

Quarterly Report

On the

Activities

of

Protection for Persons in Care

Including

Outcomes for January 1 - March 31, 2002
Incoming Reports for April 1 - June 30, 2002



**Protection for
Persons in Care**

A PROGRAM OF

**ALBERTA
COMMUNITY
DEVELOPMENT**

PROTECTION FOR PERSONS IN CARE

PART I

INVESTIGATION OUTCOMES AND RECOMMENDATIONS

FROM CASES REPORTED

JANUARY 1, 2002 – MARCH 31, 2002

INVESTIGATION RECOMMENDATIONS

Fourth Quarter 2001 – 2002

INVESTIGATION RESULTS FOR FILES CLOSED JANUARY 1, 2002 – MARCH 31, 2002:

- During this three-month period, 125 of the 126 cases investigated were closed. There is one report still under investigation by the police.
- 68% of the cases were dismissed as unfounded or due to insufficient evidence and 4.0% were referred to the police.
- Overall for the fiscal year 2001-2002, 60% of the allegations in Person with Developmental Disabilities (PDD) services were dismissed, 61% were dismissed in facilities governed by regional health authorities and 51% were dismissed in senior's lodges.
- Although allegations of abuse may be dismissed as unfounded or due to insufficient evidence of intent or harm, based on the definition of abuse in the *Act*, systemic recommendations are often made in an effort to assist facilities in preventing similar incidents from occurring.

RECOMMENDATIONS AS RELATED TO HUMAN RESOURCES:

- In 24 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: completion of performance appraisals, completion of educational reading and training, and other forms of disciplinary action such as written reprimands, suspensions and terminations.
- Within the 24 reports, there were 11 staff terminations and one staff resignation. Overall, in 2001 – 2002, 26 staff were terminated and nine resigned. The number of staff terminated has steadily increased each quarter.

COMMON THEMES FOR RECOMMENDATIONS MADE TO AGENCIES:

General Recommendation all facilities:

- It should be noted that an employee may work in more than one setting within the geographical region or move to another facility in a short period of time, thus thorough reference checks are recommended.

PDD Setting Recommendation:

- Agencies should provide clear direction and guidelines to staff regarding professional boundaries with clients.
- Provide staff training in the area of effectively working with clients who have psychiatric difficulties, including assessment of needs and effective communications.
- Ensure that all staff are familiar with and implement the Risk Behaviors and Intervention procedures when an alleged abuser demonstrates inappropriate physical contact.
- Ensure the client's guardian is aware of and has approved any changes to the client's care/service plan.

Long Term Care Recommendations:

- Care plans should be reviewed with all appropriate staff and active family members, as clear communication about the care requirements is vital to the client, staff and family members. It is especially important to assist family members in understanding the differences between acute care interventions and continuing care services to clarify the expectations of care that can be provided.
- While residents are still competent to make decisions, provide them with information and resources related to planning for their future. Encourage and/or facilitate contact with the Office of the Public Trustee on matters of a financial nature, trusteeship and enduring power of attorney, and with the Office of the Public Guardian on matters of personal (non-financial) nature, guardianship and personal directives. For residents who have a legal guardian or trustee appointed, ensure the facility has a copy of relevant court documents.
- Staff witnessing incidents and completing incident reports should also be the individuals reporting the alleged abuse to the reporting line. A high percentage of alleged abuse complaints are reported to the reporting line by management, based on the information in the agency's incident report. Often, individuals who did not directly witness the incident do not have first hand knowledge of the incident.

Lodge Recommendation:

- Ensure that the client and their family understand the tenant's agreement and eviction policy prior to moving in.

Women's Shelters:

- Ensure that clients understand the expectations of the "Conditions of Stay and House Guidelines of the Shelter".

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 – March 31, 2002, as of July 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	8	3	0
PDD Central Alberta	26	12	0
PDD Edmonton	28	15	0
PDD Michener Facility Board	78	54	1
PDD Northeast Alberta	10	5	0
PDD Northwest Alberta	2	1	0
PDD South Alberta	2	2	0
PDD Provincially	**154	(58.4%) 98	1

REGIONAL HEALTH AUTHORITIES

	# of Reports	Dismissed*	Ongoing
RHA # 1 – Chinook	18	14	0
RHA # 2 - Palliser	8	7	1
RHA # 3 - Headwaters	5	4	0
RHA # 4 - Calgary	96	63	6
RHA # 5 - Health Authority 5	0	0	0
RHA # 6 - David Thompson	9	6	0
RHA # 7 - East Central	15	9	0
RHA # 8 – Westview	2	0	0
RHA # 9 – Crossroads	2	1	0
RHA #10 - Capital	132	68	2
RHA #11 – Aspen	8	3	0
RHA #12 - Lakeland	5	4	0
RHA #13 - Mistahia	6	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	**310	(60.3%) 187	10

Note:

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

**After the completion of the investigations, four reports were adjusted from the last Quarterly Report because the reports involved facilities that had both PDD and mental health clients.

