

**Quarterly Report**  
**On the**  
**Activities**  
**Of**  
**Protection for Persons in Care**

**Including:**

**Outcomes for April 1 – June 30, 2002**

**Incoming Reports for July 1 – September 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**

**APRIL 1, 2002 – JUNE 30, 2002**

## **INVESTIGATION RECOMMENDATIONS**

### **First Quarter 2002 – 2003**

#### **INVESTIGATION RESULTS FOR FILES CLOSED July 1, 2002 – SEPTEMBER 30, 2002:**

- During this three-month period, 127 of the 134 cases investigated were closed. There are seven reports still under investigation by a professional college.
- 66%% of the closed cases were dismissed as unfounded or due to insufficient evidence and 8.6% were referred to the police.
- Overall for the First Quarter for the fiscal year 2002-2003, 57.4% of the allegations in Person with Developmental Disabilities (PDD) services were dismissed, 56.5% were dismissed in facilities governed by regional health authorities, 46.3% were dismissed in senior's lodges and 33.3% were dismissed in Children's Services.
- 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 34 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 34 reports, there were 16 staff terminations and two staff resignations.

#### **COMMON THEMES FOR RECOMMENDATIONS MADE TO AGENCIES:**

##### **General Recommendations for all facilities:**

- Ensure employees have performance appraisals completed in a timely and regular timeframe.
- Ensure family members and guardians are kept aware of client's health changes and what that means in terms of care and changes in the client.

##### **Recommendations in PDD settings:**

- Review policy and procedure manuals and intake packages as they relate to "Client Rights" and clearly outline the expectations the agency has of clients and their family/guardian.
- Review with staff, the scope of their responsibilities, per agency policy, related to incident reporting and weekly parent/guardian debriefing.
- Review with all relief staff the reporting procedures, proper documentation and the importance of these entries as a means to better serve clients and to assist staff in tracking client behavior and medical concerns.
- Ensure that staff are given training on how to write satisfactory notations in communication, personal log and safety books.

**Recommendations in Long Term Care Settings:**

- Ensure annual care conferences are held on all residents to discuss the resident's status and assessment information and allow for dialogue between the interdisciplinary team and family members.
- Ensure care conferences are held within one month of admission and annually, or more often as required.
- Provide staff with clear performance needs and monitor the performance with respect to approaches used in the management of challenging behaviors which may be exhibited by residents and address any inappropriate staff behaviors immediately.

**Recommendation in a Lodge:**

- Ensure all resident views are known by using the Resident Council Meetings to allow all residents to present their views.

**Recommendation in Acute Care:**

- Ensure that all contracted service providers, who are doing constant observation as part of their roles and responsibilities, have training on the types of patients they will be providing constant care for and that documentation of training be kept.

## PERCENTAGE OF INVESTIGATIONS BY GOVERNING STRUCTURE

(Based on the number of reports received for the specific governing structure per regional area from April 1, 2002 – June 30, 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	2	1	1
PDD Central Alberta	4	4	0
PDD Edmonton	18	10	1
PDD Michener Facility Board	21	10	7
PDD Northeast Alberta	0	0	0
PDD Northwest Alberta	1	1	0
PDD South Alberta	1	1	0
PDD Provincially	47	(57.4%) 27	9

### REGIONAL HEALTH AUTHORITIES

	# of Reports	Dismissed*	Ongoing
RHA # 1 – Chinook	1	1	0
RHA # 2 - Palliser	3	2	1
RHA # 3 – Headwaters	1	1	0
RHA # 4 - Calgary	16	12	0
RHA # 5 - Health Authority 5	2	2	0
RHA # 6 - David Thompson	9	2	6
RHA # 7 - East Central	2	1	0
RHA # 8 – Westview	0	0	0
RHA # 9 – Crossroads	2	1	0
RHA #10 - Capital	29	15	5
RHA #11 – Aspen	1	0	0
RHA #12 - Lakeland	2	1	1
RHA #13 - Mistahia	0	0	0
RHA #14 - Peace	0	0	0
RHA #15 – Keeweenok Lakes	0	0	0
RHA #16 - Northern Lights	0	0	0
RHA #17 - Northwestern	0	0	0
RHA Provincially	69	(56.5%) 39	13

**Note:**

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

## LODGE FOUNDATIONS AND UNIQUE HOMES

Foundation/Unique Homes	# of Reports	Dismissed*	Ongoing
Lodge Foundations	13	6	3
Unique Homes	0	0	0
Provincially	13	(46.1%) 6	3

