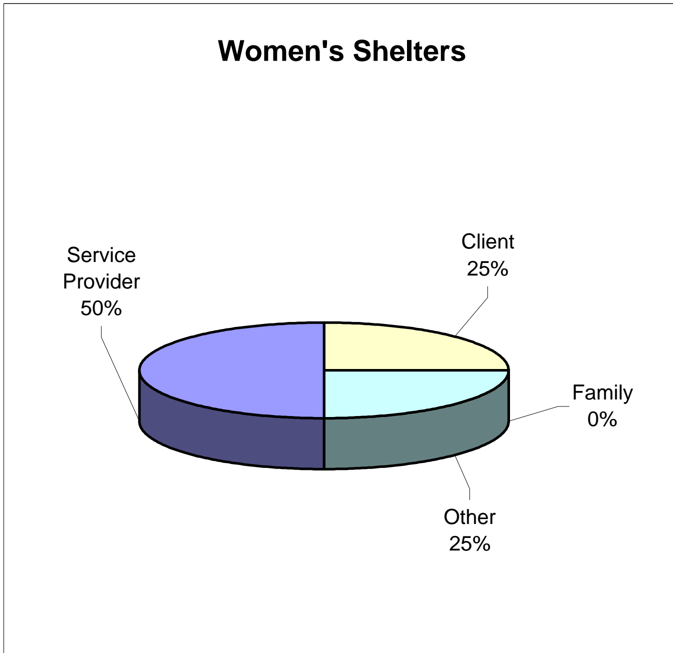
Figure 2

Protection for Persons in Care
Categories of Alleged Abusers by Organizational Structure
April 1, 2001 - September 30, 2001 (6 Months)









Human Resources and Employment Facilities: 0 Reports

Figure 3

REPORTED ALLEGATIONS BY GOVERNING STRUCTURE
PRO-RATED: JULY 1, 2001 – SEPTEMBER 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	6
PDD Edmonton	4
PDD Northeast - St. Paul	2
PDD Northwest Alberta - Peace River	0
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 37 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	2
RHA # 2 - Palliser	2
RHA # 3 - Headwaters	9
RHA # 4 - Calgary	4
RHA # 5 - Health Authority 5	0
RHA # 6 - David Thompson	2
RHA # 7 - East Central	1
RHA # 8 - Westview	0
RHA # 9 - Crossroads	0
RHA #10 - Capital	7
RHA #11 - Aspen	2
RHA #12 - Lakeland	1
RHA #13 - Mistahia	5
RHA #14 - Peace	0
RHA #15 – Keeweetinok Lakes	0
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.

OTHER GOVERNING BODIES:

The number of reports from lodge foundations, unique homes, Children's Services and AADAC are too small to formulate any projections.

PROTECTION FOR PERSONS IN CARE

PART II

INVESTIGATION RECOMMENDATIONS

APRIL 1, 2001 – June 30, 2001

* Recommendations from investigations in the quarter July 1, 2001-September 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 Quarter 2001 – 2002
(April 1, 2001 – June 30, 2001)

- As of October 1, 2001, 125 cases were received during this three-month period with 88 files closed. There are 37 reports still under investigation. Of the open files, contracted investigators are investigating 31 of the reports, one is under investigation by the police and five are being investigated by a professional college.
- Of the 88 closed files, 44.8% were dismissed as unfounded or due to insufficient evidence and 4.0% were referred to the police.
- In reviewing the closed files during this quarter, 58% of reports from facilities under the governance of regional health authorities were dismissed, 70% of the reports from persons with developmental disabilities facilities were dismissed, and 71% of the reports from seniors' lodges were dismissed.

INVESTIGATION RESULTS FOR FILES CLOSED THIS QUARTER:

EXAMPLES OF COMMON RECOMMENDATIONS MADE TO THE AGENCY:

