

Protection for Persons in Care

Quarterly Report

October 1, 2001 – December 31, 2001



Protection for
Persons in Care

A PROGRAM OF

**ALBERTA
COMMUNITY
DEVELOPMENT**

PROTECTION FOR PERSONS IN CARE

PART I

REPORTED ALLEGATIONS

OCTOBER 1, 2001 – DECEMBER 31, 2001

PROTECTION FOR PERSONS IN CARE

REPORTED ALLEGATIONS: Third Quarter 2001 - 2002 (October 1-December 31, 2001)

NUMBER OF REPORTS:

- During this quarter, 121 reports were received by the Protection for Persons in Care (PPC) reporting line. This was a 29% decrease from last quarter.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment and Children's Services this quarter.
- The majority of allegations continue to involve persons in care in long term care facilities but considering the number of people in long term care as compared to the other care settings, this is not unrealistic.
- This quarter there was a marked decrease in the number of reports from Persons with Developmental Disabilities (PDD) settings. Last quarter there were a number of reports from one particular PDD facility after the facility held extensive training sessions on PPC. There was also a decrease in reports from lodges because last quarter one lodge had nine reports.

Agency/Ministry Responsibility	# of Reports				
	1st Quarter	2 nd Quarter	3 rd Quarter	Fiscal Year	
				Total	%
Regional Health Authorities/ H&W	83	83	66	232	55.8%
Persons with Developmental Disabilities/CD	27	56	36	119	28.6%
AADAC/H&W	4	0	1	5	1.2%
Alberta Mental Health Board /H&W	0	2	3	5	1.2%
Management Bodies/Alberta Seniors	7	29	15	51	12.2%
Children and Family Services Authorities/CS	4	0	0	4	1.0%
Total	125	170	121	416	100.0%

See 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				
	1 st Quarter	2 nd Quarter	3 rd Quarter	Fiscal Year	
				Total	%
Physical	38	61	41	140	25.6%
Emotional	76	96	58	230	42.1%
Inappropriate medications	1	1	3	5	1.0%
Sexual	7	21	11	39	7.1%
Financial	5	18	8	31	5.7%
Neglect	41	29	31	101	18.5%
Total	168	226	152	546	100.0%

See figure 2 for individual breakdown by organizational structure

ALLEGED ABUSERS:

Service providers remain the largest category of alleged abusers. In this quarter, there is an increase in the percentage of allegations where clients are named as alleged abusers. This is mainly in PDD facilities.

Alleged Abuser	1 st Quarter	2 nd Quarter	3 rd Quarter	Fiscal Year Total	
				Total	%
Service Provider	96	113	73	282	67.8%
Client	18	41	36	95	22.8%
Family	9	14	9	32	7.7%
Other	2	2	3	7	1.7%
Total	125	170	121	416	100%

See figure 3 for further breakdown by organizational structure

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

INVESTIGATORS:

In this 3rd quarter of 2001-2002, contracted investigators conducted approximately 81% of the investigations, 11% were conducted by a professional college and 3% by a police service.

Investigator	1 st Quarter	2 nd Quarter	3 rd Quarter	Fiscal Year Total	
				Total	%
Contracted Investigators	116	150	98	364	85.2%
Professional Colleges:	10	12	13	35	8.2%
-AARN (RNs)	8	5	8	21	
-CLPN (LPNs)	2	2	2	6	
-CPS (Physicians)	0	1	1	2	
-Other (CPTA, RPNA)	0	4	2	6	
Police	3	11	4	18	4.2%
Other bodies (MHPAO)	0	1	1	2	.5%
Not Investigated	0	3	5	8	1.9%
Total	**129	***177	121	427	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 - December 31, 2001 (9 months)