## OTHERS:

Organizational Structure	# of Reports	Dismissed*	Ongoing
AADAC	1	0	1
AMHB	1	(100%) 1	0
CFSA's	3	(33.3%) 1	2

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

**PROTECTION FOR PERSONS IN CARE**

**PART II**

**REPORTED ALLEGATIONS**

**JULY 1, 2002 – SEPTEMBER 30, 2002**

## PROTECTION FOR PERSONS IN CARE

### REPORTED ALLEGATIONS: Second Quarter 2002 - 2003 (July 1-September 30, 2002)

#### NUMBER OF REPORTS:

- During this quarter, 149 reports were received by the Protection for Persons in Care (PPC) reporting line, which is a slight increase from the last quarter.
- There were no cases reported from facilities under the responsibility of Human Resources and Employment and Children's Services this quarter.

Agency/Ministry Responsibility	# of Reports			
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	Fiscal Year	
			Total	%
Regional Health Authorities/H&W	69	101	170	60.0%
Persons with Developmental Disabilities/CD	47	38	85	30.0%
AADAC/H&W	1	1	2	0.7%
Alberta Mental Health Board/H&W	1	0	1	0.4%
Management Bodies/Alberta Seniors	13	9	22	7.8%
Children and Family Services Authorities/CS	3	0	3	1.0%
<b>Total</b>	<b>134</b>	<b>149</b>	<b>283</b>	<b>100.0%</b>

See Part III figure 1 for further breakdown by organizational structure

#### TYPES OF ALLEGED ABUSE:

Types of Abuse	# of Reports			
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	Fiscal Year	
			Total	%
Physical	45	61	106	28.6%
Emotional	75	81	156	42.1%
Inappropriate medications	2	1	3	1.0%
Sexual	13	8	21	5.7%
Financial	11	8	19	5.1%
Neglect	29	36	65	17.5%
<b>Total</b>	<b>175</b>	<b>195</b>	<b>370</b>	<b>100.0%</b>

See Part III figure 2 for individual breakdown by organizational structure

#### ALLEGED ABUSERS:

Alleged Abusers	# of Reports			
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	Fiscal Year	
			Total	%
Service Provider	95	99	194	68.6%
Client	23	32	55	19.4%
Family	13	11	24	8.5%
Other (volunteers/visitors/non-family)	3	7	10	3.5%
<b>Total</b>	<b>134</b>	<b>149</b>	<b>283</b>	<b>100.0%</b>

See Part III figure 3 for further breakdown by organizational structure

## INVESTIGATORS:

Investigators	# of Investigators			
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	Fiscal Year	
			Total	%
Contracted Investigators	113	128	241	84.0%
Professional Colleges:	8	10	18	6.3%
-AARN (RNs)	-0	-1		
-CLPN (LPNs)	-7	-7		
-CPS (Physicians)	-1	-2		
-Other (CPTA, RPNA)	-0	-0		
Police	11	3	14	4.9%
Other bodies (MHPAO)	1	0	1	0.3%
Not Investigated	5	8	13	4.5%
Total	*138	149	287	100.0%