- Display brochures and posters related to PPC to make all clients, staff and visitors aware of the reporting line.
- Finalize and clarify the restraint policy to include a clear definition, delineating what is and what is not a restraint at this facility.
- Consider informing all staff of the circumstances surrounding the incident so that they may monitor the interaction between both clients and prevent further occurrences.
- Consider incorporating into its Risk Management Program the frequency of oxygen tank changes and identification of the appropriate personnel or persons that change oxygen tanks.
- Develop a policy for found property and the safekeeping of resident valuables and communicate this to all clients, guardians and staff.
- Consider holding family conferences, as outlined in its Resident Information Booklets to discuss the resident's status and assessment information, and allow for dialogue between the inter-disciplinary team and the resident's family.
- Consider working with the home care nurse to determine the resident's ability to use the phone or to arrange to have a staff person or volunteer available for prearranged telephone calls on a regular basis, so as not to isolate the resident from her out of town daughters.
- Review and enhance facility policies regarding outings and caregivers' responsibilities while out with clients.
- Review its process of assessing resident transfers and communicating to staff the safest method to use when transferring residents, including information at the bedside and on the resident's care plan, differences in physiotherapy practices and the manner in which improper transfers are reported and managed.
- In one case, a file was referred to a Professional College to review the practice standards of the individual regarding patient assessment. The Professional College ordered that the service provider be issued a reprimand, take and successfully complete a variety of courses within a certain timeframe, and failure to comply will result in an automatic suspension of the service provider's registration.

RECOMMENDATION REGARDING PERSONAL DIRECTIVES

- That the Administrator of the facility request documentation that confirms that an agent has been legally appointed. Many family members are not aware that merely naming an agent in a Personal Directive document or Powers of Attorney document does not constitute the legal appointment of that agent. The court must enact the documents. A useful resource for the facility is "Seniors and the Law: A Resource Guide", available through Faculty of Law, University of Calgary, 2500 University Drive NW, Calgary, Alberta, T2N 2N4, (403) 220-2505.
- That the facility administrator considers meeting with the agent(s) of infirm residents to explore options that might be available to the agent in providing increased levels of care or supervision within the facility setting.

RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:

In 23 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: staff reassignments, written and verbal reprimands, attendance and successful completion of educational training, and educational reading. There was one staff termination.

EXAMPLES OF FACILITY RESPONSES TO RECOMMENDATIONS:

- "We are in the process of implementing regular audits to the call bell response times (all shifts). Meanwhile, we continue to enforce the current requirement that call bells must be answered by a staff member immediately, or as soon as possible should they be in the process of assisting a Resident, when the bell is activated."

- "The resident now has a "ROHO" cushion in her wheelchair. Due to her increased weakness and difficulty with transfers, a wheelchair tray is used for her meals. With this method the height is appropriate for her to reach her meal items and see what she is eating."

- "…the Regional Health Authority invited…Outreach Education Services from…to present a Dementia Care/Behavior Management Workshop for the Continuing Care staff in …"

- "We are in the process of formulating a written abuse policy and should have it completed this year, however, all staff are aware of the reporting protocol."

- "We have established team leader positions for the day and evening shifts. The staffing ratio remains the same but the team leaders are given extra decision making authority so situations can be handled promptly and effectively. The Executive Director has increased the level of supervision of the program, both directly and through the Program Co-ordinator."

- "A member of the (facility) Organizational Development Department gave the (alleged abuser) a one on one in-service on the Dementia A curriculum, Crisis Prevention Interventions course, Respectful treatment of residents, the importance of team work in her work area, strategies on how to cope with difficult people, and how to identify when appropriate behavior is changing in herself or the people around her and how to handle it."

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 - June 30, 2001, as of October 1, 2001)

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	2	0	1
PDD Central Alberta	6	6	0
PDD Edmonton	4	1	1
PDD Michener Facility Board	13	7	2
PDD Northeast Alberta	1	0	0
PDD Northwest Alberta	1	0	1
PDD South Alberta	0	0	0
PDD Provincially	27	14	5

REGIONAL HEALTH AUTHORITIES

	# of Reports	Dismissed	Ongoing
RHA # 1 – Chinook	2	1	1
RHA # 2 - Palliser	6	4	0
RHA # 3 - Headwaters	0	0	0
RHA # 4 - Calgary	26	12	7
RHA # 5 - Health Authority 5	0	0	0
RHA # 6 - David Thompson	1	1	0
RHA # 7 - East Central	4	0	1
RHA # 8 – Westview	2	0	2
RHA # 9 – Crossroads	1	1	0
RHA #10 - Capital	32	9	11
RHA #11 – Aspen	2	2	0
RHA #12 - Lakeland	3	1	2
RHA #13 - Mistahia	0	0	0
RHA #14 - Peace	0	0	0
RHA #15 – Keeweetinok Lakes	4	2	2
RHA #16 - Northern Lights	0	0	0
RHA #17 - Northwestern	0	0	0
RHA Provincially	83	33	26