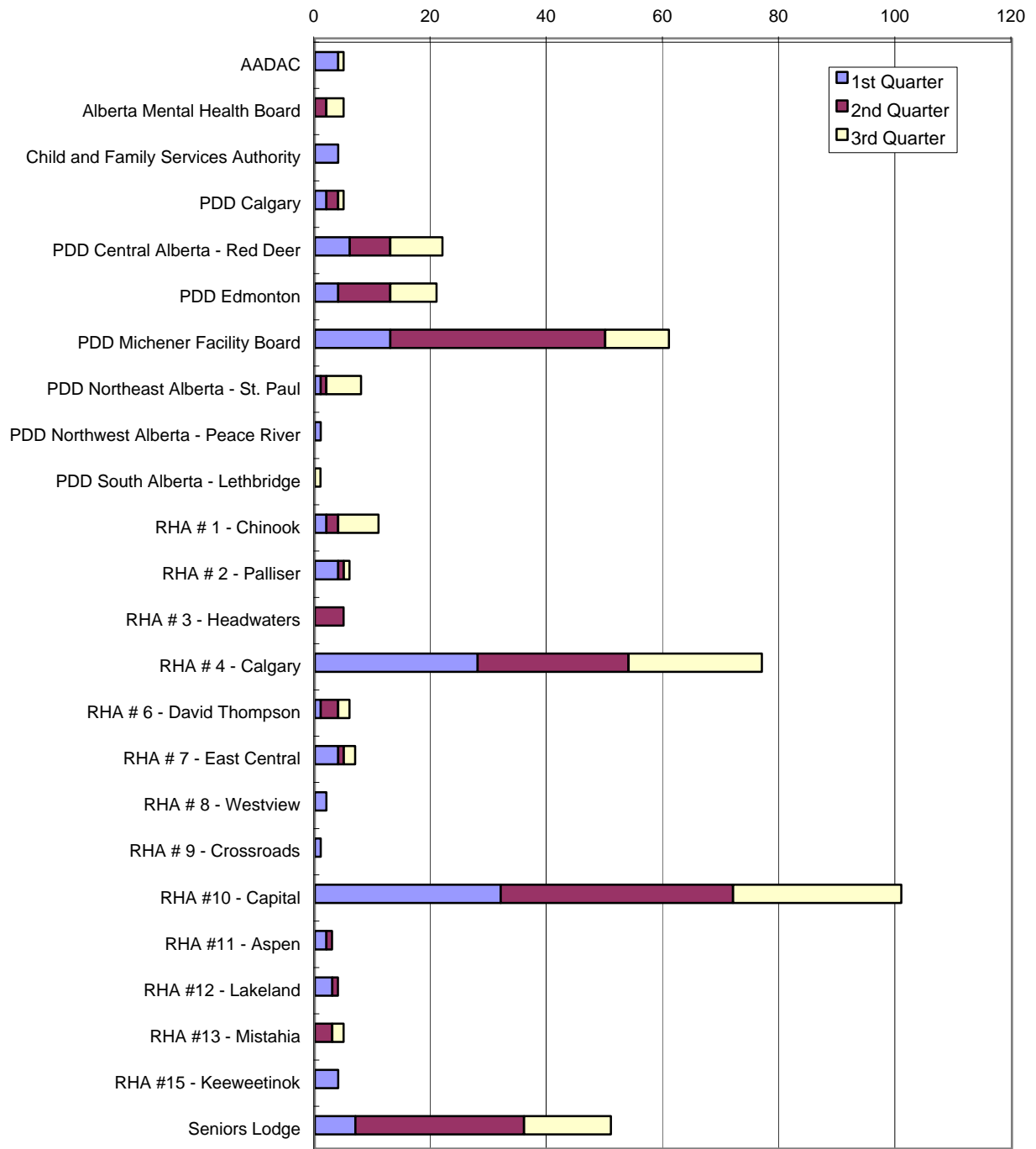
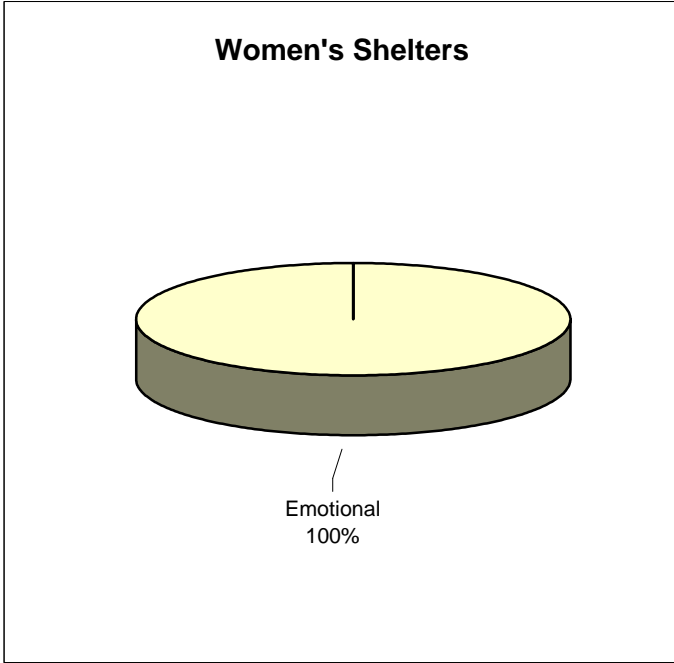
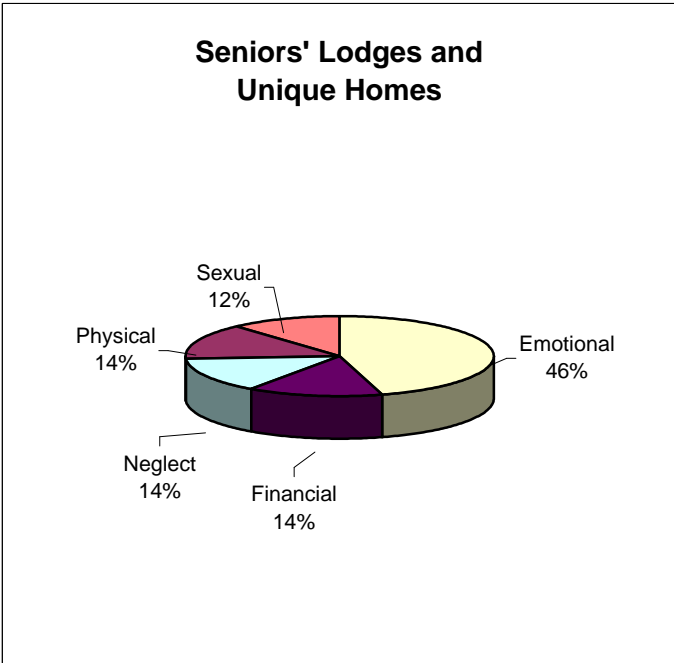