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

## **PROTECTION FOR PERSONS IN CARE**

### **PART III**

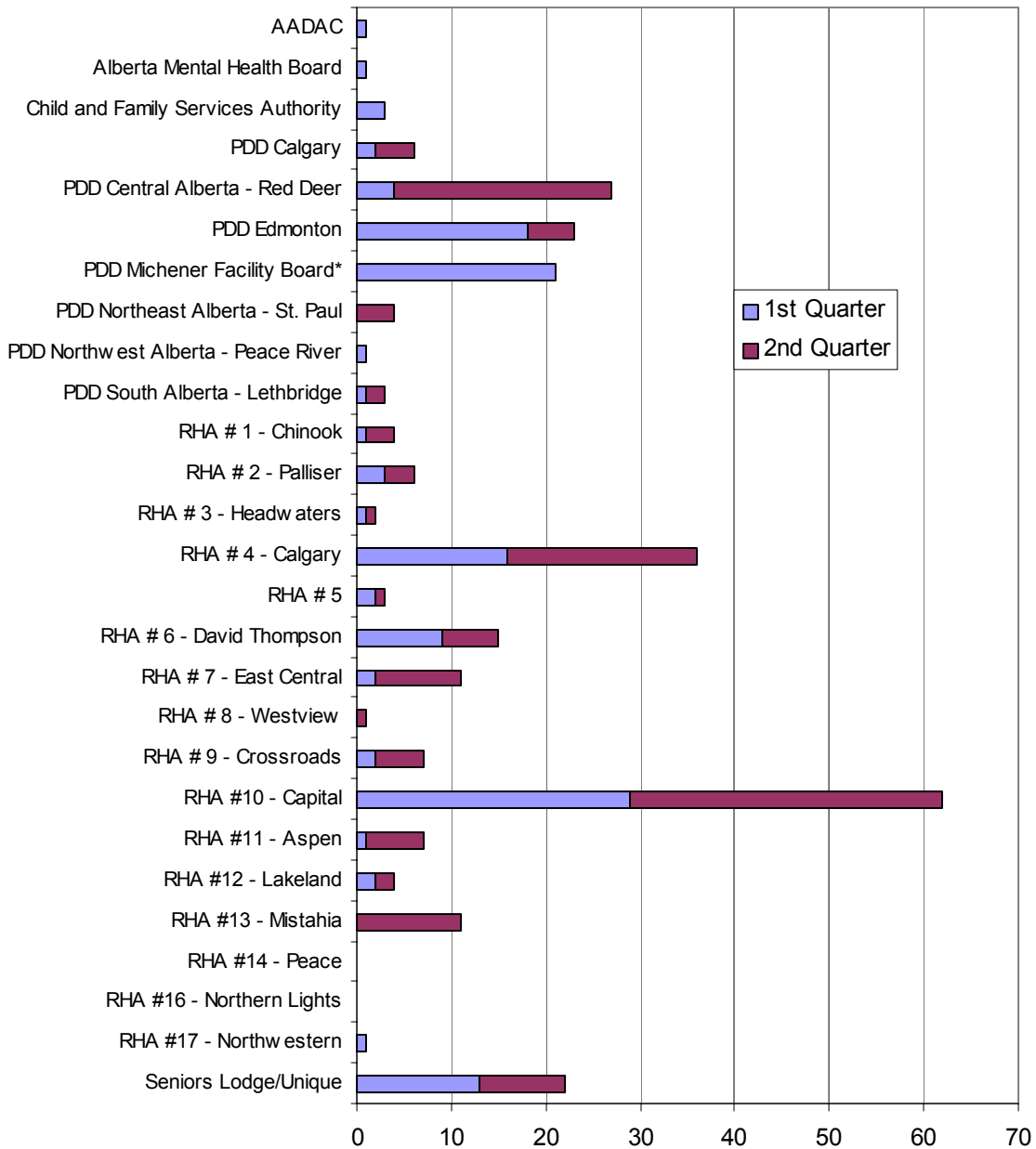
#### **SUMMARY GRAPHS AND CHARTS OF REPORTED CASES**

##### **Second 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 - September 30, 2002 (6 months)**



**Figure 1**

\* As of July 2002, Michener Facility Board under Central Alberta Board

## REPORTED ALLEGATIONS BY GOVERNING STRUCTURE PRO-RATED: APRIL 1, 2002 – SEPTEMBER 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	2
PDD Central Alberta - Red Deer (includes Michener)**	20
PDD Edmonton	2
PDD Northeast - St. Paul	9
PDD Northwest Alberta - Peace River	0
PDD South Alberta - Lethbridge	2

\*Based on figures from Annual Report 2000/2001

\*\*Michener Facility Board was transferred to Central Alberta Board, July 23, 2002

### REGIONAL HEALTH AUTHORITIES:

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

RHA	Reports
RHA # 1 – Chinook	3
RHA # 2 - Palliser	5
RHA # 3 - Headwaters	2
RHA # 4 - Calgary	3
RHA # 5 - Health Authority 5	0
RHA # 6 - David Thompson	4
RHA # 7 - East Central	12
RHA # 8 - Westview	2
RHA # 9 - Crossroads	18
RHA #10 - Capital	5
RHA #11 - Aspen	11
RHA #12 - Lakeland	3
RHA #13 - Mistahia	18
RHA #14 - Peace	0
RHA #15 – Keeweenok 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.

