

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

**Including:**

**Outcomes for July 1 - September 30, 2002**

**Incoming Reports for October 1 - December 31, 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**

**JULY 1, 2002 – SEPTEMBER 30, 2002**

## **INVESTIGATION RECOMMENDATIONS**

### **Second Quarter 2002 – 2003**

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

- During this three-month period, 145 of the 149 cases investigated were closed. There are three reports still under investigation by a professional college and one by an external investigator.
- 63% of the closed cases were dismissed as unfounded or due to insufficient evidence and 4.0% were referred to the police.
- Overall for the Second Quarter for the fiscal year 2002-2003, 73% of the allegations in Person with Developmental Disabilities (PDD) services were dismissed, 60% were dismissed in facilities governed by regional health authorities, 56% 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 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: written reprimands, suspensions and terminations as well as completion of educational reading, additional training or extension of probation periods.
- Within the 34 reports, there were four staff terminations and five staff resignations.

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

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

- Ensure employees are aware of the client's care plan and perform their duties accordingly.
- Ensure employees are completing incident reports and other types of charting within appropriate timelines.

##### **Recommendations in PDD Settings:**

- Encourage staff to participate in their refresher courses on identifying medical concerns and on coping with unusual client behaviors.
- Facilities should provide increased guidance and supervision to new relief staff regardless of their previous background to ensure their effectiveness.
- Facilities consider providing caregivers the expertise of outside agencies such as Canadian Mental Health Patient Advocate or Alberta Mental Health Services to provide training to work with the clients and other individuals with complex needs.
- Facilities should do follow up and monitor expectations identified to staff about their unprofessional conduct (swearing) around the resident.

### **Recommendations in Long Term Care Settings:**

- Ensure the facilities review their policies and procedures regarding Unusual Incident Reports and their investigation processes to reflect the analytical review of contributing factors and the use of the reports as a preventative step in guiding practice change.
- Ensure facilities identify the options in managing falls including the reasons that some options are not followed, i.e. bed rails as an option of choice, the amount of acceptable risk versus the amount of protective measures to be taken. This should be documented on the resident's care plan with clearly identified responsibilities of staff, the resident and family as well as the ongoing communication that should occur about further falls.
- Ensure that facility staff are aware of resident care requirements (especially where two staff are required for transfers) and ensure there is adequate staff available to provide this level of care.

### **Recommendations in Lodge Settings:**

- Ensure all residents receive a thorough review of the Resident Tenancy Agreement before they sign it and move in.
- Ensure the lodge policies include an abuse protocol with reference to the mandatory reporting of abuse or suspected abuse to the Protection for Persons in Care reporting line.

**PROTECTION FOR PERSONS IN CARE**

**PART II**

**REPORTED ALLEGATIONS**

**OCTOBER 1, 2002 – DECEMBER 31, 2002**

## PROTECTION FOR PERSONS IN CARE

### REPORTED ALLEGATIONS: Third Quarter 2002 - 2003 (October 1-December 31, 2002)

#### NUMBER OF REPORTS:

- During this quarter, 131 reports were received by the Protection for Persons in Care (PPC) reporting line, which is a decrease from the last quarter, particularly in facilities under Health and Wellness (H&W).
- There were no cases reported from facilities under the responsibility of Human Resources and Employment and Children's Services (CS) this quarter.

Agency/Ministry Responsibility	# of Reports				
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	Fiscal Year	
				Total	%
Regional Health Authorities/H&W	69	101	85	255	61.6%
PDD/Community Development	47	38	38	123	29.8%
AADAC/H&W	1	1	1	3	0.7%
Alberta Mental Health Board/H&W	1	0	0	1	0.2%
Management Bodies/Alberta Seniors	13	9	7	29	7.0%
Children and Family Services Authorities/CS	3	0	0	3	0.7%
<b>Total</b>	<b>134</b>	<b>149</b>	<b>131</b>	<b>414</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	3 <sup>rd</sup> Quarter	Fiscal Year	
				Total	%
Physical	45	61	31	137	25.7%
Emotional	75	81	90	246	46.0%
Inappropriate medications	2	1	9	12	2.2%
Sexual	13	8	6	27	5.0%
Financial	11	8	12	31	5.8%
Neglect	29	36	17	82	15.3%
<b>Total</b>	<b>175</b>	<b>195</b>	<b>165</b>	<b>535</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	3 <sup>rd</sup> Quarter	Fiscal Year	
				Total	%
Service Provider	95	99	81	275	66.4%
Client	23	32	33	88	21.3%
Family	13	11	10	34	8.2%
Other (volunteers/visitors/non-family)	3	7	7	17	4.1%
<b>Total</b>	<b>134</b>	<b>149</b>	<b>131</b>	<b>414</b>	<b>100.0%</b>