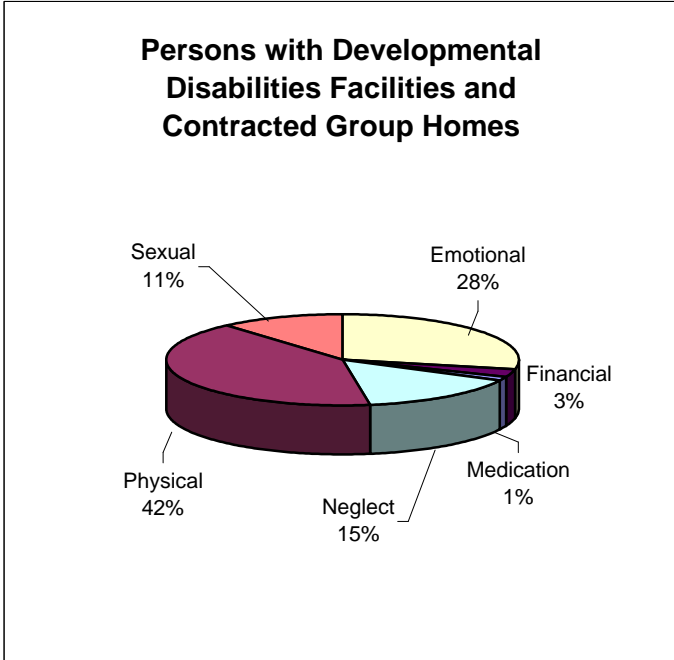
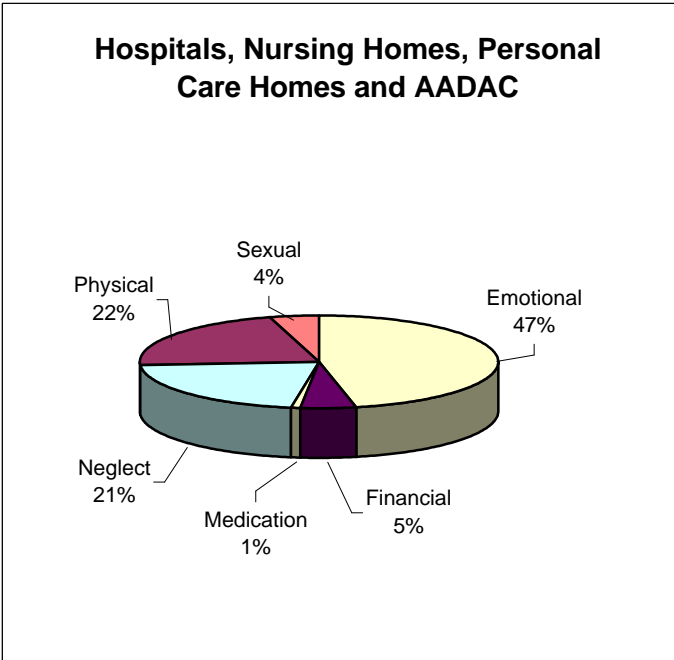