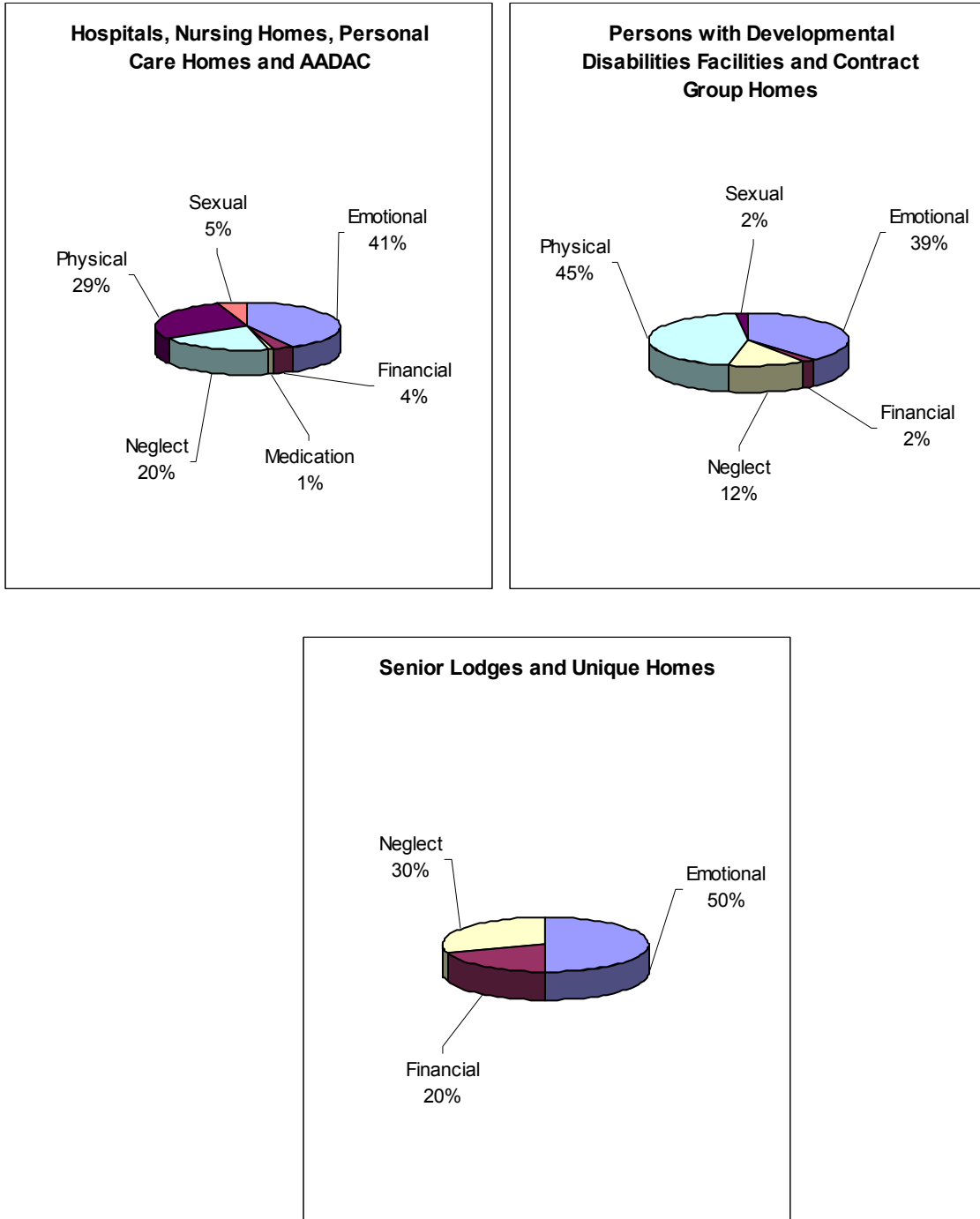
### LODGE FOUNDATIONS/UNIQUE HOMES:

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

Province Wide	Reports
Units	1.1

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

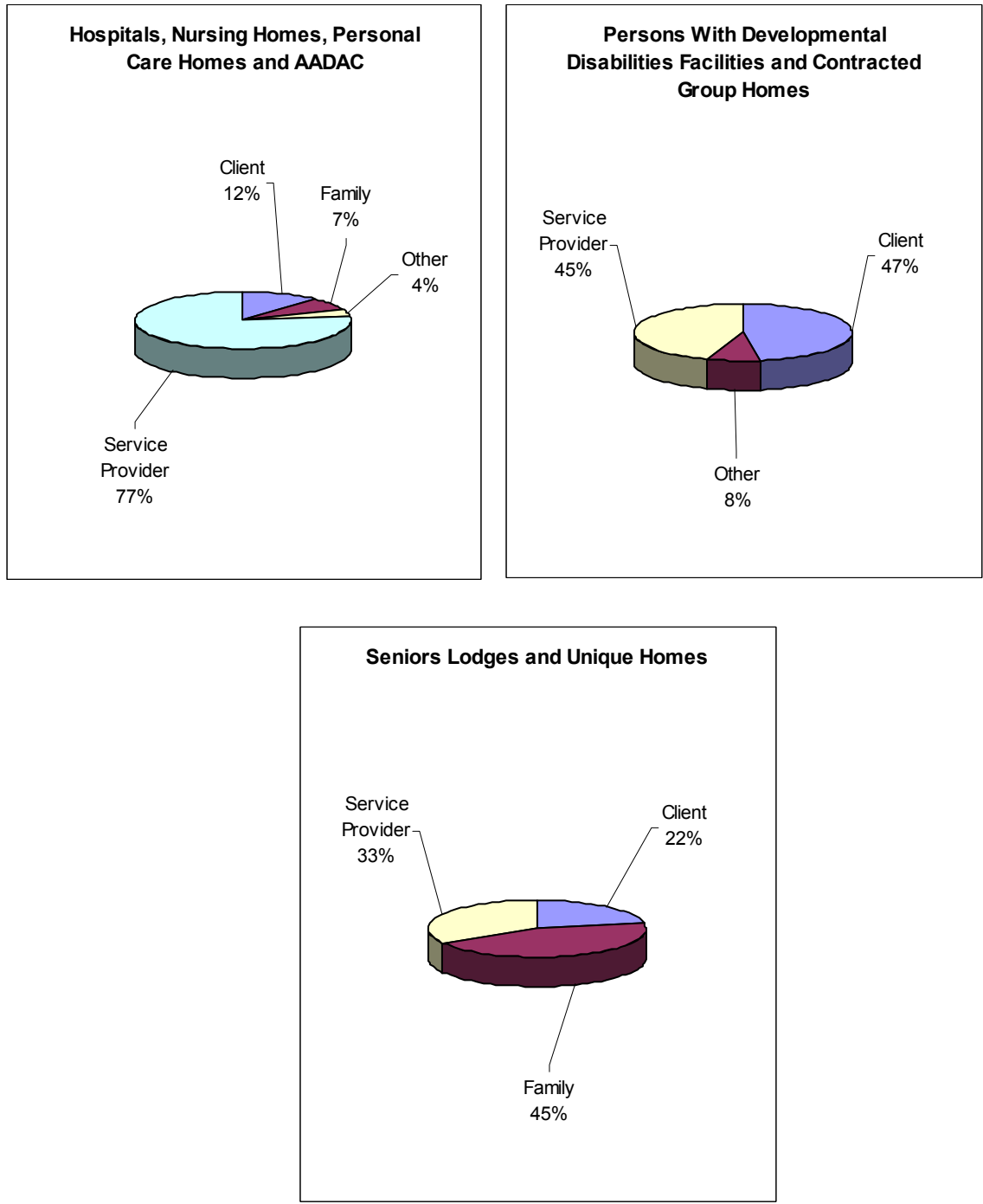
**Protection For Persons in Care  
Types of Alleged Abuse by Organizational Structure  
July 1, 2002 – September 30, 2002**



**Human Resources and Employment: 0 Reports**  
**Child and Family Services Authority: 0 Reports**

Figure 2

**Protection For Persons in Care  
 Categories of Alleged Abusers by Organizational Structure  
 July 1, 2002 – September 30, 2002**



**Human Resources and Employment: 0 Reports**  
**Child and Family Services Authority: 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: Personal Care Home
- Case D: Lodge

## 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*. They were selected for their possible relevance to other facilities in noting the need for open communication between facility staff and clients and/or families and between management and staff regarding performance issues.