See Part III figure 3 for further breakdown by organizational structure

## INVESTIGATORS:

Investigators	# of Investigators				
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Fiscal Year	
	Quarter	Quarter	Quarter	Total	%
Contracted Investigators	113	128	108	349	83.1%
Professional Colleges:	8	10	11	29	7.0%
-AARN (RNs)	-0	-1	-2		
-CLPN (LPNs)	-7	-7	-7		
-CPS (Physicians)	-1	-2	-2		
-Other (CPTA, RPNA)	-0	-0	-0		
Police	11	3	5	19	4.5%
Other bodies (MHPAO)	1	0	0	1	.2%
Not Investigated***	5	8	9	22	5.2%
Total	138*	149	133**	420	100.0%

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

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

\*\*\* Not investigated for reasons such as the facility was not under the *Protection for Persons in Care Act* or reporters reported potential harm when no actual harm occurred.

## **PROTECTION FOR PERSONS IN CARE**

### **PART III**

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

##### **Third Quarter Fiscal Year 2002/2003**

- Figure 1 – Number of reports
- Figure 2 – Types of alleged abuse
- Figure 3 – Categories of alleged abusers

## Protection for Persons In Care Number of Reports

**April 1, 2002 - December 31, 2002 (9 months)**

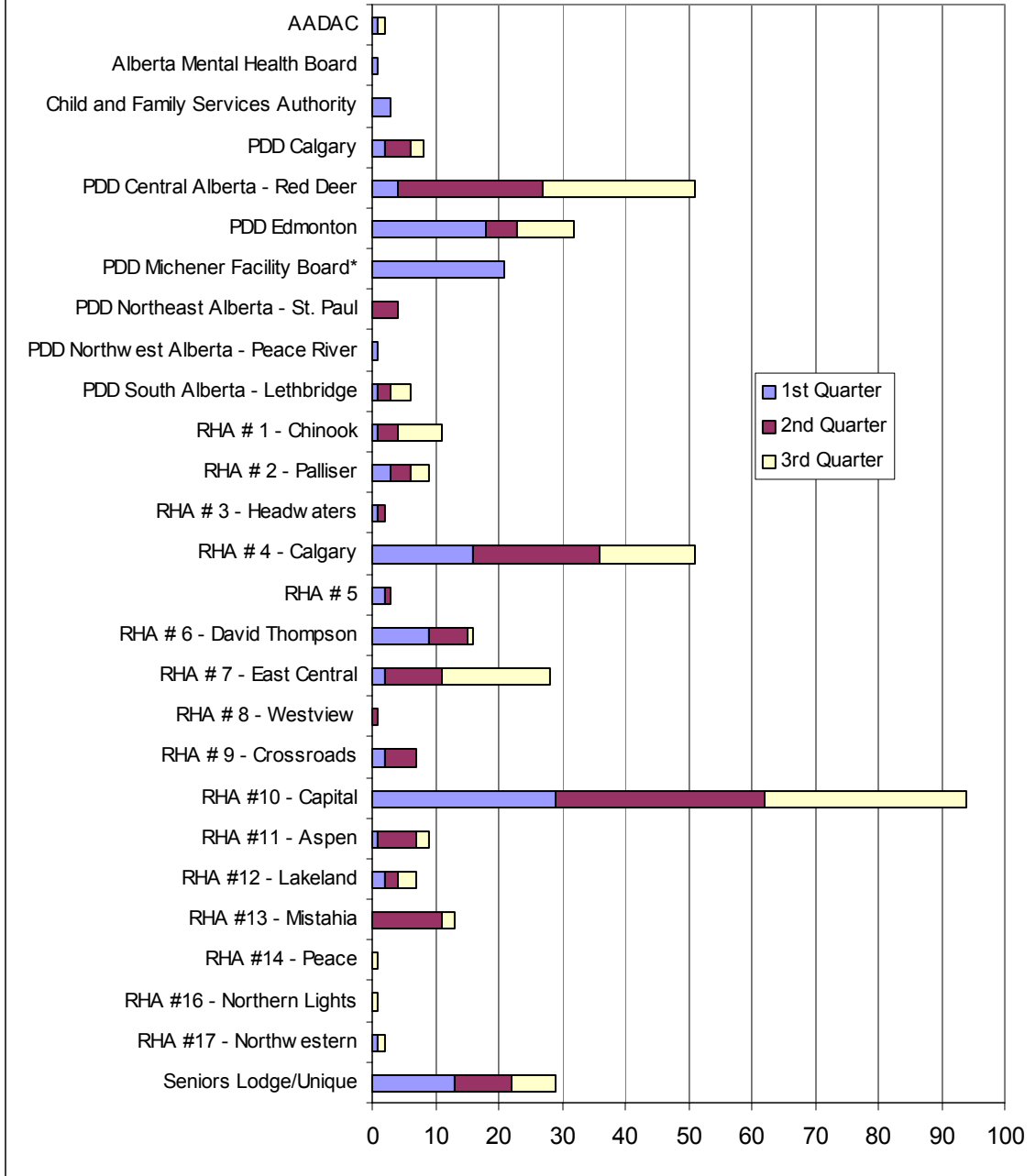
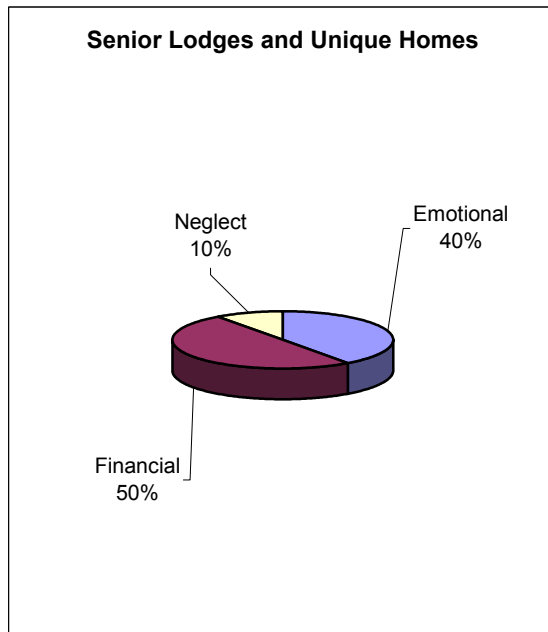
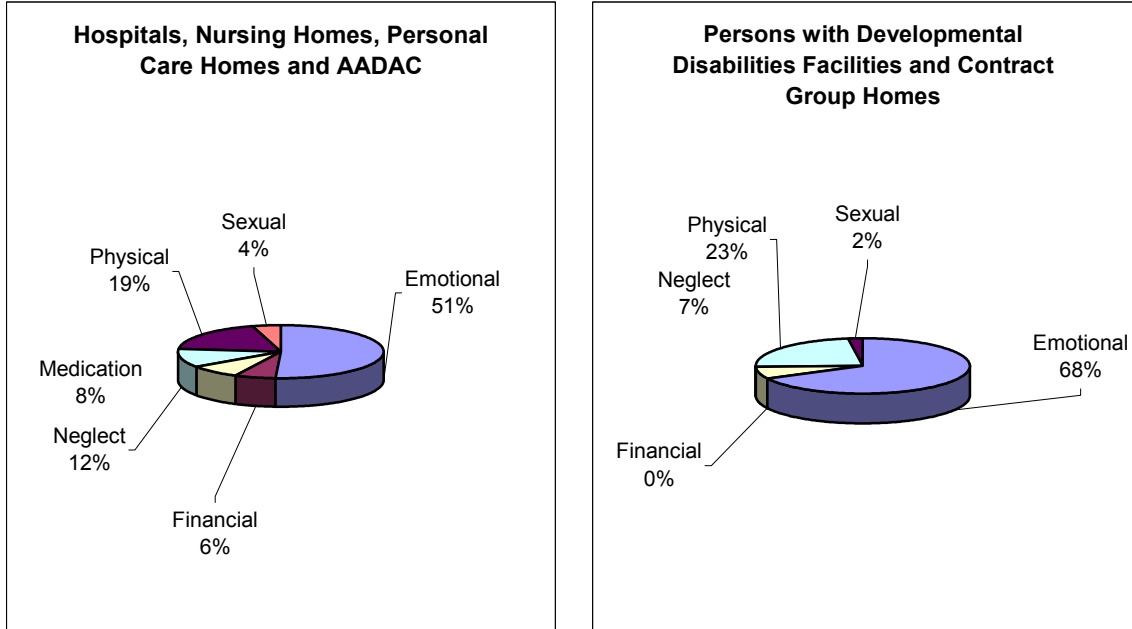