LODGES FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Dismissed	Ongoing
Lodge Foundations	7	5	0
Unique Homes	0	0	0
Provincially	7	5	0

OTHERS:

Organizational Structure	# of Reports	Dismissed	Ongoing
AADAC	4	0	4
AMHB	0	0	0
CFSA’s	4	4	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 causing emotional harm and subjecting to non-consensual sexual contact, activity or behavior**
Agency: a PDD facility day program and PDD facility residential program
Alleged abuser: service provider (residential program staff)

The allegation was that a service provider of the PDD facility residential program sent a female client sexually suggestive e-mail material, with some items including profanity.

The client receives services from two PDD facilities, one for a residential program and one a day program.

Investigator's Findings

The client had established a relatively new hotmail e-mail account outside of the agency and had used a computer before. A witness was helping the client to read her e-mail messages while at the day program on the day of the incident. The witness observed that twelve messages had been received from a service provider and that four or five were sexually suggestive, including both visual images and text.

When the witness realized that some of the messages were inappropriate, she asked the client who the person was that sent them to her and the client confirmed it was a service provider and commented that she did not know why the service provider sent her those, stating some of them were not nice. The witness then helped the client to delete the material and they could not subsequently be retrieved as hotmail emptied the trash folder.

The service provider has worked with the agency for six years and has a good work record. Evidence indicates that he would have participated in an in-service on abuse at orientation.

The service provider indicated the client had approached him with her e-mail address and asked him to send her some e-mail, which he acknowledged he did, and he denied that any were inappropriate, or of a sexual nature. The service provider did indicate that he did not recall all the e-mails that he may have sent, and if inappropriate e-mail had been sent, he claimed it was done by accident and apologized.

The service provider has the experience and education to know that material containing sexual content is not acceptable to give a client.

The client did not respond in a manner that would indicate that she was emotionally harmed by the e-mail material.

Investigator Recommendations to the Facility:

- That the PDD facility (residential program) consider taking disciplinary action against the service provider, for the alleged abuse of subjecting a client to non-consensual sexual contact, activity or behavior, which may include reviewing the location of his placement in the future.

Case A: (Cont'd)

- That the allegation of intentionally causing emotional harm be dismissed as the complaint is unfounded.

- That the two PDD facilities develop policies regarding use of e-mail and Internet services by clients, including guidelines on instructing clients on security issues and action to take when inappropriate information is received by clients, and acceptable staff/client contact through the medium of e-mail.

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

Note: These recommendations may be relevant to all settings where clients are using email.

Case B: **Type of alleged abuse: intentionally failing to provide the basis necessities of life**
Agency: a long term care centre
Alleged abusers: two service providers referred to as A and B (personal care aides)

The alleged incident occurred during the alleged victim's stay at the facility. The alleged victim was one of several residents who tested positive for an infectious outbreak at the facility's Alzheimers unit. The facility was required to use strict precautionary measures to contain and prevent the infection from spreading to other residents.

Investigator's Findings

The alleged victim had experienced a very rough and disruptive afternoon and early evening, and had been wandering from table to table in the dining room not following the routine for the outbreak. Several attempts were made to return the alleged victim to her assigned seating.

Near the end of supper, the resident was making a lot of noise and disrupting the other residents. She was taken by PCA-B to the other side of the dining room doors, which is also a set of fire doors.

After a few minutes of yelling and banging on the doors, another staff person found the alleged victim lying on the floor screaming and making huge amounts of noise and advised PCA-A. PCA-A insisted several times that the alleged victim was just having a tantrum and to leave her.

At that time a staff person and PCA-B assisted the resident to her room, which was only a few feet away. They did not notice anything that would suspect any injury.

Approximately 20 minutes later PCA-A and another PCA assisted the alleged victim to the bathroom and noticed that the resident was in extreme pain and could not bear weight on her right leg. A registered nurse was called and an ambulance transferred the resident to the hospital for an x-ray and treatment.

The alleged victim had broken her hip, which may have been caused by a fall to the floor or by kicking aggressively at the wall. There were no witnesses to confirm that a fall had occurred and the resident was kicking the wall for only a short period of time.

There was no evidence that either PCA intentionally failed to provide the basic necessities of life or pulled the resident down the hall. However, PCA-A demonstrated bad judgment and poor conduct in not identifying the differences between a temper tantrum and a catastrophic event.