LODGE FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Dismissed*	Ongoing
Lodge Foundations	58	30	1
Unique Homes	0	0	0
Provincially	58	(51.7%) 30	1

OTHERS:

Organizational Structure	# of Reports	Dismissed*	Ongoing
AADAC	6	(66.7%) 4	0
AMHB	7	(71.4%) 5	0
CFSA's	7	(85.7%) 6	0

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

PROTECTION FOR PERSONS IN CARE

PART II

REPORTED ALLEGATIONS

APRIL 1, 2002 – JUNE 30, 2002

PROTECTION FOR PERSONS IN CARE

REPORTED ALLEGATIONS: First Quarter 2002 - 2003 (April 1-June 30, 2002)

NUMBER OF REPORTS:

- During this quarter, 134 reports were received by the Protection for Persons in Care (PPC) reporting line, which is consistent with other quarters from last fiscal year.
- There have been more reports from women's shelters this quarter than in most quarters from last fiscal year.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment this quarter or this fiscal year.

Agency/Ministry Responsibility	1 st Quarter 2002 - 2003		Average for 2001-2002	
	# of Reports	%	# per Quarter	%
Regional Health Authorities/ H&W	69	51.5%	76.5	56.5%
Persons with Developmental Disabilities/CD	47	35.1%	39.5	29.1%
AADAC/H&W	1	.7%	1.5	1.1%
Alberta Mental Health Board /H&W	1	.7%	1.75	1.3%
Management Bodies/Alberta Seniors	13	9.7%	14.5	10.7%
Children and Family Services Authorities/CS	3	2.3%	1.75	1.3%
Total	134	100.0%	135.5	100.0%

See Part III figure 1 for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE:

Types of Abuse	1 st Quarter 2002-2003		Average for 2001-2002	
	# of Types	%	# per Quarter	%
Physical	45	25.7%	46.7	25.6%
Emotional	75	43.0%	75.2	41.3%
Inappropriate medications	2	1.1%	2.0	1.1%
Sexual	13	7.4%	11.7	6.4%
Financial	11	6.2%	10.2	5.6%
Neglect	29	16.6%	36.2	20.0%
Total	175	100.0%	182.0	100.0%

See Part III figure 2 for individual breakdown by organizational structure

ALLEGED ABUSERS:

Alleged Abuser	1 st Quarter 2002-2003		Average for 2001-2002	
	# of Alleged Abuser per type	%	# per Quarter	%
Service Provider	95	71.0%	91.7	67.7%
Client	23	17.1%	29.5	21.8%
Family	13	9.7%	11.0	8.1%
Other (volunteers/visitors/non-family)	3	2.2%	3.2	2.4%
Total	134	100.0%	135.5	100.0%

See Part III figure 3 for further breakdown by organizational structure

INVESTIGATORS:

- There was a small increase in police service as investigators this quarter relative to the average number of reports from last fiscal year.

Investigator	1 st Quarter 2002-2003		Average Investigator Types for 2001-2002	
	# of Investigator Types	%	# of Investigator	%
Contracted Investigators	113	81.9%	118.7	85.8%
Professional Colleges:	8	5.8%	8.7	6.3%
-AARN (RNs)	-0			
-CLPN (LPNs)	-7			
-CPS (Physicians)	-1			
-Other (CPTA, RPNA)	-0			
Police	11	8.0%	7.0	5.1%
Other bodies (MHPAO)	1	.7%	.5	.3%
Not Investigated	5	3.6%	3.5	2.5%
Total	*138	100.0%	138.4	100.0%

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

PROTECTION FOR PERSONS IN CARE

PART III

SUMMARY GRAPHS AND CHARTS OF REPORTED CASES

1st Quarter Fiscal Year 2002/2003

- Figure 1 – Number of reports
- Reported Allegations by Governing Structure Pro-rated
- Figure 2 – Types of alleged abuse
- Figure 3 – Categories of alleged abusers