Figure 1

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

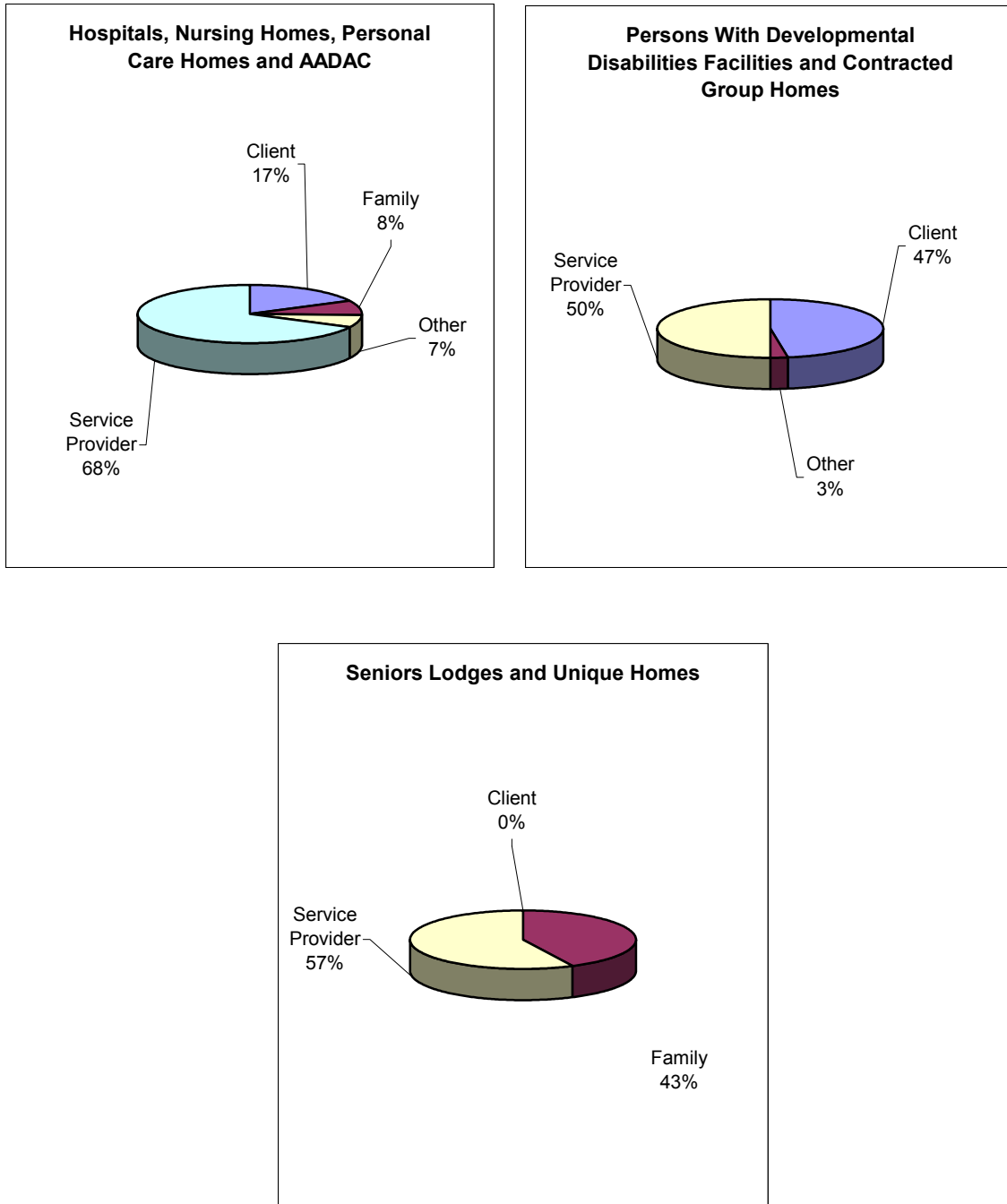
**Protection for Persons In Care  
Types of Alleged Abuse by Organizational Structure  
October 1, 2002 – December 31, 2002**