Figure 1
PPC 3rd Quarterly Report 2001 - 2002

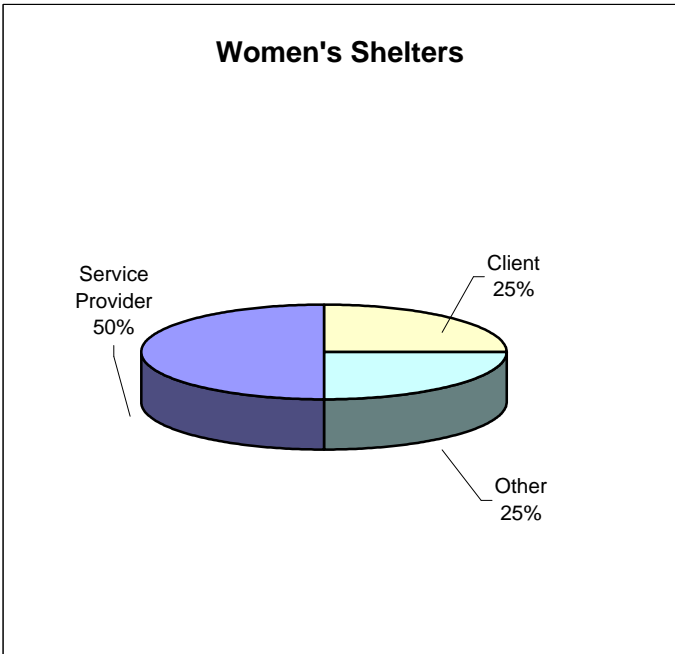
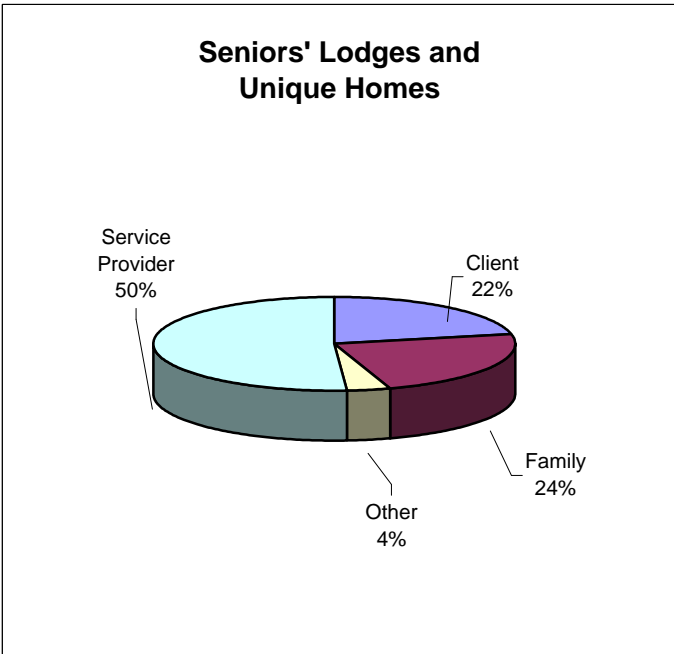
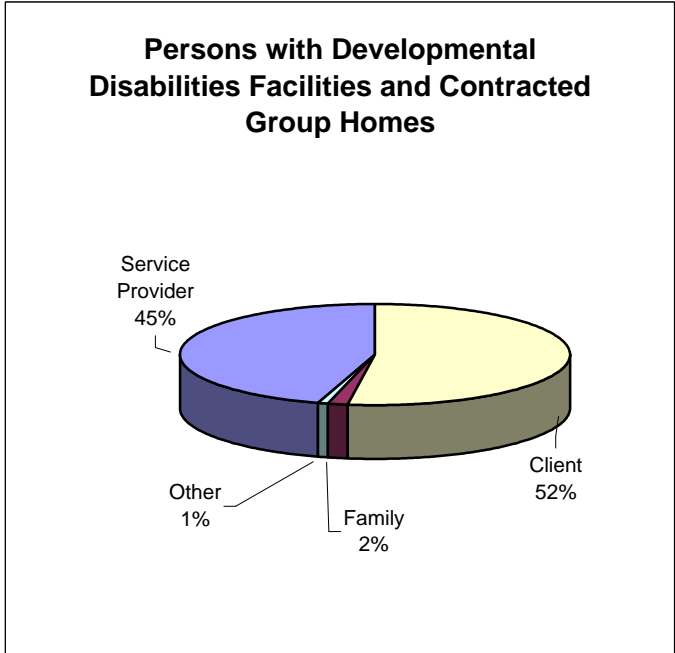
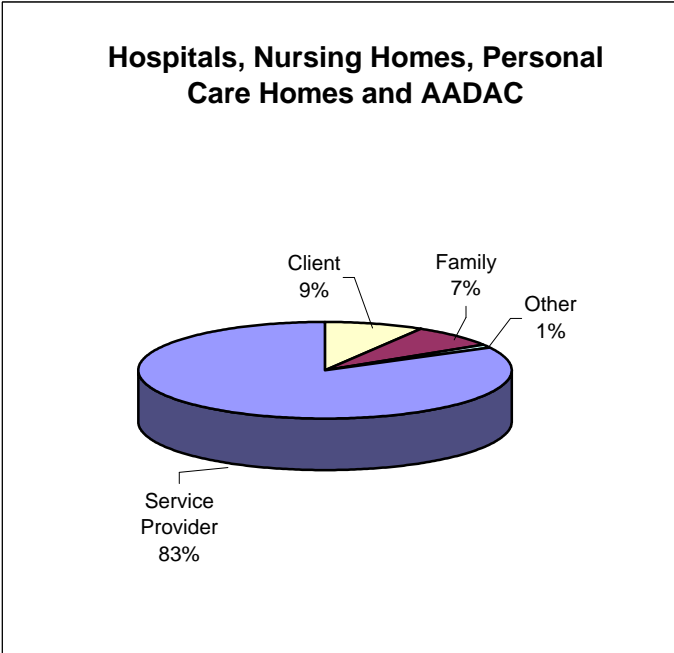
**Protection for Persons in Care
Types of Alleged Abuse by Organizational Structure
April 1, 2001 - December 31, 2001 (9 months)**