**Protection for Persons In Care
Number of Reports**

**April 1, 2002 - June 30, 2002 (3 months)
1st Quarter**

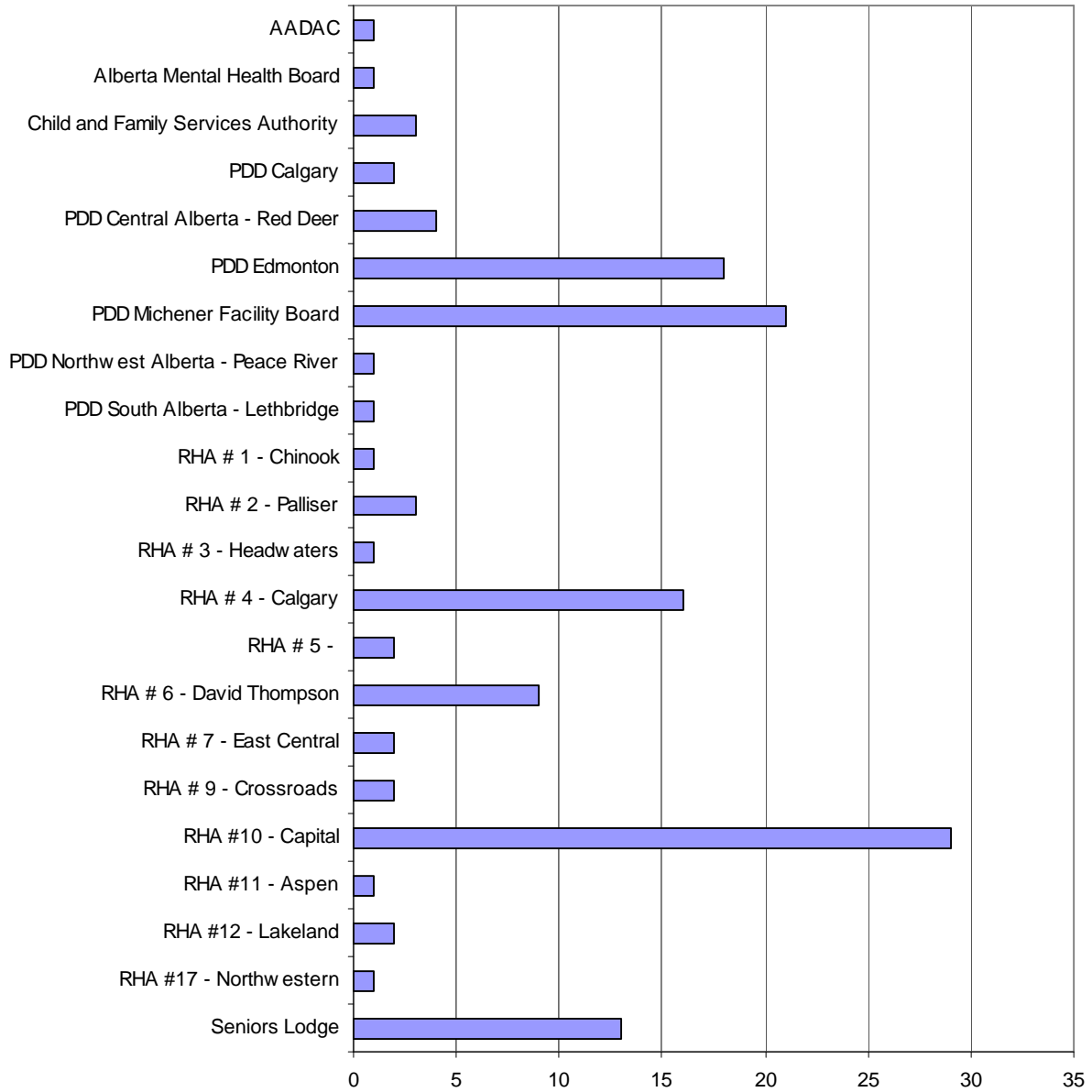


Figure 1

REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRO-RATED: APRIL 1, 2002 – JUNE 30, 2002

To better reflect the number of reports regionally across Alberta per large 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 (excludes Michener)	3
PDD Edmonton	7
PDD Northeast - St. Paul	0
PDD Northwest Alberta - Peace River	3
PDD South Alberta - Lethbridge	1

*Based on figures from Annual Report 2000/2001

REGIONAL HEALTH AUTHORITIES:

(Reports by Region adjusted per 100,000 population over the age of 19*)

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

*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.