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  
 October 1, 2002 – December 31, 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: Acute Care Hospital
- 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 for the following reasons:

Case A: to convey the need for caution when clients are on outings and that staff should be well prepared for any reaction from clients.

Case B: the facility was commended for trying to be accommodating to the client when expectations of the client/family were higher than the facility was able to provide.

Case C: a recommendation for discipline was made in a case where the facility had not disciplined.

Case D: the lodge, in keeping with its mandate, tried to promote independence when expectations from family were that the resident should receive more care.

**Case A: Type of alleged abuse: intentionally causing emotional harm**  
**Agency: a persons with developmental disabilities agency (PDD contracted)**  
**Alleged abusers: service provider (support worker)**

*The allegations were that a support worker (SW) yelled at and used profanity with the client.*

### **Investigation Facts:**

- A client was on vacation at an out of town lodge. During the stay the client experienced some difficulties with his fishing equipment, became frustrated by the lack of fish bites and the disposal of his pop cans in error. During the time staff tried to resolve the incident around the pop cans, the client became aggressive and hit a staff person.
- Contact was made with the agency Team Leader (TL) several times by phone to get direction on how to handle the situation.
- While the client was getting into the truck, he hit his head on the doorframe and the client began hitting a staff person across the chest. The staff person said that she tried to deflect the blows while unbuckling her seat belt. The staff person said that she remembers the SW yelling at the client but she was scared and does not remember what the SW said. The staff person said that the client paused for a minute and she was able to get out of the vehicle.
- The client did get out of the vehicle and was returned to the lodge. The TL was called again and after an hour and a half the police were called to assist the staff. The client then complied and went to his cabin and went to bed. On the way home the client had one further episode of acting inappropriately.
- Witness # 1 said that there was a lack of planning information on the client and she was not aware of any behavioral information on how to handle the client.
- Witness # 2 said that she heard the SW swear at the client and she and other bystanders looked on in astonishment.
- The SW said that she calmly asked the client to get out of the truck but when the client was hitting the staff person she was scared for the staff person's safety. The SW said that she did yell and use profane language with the client to get him to stop hitting her colleague.
- The SW said that she did not intend to hurt the client but she and all staff were frustrated. The SW said that the client was not hurt by her comments. The SW visited with the client shortly after the incident and there were no hard feelings.

### **Action taken by the facility:**

- The SW was disciplined and appropriate means of crisis interventions, interactions and support required in some client situations will be discussed with the SW.

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

- That the allegations of intentionally causing emotional harm be dismissed due to insufficient evidence of intent to cause harm however, the SW did act unprofessionally.
- That the facility ensures that staff taking clients on a vacation have adequate information on the client's program to comfortably meet the client's needs in all behavioral situations.