Human Resources and Employment: 0 Reports

Figure 2
PPC 3rd Quarterly Report 2001 - 2002

**Protection for Persons in Care
 Categories of Alleged Abusers by Organizational Structure
 April 1, 2001 - December 31, 2001 (9 Months)**



Human Resources and Employment: 0 Reports

REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRO-RATED: APRIL 1, 2001 – DECEMBER 31, 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	3
PDD Central Alberta - Red Deer	19
PDD Edmonton	9
PDD Northeast - St. Paul	18
PDD Northwest Alberta - Peace River	3
PDD South Alberta - Lethbridge	1

*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 50 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	11
RHA # 2 - Palliser	9
RHA # 3 - Headwaters	9
RHA # 4 - Calgary	11
RHA # 5 - Health Authority 5	0
RHA # 6 - David Thompson	4
RHA # 7 - East Central	10
RHA # 8 - Westview	3
RHA # 9 - Crossroads	4
RHA #10 - Capital	17
RHA #11 - Aspen	5
RHA #12 - Lakeland	5
RHA #13 - Mistahia	8
RHA #14 - Peace	0
RHA #15 – Keewetinok 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	6

*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

PART II

INVESTIGATION RECOMMENDATIONS

JULY 1, 2001 – SEPTEMBER 30, 2001

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

INVESTIGATION RECOMMENDATIONS

Second Quarter 2001 – 2002

(July 1, 2001 – September 30, 2001)

- As of January 2, 2002, 170 cases were received during this three-month period with 150 files closed. There are 20 reports still under investigation. Of the open files, contracted investigators are investigating 17 of the reports and a professional college is investigating three reports.
- Of the 150 closed files, 55.3% were dismissed as unfounded or due to insufficient evidence and 6.6% were referred to the police.
- Overall this fiscal year, 57% of the allegations in PDD facilities were dismissed, 62.5% were dismissed in facilities governed by regional health authorities and 63% were dismissed in seniors lodges.

INVESTIGATION RESULTS FOR FILES CLOSED THIS QUARTER:

EXAMPLES OF RECOMMENDATIONS MADE TO AGENCIES:

Education and Training:

- Agency make an effort to ensure that all staff are knowledgeable of restrictive procedures policy and use of least restrictive alternatives, and that they are adequately trained on how and when to use them competently.
- Facility ensure staff on this unit have the skills and ability to provide care to all patients including those with impeded ability, i.e. patients with strokes or larger framed patients.
- Facility review the nursing attendants' training and ensure that they are aware of their direct responsibility for providing complete personal care to assigned residents regardless if students are in the unit.

Policies and Procedures:

- Review with staff the need to complete incident reports and the procedure for notifying the client's guardian of the incident.
- Facility consider adding a clause to the Resident Information Handbook and the Terms and Conditions Agreement for Lodges that would include information regarding action to be taken, such as eviction without notice if a resident caused harm or infringed on the rights of an other resident.
- Facility consider developing a policy outlining criteria for admission or rejection of residents who have previously demonstrated behaviors that could be harmful to other residents.

Other:

- Regional health authority and facility review the care received by the resident.
- Facility explore with the Office of the Public Trustee the option of having a trustee appointed to manage the affairs of the resident.
- Agency ensure that staff supervise the food consumption of any client with a known eating difficulty or disorder.

PERSONAL DIRECTIVES and ENDURING POWER OF ATTORNEY:

- The last quarterly report contained incorrect information pertaining to enacting a personal directive and/or power of attorney. *The correction should note that these documents do not need to be enacted by the court.*
- The following is some further information that the facility should be aware of:

Many family members may not be aware that a written declaration is required to bring a personal directive into effect and to bring some types of enduring power of attorney documents into effect. To bring a personal directive into effect, a Declaration of Incapacity (Form 1 or Form 2) must be completed. These forms are specified in the *Personal Directives Act Regulation*. The maker of a personal directive may designate one or more persons to bring the personal directive into effect.