** Based on very small population projections

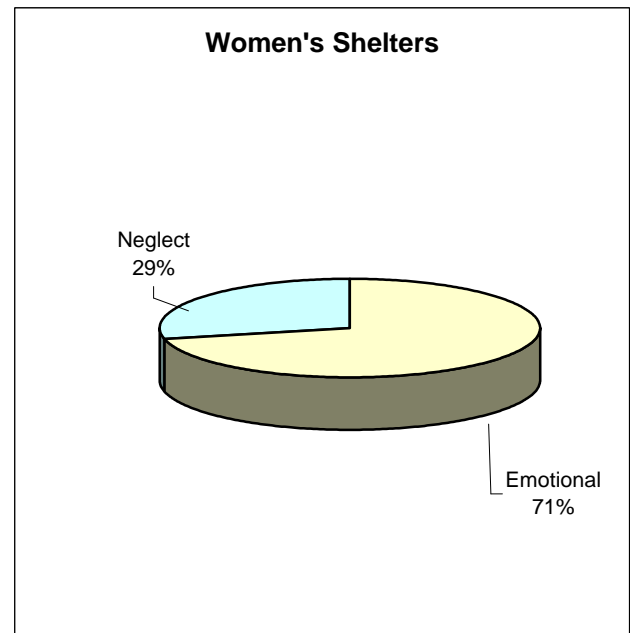
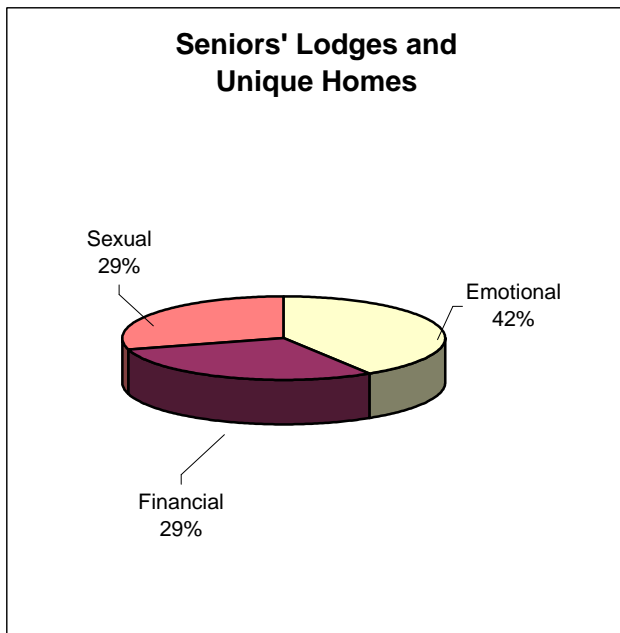
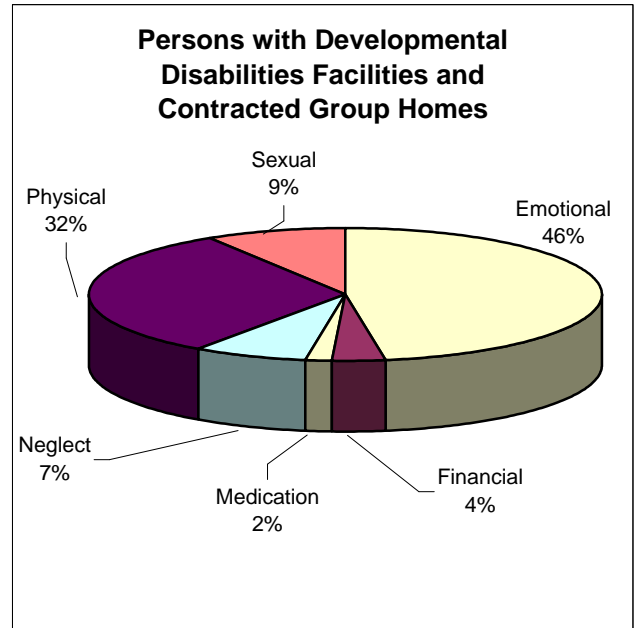
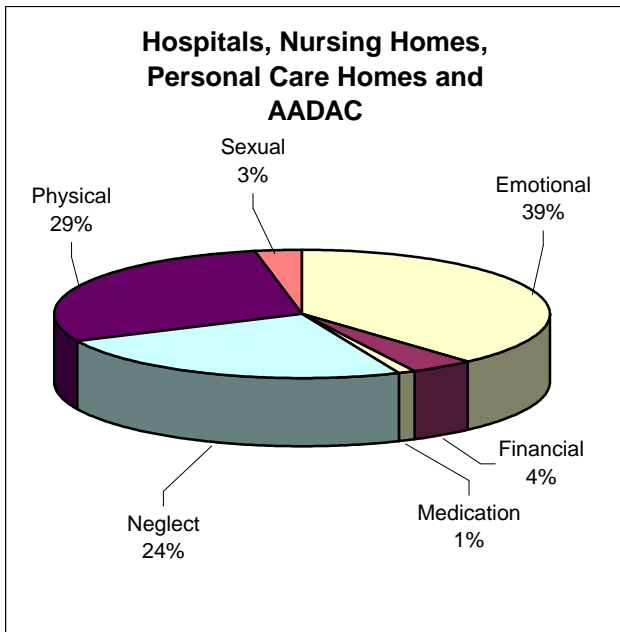
LODGE FOUNDATIONS/UNIQUE HOMES:

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

Province Wide	Reports
Units	1.6

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

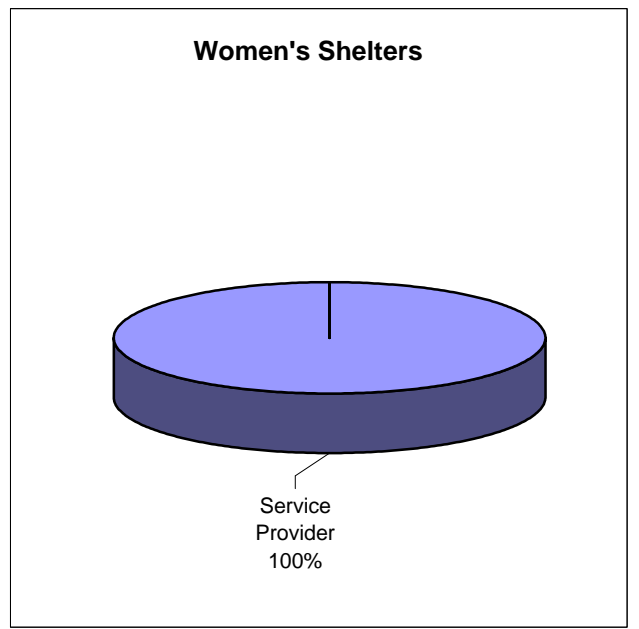
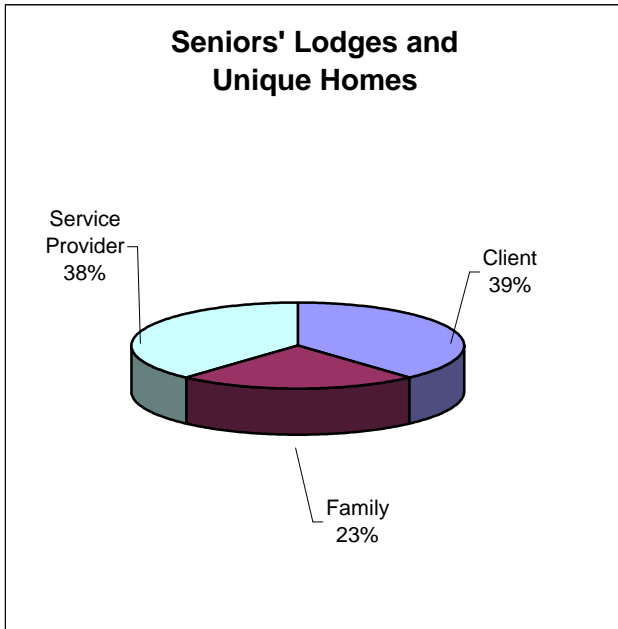
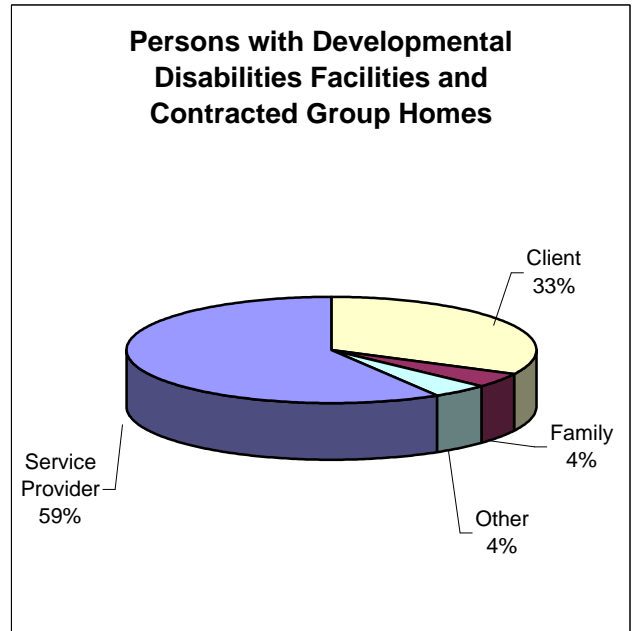
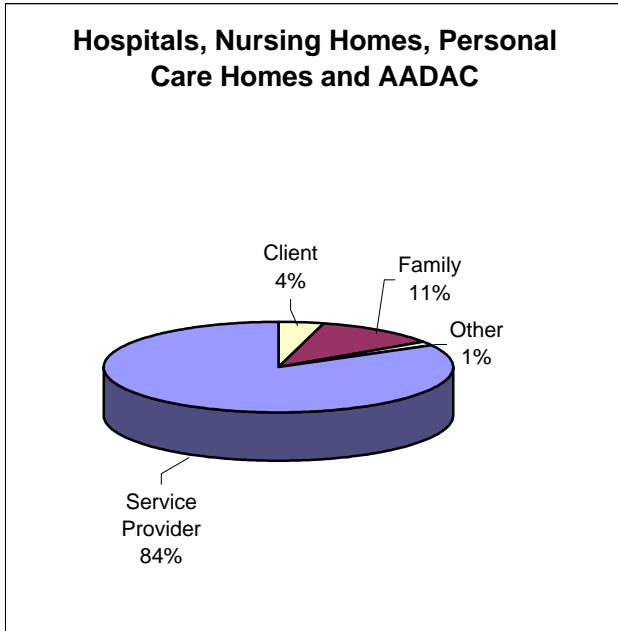
**Protection for Persons in Care
Types of Alleged Abuse by Organizational Structure
April 1, 2002 - June 30, 2002 (3 months)**