Case B: (Cont'd)

Investigator Recommendations to the Facility:

- That the allegation of intentionally failing to provide the basic necessities of life be dismissed because the evidence is insufficient.
- That annual performance appraisals of staff should be done on a regular basis to provide them with information on the areas they are proficient in and areas where improvement is required with timelines for correction.
- The facility consider providing additional educational supports for nursing staff to assist and better equip them in providing care to the Alzheimer's type of geriatric resident.
- That the facility provides an in-service to all staff in regards to what constitutes abuse and their responsibilities under the *Protection for Persons in Care Act* and in accordance with the facility policy.

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

Case C: Type of alleged abuse: intentionally causing bodily harm
Agency: a long term care centre
Alleged abuser: service provider (hairdresser)

Investigator's Findings
The alleged incident involves a report of intentionally causing bodily harm by the facility hairdresser to the alleged victim. A service provider had noticed the door to the hairdressing salon was closed and locked. The service provider knocked and was let in by the hairdresser. She was telling the service provider that the alleged victim did not want to stay in the shop to get her hair done. The alleged victim told the service provider that the hairdresser had hit her and the alleged victim was holding up her hand. The service provider noticed what she thought was a bruise on the alleged victim's wrist. The alleged victim was asking to leave. A registered nurse was called to check if the "bruise" was present prior to the alleged victim going to the hairdresser. The registered nurse returned the alleged victim to her room. The alleged victim continued to tell other residents and the staff that the alleged abuser had hit her. The alleged victim did not sustain injury and what was thought to be a bruise was actually a black mark caused by the resident's purse.

The hairdresser stated she did not hit the resident but she did put her hand on the resident's wrist and told her to "stay there", when she was resisting having her hair dried.

The hairdresser advised the resident's daughter that her mother had accused her of hitting her. An independent witness in the hair salon at the time of the incident stated that nothing happened, the hairdresser did not hit the alleged victim.

The hair salon door is generally open at all times to facilitate entry and to make it friendlier. On this occasion the door was shut and locked. The hairdreser said she did not know the door was locked. She closed the door because two other residents were trying to leave.

The facility policy is that if there is a problem with a resident being combative in the hair salon, the procedure is to be stopped and the hairdresser is to use the telephone to call for assistance. The hairdresser followed this procedure on previous occasions. The hairdresser did not call for assistance this time and tried to force the resident to have her hair done because her daughter wants the resident's hair done every week.

Case C: (Cont'd)

The hairdresser has not had an orientation to the abuse policy, nor specific in-service on providing care to persons with dementia.

Investigator Recommendations to the Facility

- That the allegation of intentionally causing bodily harm be dismissed as it is unfounded.
- That the facility examine alternatives for the hair saloon door locking mechanism in the interest of residents and staff safety and to ensure immediate emergency access from the hall area.
- That the facility review their orientation and on going in-service training processes to address the needs of contract employees to be familiar with and updated on dementia care issues, including dealing with aggressive residents.
- That the facility re-examine means to integrate and harmonize resident/family and facility expectations with respect to the quality of life issues, such as hair care.

Facility's Response to the Recommendations:

- The hairdresser now ensures that the door is unlocked on the day on which she provides services.

- The hairdresser has reviewed the video on the *Protection for Persons in Care Act*, and the relevant facility policies. Approaches to residents with dementia have been discussed. Managers have been reminded that all contract employees must have this education.

- The facility continues to work with the family members both through informal discussions and scheduled meetings.

PROTECTION FOR PERSONS IN CARE

PART IV

ADMINISTRATION

ADMINISTRATION OF THE *ACT*

- Reports of Decisions now contain the following preface, to clarify the role of the investigator as only gathering facts and making recommendations:

  "This report seeks to set out the facts and to make recommendations pursuant to section 8 of the *Act* without making findings of legal responsibility or drawing conclusions of law."

- There were over 1000 calls to the reporting line during this six-month period of time. Approximately 55% of the calls are for information, 20% for referrals to PPD protocol or agencies like the elder intervention team, and 25% resulted in reports.

- In the first and second quarter of 2001/2002, over 500 posters and approximately 12,000 brochures have been requested.

- 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. Posters and brochures are available by calling the reporting line at 1-888-357-9339.

- Stakeholders are also 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". This medium will be used for information in the future.

- 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.

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