**Case B: Type of alleged abuse: intentionally failing to provide the basic necessities of life**  
**Agency: a long term care centre**  
**Alleged abuser: service provider (staff in general)**

*The allegation was that staff: a) leave the resident sitting in her wheelchair too long in feces; b) do not bring the resident her newspaper until 0930 hours, and c) do not provide good security for the resident.*

#### **Investigation Facts:**

##### Staff leaving the resident sitting in her wheelchair too long in feces:

- The resident's guardian stated that staff leaves her in her wheelchair too long and her "butt" has painful sores. The resident said she gets pain medication "when I get it".
- The Care Manager (CM) said that the resident is very demanding and staff do the best they can, staff ask the resident if she wants to get up and if the resident says no they leave her. The CM said if the resident says she wants to get up, staff dresses her and often when they put her in the chair she will say, "I'm not getting up".
- The CM said that the resident does not have any bedsores and when she is in the chair she is able to readjust her upper body to relieve pressure off her buttocks.
- The CM stated that the resident is incontinent of feces and chooses not to use a commode, although she is able. The CM said that if the resident has not had good results from her suppository she would not get up in the chair so it would be unusual for the resident to have a bowel movement in the chair.

##### Staff does not bring the resident her newspaper until 0930 to 0945 hours:

- The resident stated that she used to get her paper at 0630 hours and now gets it three hours later. A staff member used to bring the resident her paper at 0715 hours, but now the papers do not get to the facility until 0900 hours, then they are classified according to floor and distributed. This has been explained to the resident on a number of occasions.

##### Staff does not provide good security for the resident:

- The resident stated that her clothes are stolen and her hangers disappear because the security is not good at the facility. The resident's guardian said anyone could walk into the resident's room. He said that he has never been questioned when he comes to the facility. The guardian said if the person at the front desk is busy no one can see who comes in the facility.
- The CM said that there has never been a problem with theft from a resident by strangers. The CM stated that the resident had complained on occasion that some of her clothes had gone to the laundry when they are not delivered right away but they would be back the following day.
- The Program Director (PD) said that anyone can visit the facility and there is no sign-in book. She said that the front door is locked from 2000 to 0800 hours (0900 hours on the weekend). The PD said that if someone wants to enter the facility after hours they have to ring a bell and are viewed on video by the charge nurse, who decides if the person should come in. There is a receptionist in the lobby from 0800 to 2100 hours. A security company checks the external doors. The receptionist verified that if someone suspicious came to the facility, she would contact the PD to deal with them.

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

- That the allegation of intentionally failing to provide the basic necessities of life be dismissed due to

insufficient evidence.

- That the facility consults the Long Term Care Psychiatric Services to assess the resident.
- That the facility consider scheduling, in discussion with the resident/guardian, an appropriate time to assist the resident back to bed and document if the resident refuses to go back to bed.
- That the facility reviews the “Resident Entitlements and Responsibilities” document with the resident.
- That the facility be commended for the extent to which staff have gone in attempting to meet the resident’s needs and wants.

**Response by the Facility to Recommendations:**

- The Long Term Care Psychiatric Team was consulted long before this complaint was made and the recommendations from the team have been followed for several years. The team stated there is no cure for this type of personality disorder.
- The resident’s care plan outlines the resident’s behavior modification program that was developed some time ago.
- Due to the limitations and best approaches for this resident’s personality disorder, the Program Manager for Care Services only reviewed the “Resident Responsibilities” section of this document with the resident.

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

**Agency: an acute care facility**

**Alleged Abuser: service provider (nursing attendant)**

*The allegations were that a Nursing Attendant (NA) a) pulled on a resident’s arms and legs, told her to stop complaining and called her an “old women”, and b) tossed a package of sugar at the resident, which landed on the resident’s glasses.*

**Investigator’s Facts:**

a) Regarding pulling the resident’s arms and legs and approach to the patient:

- The patient said a “young caregiver” at the facility was “rough and rude” with her which upset her. She said the caregiver called her “demented and lazy” and grabbed and twisted her leg, which was very painful.
- The NA was identified as the alleged abuser from the staff/patient assignment and by her recognition of the incident being investigated.
- The NA denied being abusive or having “bad intentions” towards patients generally or to this patient in particular.
- Documentation indicated that other staff had handled the patient’s leg during the provision of care and the patient did not complain about them.
- The NA said that she never yelled at the patient but might sometimes raise her voice to patients with hearing problems. The NA denied ever calling the patient demented, or even knowing what the term means.

b) Regarding the throwing of sugar:

- The patient said that she asked for a package of sugar and the caregiver threw the sugar at her and the sugar landed on her glasses. The NA said that it was another patient who threw the sugar at the patient and the patient did not see where it landed. The NA said that she picked the sugar up and gave it to the patient.