Human Resources and Employment: 0 Reports

Figure 2

**Protection for Persons in Care
 Categories of Alleged Abusers by Organizational Structure
 April 1, 2002 - June 30, 2002 (3 Months)**



Human Resources and Employment: 0 Reports

Figure 3

PROTECTION FOR PERSONS IN CARE

PART IV

CASE SUMMARIES

- Case A: Persons with Developmental Disabilities Group Home
- Case B: Long Term Care Centre
- Case C: Long Term Care Centre
- Case D: Women's Shelter

CASE SUMMARIES

The following four summaries of investigation reports are representative of the types of complaints and facilities investigated under the *Protection for Persons in Care Act* and were selected for their possible relevance to other facilities in the action taken by the facility or in recommendations made.

Case A: Type of alleged abuse: intentionally failing to provide the basic necessities of life
Agency: a Persons with Developmental Disabilities Agency (PDD contracted)
Alleged abusers: service provider (Community Support Worker 1)

The allegation was that the alleged abuser (AA), through apparent incapacity, did not attend to the essential needs of three totally dependent residents under her care on night shift.

Investigation Facts:

- Two day shift workers arrived at the facility in the early morning and could not obtain access into the home because they did not have a key, therefore contacted the Executive Director and a Board Member who is also the parent of one of the clients.
- Evidence indicated that the alleged abuser (AA) experienced a fall, resulting in injury and likely unconsciousness, which may or may not have been connected to the consumption of alcohol. She admitted to consuming alcohol while on duty.
- Day shift staff observed that the one resident had not had his feeding tube flushed, which should have occurred during the night.

Action taken by the Facility:

- The AA was terminated from the facility.
- Administration said that the facility would use this incident to review their policies to ensure that appropriate precautions are in place to prevent the likelihood of these types of incidents from occurring and that they are considering a different emergency phone listing and providing keys to select neighbors as well as doing spot checks.

Case B: Type of alleged abuse: intentionally causing emotional harm
Agency: a Long Term Care Centre
Alleged abuser: service provider (Care Aid)

The allegation was that the alleged abuser (AA) dressed a male resident in a lady's dress and then took him to breakfast.

Investigation Facts:

- A witness stated that when the alleged abuser (AA) was getting the resident ready for breakfast and noticed that he did not have a housecoat, she said, "not even a housecoat, the family could at least buy him a housecoat". She then went to the utility room and got a back opening dress and said she was going to put it on the resident. The witness said that she questioned the AA about putting the dress on the resident.
- Documentation indicated that the resident was severely cognitively impaired. The witness said that the resident did not seem emotionally upset over what he was wearing. The witness admitted to laughing at seeing the resident in a dress. Other residents took long looks at the resident wearing a dress and the resident's spouse said he would have been upset to be wearing a dress.

Case B (Cont'd)

Action taken by the facility:

- The Manager met with the AA, six hours following the incident, and discussed the incident with the AA. The AA confirmed the incident and said that she did not “do this to hurt him”. She said that she did not know putting a dress on the resident was abuse.
- The AA was terminated from her position with the facility.