The court does not have a role in bringing a power of attorney or enduring power of attorney into effect. If the enduring power of attorney states that it comes into effect at a specified future time or on the incapacity or infirmity of the donor, a written declaration is required to bring it into effect. The donor may designate one or more persons to bring the document into effect, but if no person is designated, then two medical practitioners must make a written declaration. However, there is one type of enduring power of attorney that can take effect immediately on the day that it is executed but again, the court has no role in bringing it into effect.

In the case of guardianship and/or trusteeship under the *Dependent Adults Act*, the Court appoints a guardian and/or trustee by granting an order.

RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:

In 18 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: monitoring job performance, staff reassignments, written and verbal reprimands, completion of educational training, and educational reading. There were five staff terminations and seven staff resigned from their positions.

EXAMPLES OF FACILITY RESPONSES TO RECOMMENDATIONS:

- Long Term Care: "...the facility uses a lift and transfer assessment form to determine the lift that is required and this includes the assessment of when a Golvo should be used."
- PDD: "...staff have reviewed this serious occurrence thoroughly and have continued to review preventive action to deter aggressive behaviour by the specific client involved and others in this facility. ...staff are currently involved in additional training in the management of crisis and aggressive behaviours. This training emphasizes prevention first and the maintenance of a safe environment for all clients."
- Mental Health: "The Executive Director met with the employee and initiated "Step 1 – Verbal Warning" of the Disciplinary Process."

EXAMPLES OF FACILITY RESPONSES TO RECOMMENDATIONS: (Continued)

- PDD: “The agency has expanded current policies and procedures to include a policy, procedure and self-study guide regarding the *Protection for Persons in Care Act*. All staff will have to sign that they have read and discussed the *Act* with the Executive Director. The policies and procedures for the agency are part of an orientation package for new staff, with the signature required.”
- PDD: “The alleged abuser has been temporarily moved to an alternative individual living arrangement with one to one staff. He is undergoing a complete medication change. He will be returned to his home once he has been stabilized with the new medication regime, at which time he will continue to be closely monitored.”
- Long Term Care: “A designated area has been established for families and visitors to access information that would help them to understand some of the behaviours family member/friends are demonstrating. We also have some excellent 15-20 minute videos that would be suitable for family/friends viewing and will also make these available.”
- Long Term Care: “Facility recently completed a trial for a new laundry hamper system which helps to address odors from soiled linens. Now that the trial has been completed and the results being that these hampers do decrease the odors, the facility has planned to purchase these hampers in the new year. This hamper system is lined with impermeable plastic bags with lids covering the hampers. These bags will be monitored to ensure soiled laundry is removed on a regular basis.”
- Long Term Care: “The care plan has been changed. An incontinent mapping is done and once a pattern is established and known, the care plan will show how often and the time to change the incontinent garment. This will eliminate the need to physically touch the resident’s garment to see if it requires changing.”
- Long Term Care: “...[Director of Care] (DOC) at the time of the incident was commended for her perseverance and professionalism. DOC received a copy of the letter sent by your office for her file and a copy was placed in her employee file as well. DOC was given a gift certificate for dinner and theater to use at her discretion.”
- Lodge: “...The Foundation is implementing activity programs at each lodge. As part of this program the Foundation will provide informational sessions focusing on the residents to address lifestyle issues and quality of life. As always family members and friends of residents are welcome to attend.”
- Lodge: “...Will arrange a session on aging for the residents of the ... Lodge”.

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 – September 30, 2001, as of January 2, 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	4	2	0
PDD Central Alberta	13	8	0
PDD Edmonton	13	4	1
PDD Michener Facility Board	50	28	5
PDD Northeast Alberta	2	1	0
PDD Northwest Alberta	1	1	0
PDD South Alberta	0	0	0
PDD Provincially	83	44	6

REGIONAL HEALTH AUTHORITIES

	# of Reports	Dismissed	Ongoing
RHA # 1 – Chinook	4	3	0
RHA # 2 - Palliser	5	5	0
RHA # 3 - Headwaters	5	3	2
RHA # 4 - Calgary	54	35	1
RHA # 5 - Health Authority 5	0	0	0
RHA # 6 - David Thompson	4	4	0
RHA # 7 - East Central	5	0	1
RHA # 8 – Westview	2	0	2
RHA # 9 – Crossroads	1	1	0
RHA #10 - Capital	72	36	4
RHA #11 – Aspen	3	3	0
RHA #12 - Lakeland	4	3	2
RHA #13 - Mistahia	3	0	3
RHA #14 - Peace	0	0	0
RHA #15 – Keeweenok Lakes	4	2	2
RHA #16 - Northern Lights	0	0	0
RHA #17 - Northwestern	0	0	0
RHA Provincially	166	95	14

LODGES FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Dismissed	Ongoing
Lodge Foundations	36	14	14
Unique Homes	0	0	0
Provincially	36	14	14

OTHERS:

Organizational Structure	# of Reports	Dismissed	Ongoing
AADAC	4	3	0
AMHB	2	2	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* and were selected for their possible relevance to other facilities.