Other:

- There were no witnesses to either incident.
- The Patient Care Manager said staff have expressed concerns about how the NA treated patients and describe her as “rough, not a team player, rude, abrupt, interfering, uncooperative and hostile”.

**Investigator's Recommendation:**

- That the facility takes disciplinary action against the NA.

**Response by the facility to the recommendation:**

- The 90 day response is not yet due.

**Case D: Type of alleged abuse: intentionally causing emotional harm and intentionally failing to provide the basic necessities of life****Agency: Lodge****Alleged abuser: service providers (several lodge service providers)**

*The allegation was that the lodge staff a) had not provided the resident with a wheelchair, b) required the resident to dress herself, c) had the resident get her own jug or water and d) threatened that if the resident could not do things for herself, she would be sent to a care home.*

**Investigation Facts:**

- The resident speaks and understands very little English and has long-term mental health concerns. Through an interpreter, the resident said that staff at the facility treat her pretty good. The food is good and staff assists with her sometimes.
- The resident's sister said that a meeting was held with lodge staff, home care and a mental health worker and they agreed that the resident's care plan was to encourage the resident to be as self caring as possible, which she supported. The resident's sister said that she did not believe anyone at the facility intentionally tried to harm the resident nor had the resident suffered harm because of anyone's actions but felt that the facility could have seen something was wrong with the resident prior to her last fall.
- A lodge assistant (LA) said that the resident had three or four falls. With the last fall, the resident had fallen in the dining room causing a large bruise on her right arm and the resident had complained of pain in her leg. The LA said that the resident's sister had asked that the staff take the resident back and forth to the dining room in a wheelchair, but the resident had already walked to the dining room with her walker.
- The resident's family took the resident to the doctor for medical problems. The resident stayed in hospital for a few days because of medical difficulties and upon release Home Care was provided twice a week.
- The LA said that the Home Care nurse made a Care Plan to encourage the resident to do as much as she could for herself. The LA said that the staff's focus was to promote the resident's independence. The LA said that the resident is encouraged to get her own water, which is located about two doors down the hall from her room. The resident can walk there with her walker.
- The Home Care nurse said that when she met with the lodge staff and the Mental Health Worker to develop a Care Plan for the resident, it was agreed that the resident should be encouraged to be as independent as possible and advised the family of this decision. The Home Care nurse said that the lodge staff provided a significant amount of extra care for the resident and that she did not have any concerns at this time.

**Investigator Recommendations to the Facility:**

- That the allegation of intentionally causing emotional harm and intentionally failing to provide the basic necessities of life be dismissed as unfounded.

**PROTECTION FOR PERSONS IN CARE**

**PART V**

**ADMINISTRATION**

## **Protection For Persons in Care Branch New Mailing Address**

The Protection for Persons in Care Branch **has moved and the new mailing address is:** Protection for Persons in Care Branch, Community Supports Systems Division, Alberta Community Development, **Station M, Box 475 Edmonton, Alberta T5J 2K1.** The fax number (780) 415-8611 and the toll free reporting line number of 1-888-357-9339 remains the same.

### ***Protection for Person in Care Act Amendment***

On November 15, 2002 amendments were proclaimed to the *Social Care Facilities Review Committee Act (SCFRC Act)* which resulted in an amendment being made to the *Protection for Persons in Care Act Regulation*. The amendment designated the facilities to the *Protection for Persons in Care Act* that were formerly specified in the *SCFRC Act*, such as AADAC, Persons with Developmental Disabilities group settings and mental health approved homes, to continue to be under the jurisdiction of the *Protection for Persons in Care Act*.

### **Legislation Review**

The Protection for Persons in Care Legislative Review Committee has concluded its consultation and is in the process of preparing a report with recommendations to Honourable Gene Zwozdesky, Minister of Community Development.