Investigator’s Recommendations to the Facility:

- That the facility provide sensitivity training to unit staff as it relates to abuse with an emphasis on emotional harm, especially those staff that laughed at the resident in a dress.
- That the facility ensure all levels of staff understand their mandatory requirement to report abuse under the *Protection for Persons in Care Act*.

Case C: **Type of alleged abuse: intentionally causing bodily harm and intentionally causing emotional harm**

Agency: a Long Term Care Centre

Alleged Abuser: service provider (Nursing Attendant)

The allegations were that the alleged abuser (AA) placed a pillow over a resident’s face twice, and rubbed it into the resident’s face.

Investigator’s Facts:

- A witness stated that when she was putting the resident to bed, the alleged abuser (AA) came up beside the resident, startling the resident and the resident started to swing her hands at the AA.
- The witness said that the AA took a pillow from the head of the resident’s bed and put it on the resident’s face. The witness said that the AA did not say anything, he just did it and “smothered the pillow into the resident’s face”. The witness said she grabbed the pillow off the resident’s face and the AA took a second pillow and did it again. She said that she grabbed this one off as well.
- The witness said when the pillow was over the resident’s face, the resident’s hands were going and she was swinging and screaming. She said the resident appeared fine physically but seemed scared. Staff did not assess the resident or document the incident, but the Manager said she saw the resident later in the hall and “she did the little hug thing and she seemed okay”. The resident’s family was not notified of the incident or the actions taken.

Action taken by the facility:

- The Director of Care (DOC) said that the AA told her that he did it because he was teasing. She said that she asked the AA what the resident was doing when the pillow was over her face and he said, “still flailing and trying to scream”. The DOC said that the AA did not appear to understand the seriousness of his actions.
- The AA has been terminated from his employment with the facility.

Investigator’s Recommendation:

- That the facility ensure residents are assessed following any suspected incident of abuse to determine what, if any, injury occurred and that it be charted on the resident’s clinical file, along with whether or not the family/guardian was notified, to whom the incident was reported internally and any action taken.
- *The Investigator referred the allegation of intentionally causing bodily harm to a Police Service for criminal investigation.*

Case D: Type of alleged abuse: intentionally causing emotional harm
Agency: Women's Shelter
Alleged abuser: service provider (Executive Director)

The allegation was that the alleged abuser (AA), yelled at the client degrading and threatening her that if she did not clean up she would be out of the shelter.

Investigation Facts:

- The client said, when she was leaving to go to a meeting, the alleged abuser (AA) yelled at her out the patio doors saying “who’s going to clean the kitchen?” The client said this embarrassed her, as the comments were loud enough to be heard down the street.
- In another incident, the client said that the AA banged on her bedroom door and yelled at her to get up and clean the kitchen and put food away. The documentation completed by the AA indicated that staff told the AA that the kitchen was “very dirty” from breakfast.
- The AA said she knocked on the client’s door and spoke loudly within reason. A witness said the AA used “reasonable loudness”.
- A witness said that the client sounded angry and the situation was “very tense” between the client and the AA. The client said the AA told her that if she didn’t clean up, she and her children would have to leave by the afternoon. The client said she cried as she was very concerned about what to do if she had to leave.
- Failure to abide by the House Guidelines can result in asking the client to leave; however, the Dismissal Policy does not mention the lack of cleaning as a specific cause for dismissal of a client. The policy states that “Clients who show extremely abusive behaviour toward staff or other clients, repeatedly break curfew as discerned by staff, display signs of drug or alcohol abuse or who possess a weapon will be asked to leave...”
- The client arrived at the facility while the Aboriginal Worker was away on holidays; therefore this Worker was not available to talk to the client. The client felt that there was little sincere communication with the AA and other staff members who did not have Aboriginal backgrounds, as they appeared to lack cultural awareness.

Action taken by the facility:

- The matter was discussed at the Board level and a mediator was appointed to meet with the AA and the client. The mediator, who was an Elder and a Board member, said that there was a difference in perception of what constituted “yelling” and that the client is very soft spoken whereas the AA tends to speak louder naturally. The Elder said that she believed the client, because of past experiences, is very sensitive to voices and interprets them as threatening.
- The Elder indicated that all of the staff at the facility could benefit from more training in Aboriginal Awareness and the long standing cultural concerns that impact on clients.

Investigator Recommendations to the Facility

- That the facility considers having an Aboriginal staff member or an Elder volunteer available to meet, at intake or shortly thereafter, with the clients who are of Aboriginal background.
- That the Conditions of Stay and House Guidelines of the Shelter be reviewed verbally with clients after they have had an opportunity to settle into the facility and that the clients be encouraged to discuss the requirements of the House Guidelines to ensure their understanding of the expectations.
- That the policy regarding dismissal of clients be reviewed and considered by the Board as to intervention strategies and what is a reasonable length of time for dismissal relating to various infractions that may include safety and security issues, and non compliance with chores.