**Case A: Type of alleged abuse: intentionally failing to provide the basic necessities of life and intentionally causing emotional harm**  
**Agency: a persons with developmental disabilities agency (PDD contracted)**  
**Alleged abusers: family (father)**

*The allegations were that the client's father forces her to eat three to four meals at one sitting at a restaurant and yells and argues with her.*

### **Investigation Facts:**

- Staff stated that the client has significant problems with her weight and concerns existed with her overeating when visiting her father as he usually ordered more food than was necessary. Staff believed the client eats the food because she doesn't wish to disappoint her father.
- The client confirmed she overeats when she is with her father but could not provide a reason for this.
- The client's father who is her Legal Guardian, denied forcing her to eat large quantities of food but said that his daughter has always been a big eater and can have anything she wants. He was unable to relate dates or events but believed his daughter was very happy and no problems existed.
- One staff person identified a time when the client's father yelled at her for 90 minutes. No other incidents were cited. Staff stated that the client has not expressed fear of her father.
- The client told the Investigator that she is not afraid of her father and he never yells at her.
- The client's sister does not believe that her father intended to cause her sister harm but may be indulging her sister in allowing her to eat as much of anything she wants.

### **Investigator's Recommendations:**

- That the allegations of intentionally failing to provide the basic necessities of life (force-feeding) and intentionally causing emotional harm be dismissed due to lack of intent to cause harm.
- That the agency, in agreement with the client's sister, supervises visits between the client and her father.

**Case B: Type of alleged abuse: intentionally causing bodily harm**  
**Agency: a long term care centre**  
**Alleged abuser: service provider (nursing attendant)**

*The allegation was that a nursing attendant (NA) raised her voice to a resident and pushed the resident on the back causing her to lose her balance and fall.*

### **Investigation Facts:**

- A witness stated that she was taking a male resident to his room and found the alleged victim, a female resident, lying on his bed. The NA arrived at the same time so the witness and the NA started to walk the female resident out of the room.
- The witness said that the female resident was uncooperative and did not want to leave. The witness said that the NA said something like "come on (resident's name)" and gave her a little push on the back. The resident lost her balance, lunged forward, and both of her arms caught the corner of the doorframe. The witness said that as the resident got to the door, she fell down.

**Case B (Cont'd)**

- The resident was observed carefully for a few days following the incident. Five days later large bruises appeared on the resident's knees and on her shoulder. The Unit Manager (UM) stated that she followed the resident's activities following the incident and no other falls were reported between the day of the alleged incident and the appearance of the bruises. The UM said that there was no other reason to account for the bruises other than the incident.

**Action taken by the facility:**

- The NA was suspended without pay and given a written warning.

**Investigator's Recommendations to the Facility:**

- While no formal performance appraisals were completed on the NA in two years the UM cited numerous incidents of the NA not following appropriate care procedures with residents therefore the facility should complete a performance appraisal on the NA as soon as possible.

**Case C: Type of alleged abuse: intentionally causing emotional harm**  
**Agency: a personal care home**  
**Alleged Abuser: service provider (registered nurse)**

*The allegations were that a registered nurse (RN) intimidated and threatened a client, telling her she would be put in a women's shelter if she did not agree to move.*

**Investigator's Facts:**

- The client and her sister stated that the RN told the client she would be moved to a group home in the community. The client said that she was extremely upset at the prospect of moving. The client said that when she heard the proposed group home was co-ed she became increasingly upset because she said that she has a history of being taken advantage of by men and is fearful of living in close proximity to male residents.
- The client and her sister said that they were not aware that the group home was a transitional facility. The client said that she refused to move.
- The admission agreement, signed by the client did not mention that the group home was transitional. According to the agreement, the facility is "committed to providing care as a family unit in a normal homelike setting and that termination of tenancy results if the client refuses to adhere to house rules or is destructive and uncontrollable". There was no mention of termination based on the decision of the funding agency.

**Action taken by the facility:**

- The facility is not moving the client to another facility at this time.

**Investigator's Recommendation:**

- That the allegation of intentionally causing emotional harm be dismissed due to insufficient evidence of intent to cause harm.
- That the funding agency clearly defines the temporary or transitional nature of a facility to all clients and/or their families or guardians when clients are placed in the facility.
- That for temporary or transitional facilities, the funding agency include in the admission agreement, the terms of tenancy, and the conditions that all are to agree to regarding when a client should move to another facility or setting.