Case A: Type of alleged abuse: intentionally causing emotional harm
Agency: a Persons with Developmental Disabilities Agency,
Day Program
Alleged abusers: service provider (Support Worker)

The allegation was that a Support Worker (SW) spoke rudely to a client and firmly told a client to stop crying.

Investigation Facts

There is evidence to indicate that the client was emotionally upset from the interaction with the SW and felt humiliated by the experience.

The SW denied telling the client to stop crying.

There is evidence that indicates the SW has had problems with other clients and staff in the past, and has spoken to clients in a demeaning voice. The facility has told the SW on two occasions at least that her remarks to clients were unacceptable.

There is evidence to indicate that the SW has participated in training, and has the knowledge and the experience to know the effect her words would have on a client. The job description of the SW notes that her duties include being a positive role model at all times and to act as an advocate for the client to ensure her desires and needs are being met.

The agency makes information available to all staff about the client's condition, needs, likes, dislikes, and behaviors through meetings and by preparing a "client profile" for staff to read. It was found that on the day of the alleged incident, that the SW and some of the other staff, who were present, were not familiar with the client's condition. Information related to symptoms the client was displaying on the day of the incident was in the client profile, but not all the staff were aware of it.

During the investigation, the SW continued to work at the agency. Witnesses indicate that she was given a verbal warning and it was the intent of the agency to prepare a list of expectations for her.

Investigator's Recommendations to the Facility

- That the agency review with all staff the importance of becoming familiar with a client's needs and condition, monitor staff to ensure they read client profiles before outings, and explore other strategies to ensure staff respond appropriately to various client situations.
- That the agency consider including positive aspects of the client in a client profile to enable support staff to build on client's strengths.

Case A (Cont'd)

Facility's Response to the Recommendations

- The SW has been terminated.
- The agency recognizes that staff turnover is a contributing factor to familiarity of client needs and conditions amongst staff members. We have set up a mentoring system where new staff are connected on outings with seasoned staff that know the clients well.
- We have also assigned one specific staff to ensure client profiles are accurate and up to date. The profiles indicate client likes and preferences. Client needs and changes are discussed at all day program staff meetings and documented in minutes as well as client files and profile sheets.
- The agency orientates all clients to policies upon commencement into programs, including abuse and reporting procedures. These policies are reviewed with all clients on at least an annual basis, or more often, depending upon the cognitive ability of the individual.

Case B: Type of alleged abuse: intentionally causing emotional harm and intentionally failing to provide the basic necessities of life

Agency: a seniors lodge

Alleged abuser: service provider (evening staff person)

The allegation was that a client was left in a communal bathtub without being discovered by two shifts of staff. The client suffered bruising and was distressed by the incident.

Investigation Facts

The resident went to take a bath in the communal tub room in the afternoon.

The evening supervisor noticed the resident was not at supper. She then checked her room and noticed she was not there, nor was her walker. The door was unlocked, therefore it was assumed the resident was out with her son and had forgotten to sign out.

The next morning a home care aide was assisting another resident with her shower and she noticed the tub room door was closed and the light was on. She called out and knocked on the door, but heard nothing, after louder banging and calling, the resident responded. The door was jammed and the home care aide and another staff were unable to open the door therefore called the fire department. They opened the door and when the paramedics went in, the resident was in the tub and the call bell was not within reach.

Evidence supported that the resident experienced significant bruising, skin breakdown, stiffness, weakness, restrictive breathing, pain and disturbed sleep.

The evening staff person did not check every room with the night staff person at shift change, did not follow up with the resident being missing at supper, and did not call the family nor make any notation in the communication

book for the next shift to follow up. It was noted that entries in the logbook were not always clearly signed with full signatures, therefore making it difficult to identify who made the entry.