PROTECTION FOR PERSONS IN CARE

PART V

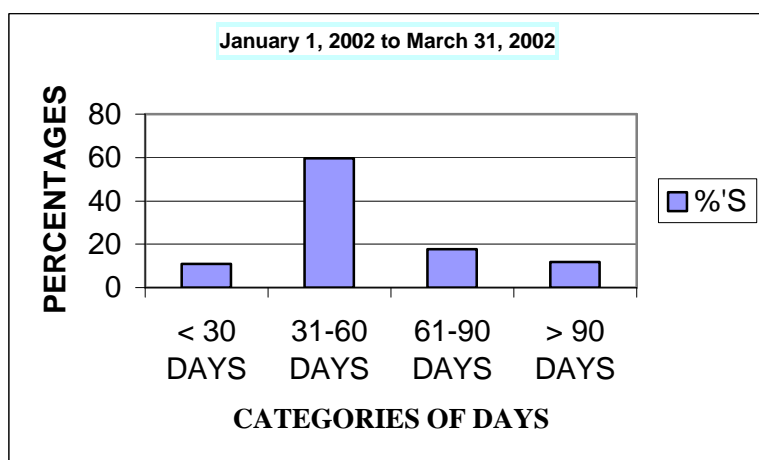
ADMINISTRATION

Protection for Persons in Care Satisfaction Survey 2001 – 2002

Thank you for taking the time to complete the survey that we had sent out with the last quarterly report. Ninety surveys were returned, which was an approximate 20% return rate. Analysis of survey results will be included in future quarterly reports.

Length of Time Files Are Open*

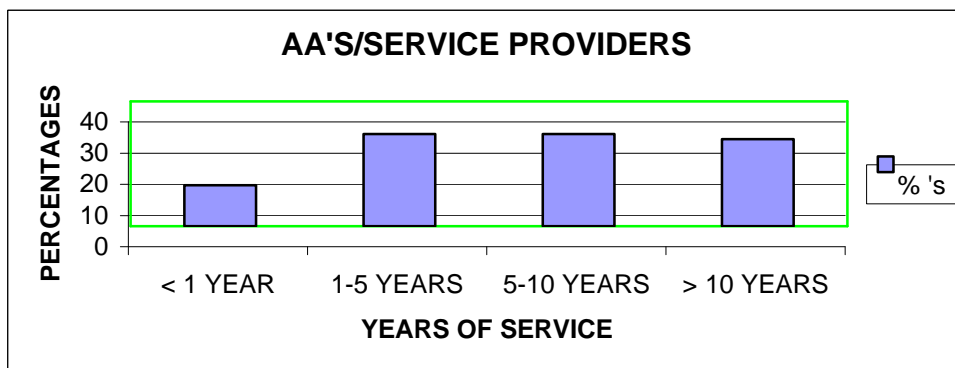
One area commented on in the survey was the length of time it takes to complete investigations. A review of the 125 closed files for the quarter of January 1 to March 31, 2002 indicated the files were closed in the following number of days: 11% of files were closed in 0 to 30 days; 60% of files were 31 to 60 days; 18% of files were closed in 61 to 90 days; and 11% of files were closed in 91 days and over. During this quarter, most files were closed within 36 to 40 days. The average was 55 days, as two police files were open 120 and 122 days respectively.



*Files are considered opened on the day the allegation is reported to the reporting line and closed as of the date on the Deputy Minister's letter to the agency and complainant.

Length of Service of Service Providers as Alleged Abusers

An area frequently commented during investigations is the frequent turnover of staff and the length of service of alleged abusers. A review of 61 files from April 1 to June 30, 2002 indicated that service providers had the following years of service: 13% had less than one year of service; 29.5% had 1 to 5 years of service; 29.5% had 5 to 10 years of service; and 27.8% had over 10 years of service.



Resources and Other Information

- Information on the *Protection for Persons in Care Act* legislative review, announced in August 2002, bulletins and copies of the quarterly reports are available from the Community Development web site at <http://www.cd.gov.ab.ca> under “Helping Albertans”.
- Currently only one copy of the quarterly report 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.
- Frequently Asked Questions document 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. Please call the reporting line at 1-888-357-9339 for copies or refer to the Web site as it will be there shortly.

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
PPCA Legislative Review (780) 415-8617 or e-mail PPCLegReview@gov.ab.ca