**Case D: Type of alleged abuse: intentionally causing emotional harm**  
**Agency: Lodge**  
**Alleged abuser: service provider (chief administrative officer)**

*The allegation was that the chief administrative officer (CAO) presented the resident with a letter requesting her to obtain alternate accommodations and verbally commented, "Your money can't buy you everything", which upset the resident.*

**Investigation Facts:**

- The Investigator was told that the needs of the resident, who had been receiving enhanced resident care, had expanded beyond the service that service providers were able to provide. An assessment had been completed and the resident had been assessed at the continuing care level.
- The resident had become more demanding by using the call bell system up to 20 times in an eight-hour shift with the majority of calls being minor in nature. Other lodge residents have complained to staff about the demands placed on staff by the resident, taking away from their care time.
- At a regular board meeting discussion occurred regarding the resident's medically fragile state and that the lodge could no longer meet her needs. Direction was provided to the CAO by the Board to inform the resident in writing that she would have to seek alternate residential accommodations. The CAO presented the letter to the resident when she was alone and briefly explained the contents of the letter to her.
- The resident's long time friend indicated that the resident was very upset in regards to the letter. The resident told her that the CAO had said to her, "Your money can not buy you everything". The CAO completely denied saying this statement or anything close in context to the alleged statement. The resident, when interviewed, could not recall any discussion of this nature.

**Investigator Recommendations to the Facility:**

- That the allegation of intentionally causing emotional harm be dismissed because the evidence is insufficient.
- That the facility consider having two staff present when administrating sensitive documents to residents, such as a notice that a resident needs to find alternate residential accommodation due to the changing needs of the resident. Alternatively, they may also wish to consider using a close resident contact in notifying of the residential change, especially in circumstances where there is no near living relatives to the resident.
- That the facility, in other similar situations, considers in the future requesting documentation that confirms that an agent has been legally appointed families and clients may not be aware that naming an agent in a Power of Attorney document or as a community contact does not constitute the legal appointment of that agent.

**Action Taken by the facility:**

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

**PROTECTION FOR PERSONS IN CARE**

**PART V**

**ADMINISTRATION**

## Referrals from the Reporting Line

The Protection for Persons in Care reporting line (1-888-357-9339) receives a variety of calls resulting in many referrals. From July 1 to September 30, 2002, 90 referrals were made. The most frequent referrals were made to:

- Police Service 11%
- Person with Developmental Disabilities (protocol) 11%
- Office of the Public Guardian 8%
- Health Facilities Review Committee 7%
- Office of Public Trustee 6%
- Social Workers in facilities 6%
- College of Licensed Practical Nurses 4%

## Protection for Persons in Care Satisfaction Survey Results

In the last Quarterly Report, it was indicated that there would be an analysis of the survey results. Again, thank you for taking the time to complete the survey that we had sent out earlier this year. Ninety surveys were returned, which was an approximate 20% return rate. Demographics were not captured as to what types of facilities or what levels of staff responded.

Comments regarding the reporting line:

- 86% of the respondents, who have had experience with the toll-free (1-888-357-9339) reporting line, were either very satisfied or generally satisfied with the reporting line. Less than 10% had used the fax line (780-415-8611) for reporting
- The majority of respondents who used the reporting line were also satisfied with these activities of the reporting line: receiving general information (91%); receiving referrals (80%); and receiving brochures or posters (96%).

Comments regarding the investigation process:

- The majority of respondents were either very satisfied or generally satisfied with the commencement of the investigations (72%); how the investigations were conducted (68%); and the way the investigators conducted themselves (80%).

Comments regarding the investigation completion:

- 55% were either very satisfied or generally satisfied with the timeliness in receiving the written results of the investigation. 18% were not at all satisfied.
- 56% were either very satisfied or generally satisfied with the relevance of the recommendations. 18% were not at all satisfied.

Comments from respondents regarding educative material:

- Over 90% were either very satisfied or generally satisfied with the information brochure, the poster, the video, the website, the quarterly reports and training sessions or presentations provided by Protection for Persons in Care staff.

Comments regarding the Protection for Persons in Care Branch:

- 91%, of those who had experience with the Branch staff, were either very satisfied or generally satisfied with the manner, knowledge and responsiveness of the Protection for Persons in Care Branch staff. 25% marked this response as not applicable.

## Legislative Review

Public consultation has been completed on the *Protection for Persons in Care Act* legislative review, which was announced in August 2002. Interested Albertans were invited to respond to a questionnaire. Over 3,000 printed discussion guides with questionnaires were distributed. Of the 262 questionnaires that were completed, 30% of respondents were from Regional Health Authorities, 21% from PDD related agencies and 10% associated with lodge/foundation facilities. In addition to the questionnaires, there were several consultation sessions, attended by nearly 200 stakeholders. The committee is currently reviewing all responses and will present their report with recommendations to the Minister of Community Development in 2003.

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