Case B: (Cont'd)

Investigator's Recommendations to the Facility

- That the facility, if it has not already done so, takes disciplinary action against the evening staff person.
- If not already done so, a full inspection of all bathrooms and renovations should be completed by qualified personnel with respect to the safety needs of the elderly, which would include emergency call bells, taps, water temperature, keys and locks.
- That staff demonstrates that they are able to open the bathroom door in an emergency, as well as the whereabouts of the key/wire required.
- That the staff continues to provide emotional support and reassurance to the resident for her sense of safety and comfort with the lodge environment.
- That the facility considers having full signatures for all entries in the communications book and all pertinent events occurring on shift should be consistently documented.
- That the facility includes the Protection for Persons in Care telephone reporting line number in the Resident Handbook.
- That the facility review Operations Policy #4.40, section 2(d), which reads that it is Administration who decides whether abuse not reported by residents should be reported externally. It should be made clear that anyone who has reasonable and probable grounds to believe and believes that there is or has been abuse against a client shall report such abuse to the Minister of Community Development or a police service or a committee, body or person authorized under enactment to investigate such an abuse regardless of internal reporting procedures.

Facility's Response to the Recommendations

The Foundation has terminated the employment of the staff person.

A full inspection of all bathing areas including the relocation of the call alarm system has taken place by Alberta Infrastructure as authorized under the Provincial Lodge Upgrading Program Agreement.

The Residence Supervisor has reiterated to employees the location and use of the bathroom keys.

The Foundation maintains a communication book to record resident and lodge activities and unusual occurrences. The Foundation will formerly reiterate the guidelines to all personnel including appropriate documentation and authorization.

The Residence Supervisor and members of the Foundation continue to provide support and comfort to the resident as a consequence of the incident. The Foundation is very careful to ensure other residents do not view our actions as favoritism.

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

The alleged incident occurred during preparation of a resident for bed. The resident was resisting and was slapping out at the personal care aide (PCA).

Investigation Facts

A witness stated that she heard the resident and the PCA arguing behind the curtain. The witness looked behind the curtain and saw the PCA hit the resident's hand.

The PCA admitted to hitting the resident but stated she did not believe this was abuse because the resident hit her first and she was just trying to get him to stop. The resident did not sustain harm.

Evidence supported that since the PCA's return to work following a leave, she has been yelling at residents and staff. Staff have been protecting the PCA and helping her deal with personal issues. The PCA was not aware of the stress she was under nor was management aware of the PCA's escalating behavior towards residents.

There was no Protection for Person in Care (PPC) information available at the facility and inservice on the PPC Act and abuse are not covered in orientation. The facility had ordered posters and brochures and will display to heighten awareness of the *ACT*.

The PCA was terminated from her employment with the facility.

Investigator's Recommendations to the Facility

That the facility provide annual refresher programs for all staff, volunteers and contracted personnel on the PPC Act and its application to care and treatment of the residents and that the regional policy on abuse be made visible and accessible to staff.

That the facility ensures PPC information is visible for staff, residents, families and visitors.

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

PROTECTION FOR PERSONS IN CARE

PART IV

ADMINISTRATION

ADMINISTRATION OF THE ACT

- During this fiscal year, 16 files have been forwarded to the Crown Prosecutor for review of special offences under the *Protection for Persons in Care Act*. These offences include suspected failure to report abuse, malicious reporting, taking adverse action against an employee and taking adverse action against an alleged victim for reporting abuse or being abused. To date no charges have been laid. However, there are several reports still with the Crown Prosecutor. The statute of limitation for special offences is six months, which is one of the reasons for charges not being laid.
- In November 2001, PPC staff and legal services met with the Executive Director and Investigation Coordinators of the Alberta Association of Registered Nurses (AARN) to discuss investigating allegations of abuse where a registered nurse (RN) is named as the alleged abuser. The following approach was agreed to:
 - When the reporting line receives an allegation of abuse identifying a RN as the alleged abuser, callers will continue to be asked if they have reported the matter to the AARN. If they indicate that they have not and that they wish to, the phone number will be provided as well as an offer to fax the AARN's complaint form to them to complete and send to the AARN.
 - If the caller does not wish to contact the AARN directly or indicates that the allegation is more than a concern about a specific RN, the reporting line will take the report. The department will appoint an investigator to investigate the matter under PPC. If the investigator recommends that a RN's practice should be reviewed and the Ministry approves this recommendation, it will be forwarded as a recommendation to the agency for consideration.
- In accordance with the *Ombudsman Act*, the Honourable Gene Zwozdesky, Minister of Community Development, published a notice of an Ombudsman Review in the Alberta Gazette, December 31, 2001. The Ombudsman will conduct an investigation into the administration of the *Act*. The investigation is expected to take a several months. At the same time, Alberta Community Development will conduct a legislative review. The legislative review will consider the scope of the *Act*, broader administrative and legal implications, its consistency with other legislation and proposed amendments. The findings from the Ombudsman's review will be considered in the context of the broader legislative review.
- 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.
- 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 PPC Office. We try to provide information that would be relevant to service providers and general public in promoting the respect and dignity of vulnerable adults in care facilities in the Alberta.

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