

**ANNUAL REPORT
2002/2003**

On the Activities of

Protection for Persons in Care

April 1, 2002 – March 31, 2003



**Protection for
Persons in Care**

A PROGRAM OF

**ALBERTA
COMMUNITY
DEVELOPMENT**

PROTECTION FOR PERSONS IN CARE

PART I

REPORTED ALLEGATIONS

APRIL 1, 2002 – MARCH 31, 2003

PROTECTION FOR PERSONS IN CARE

REPORTED ALLEGATIONS: April 1, 2002 - March 31, 2003

NUMBER OF REPORTS:

In the fiscal year, of the 584 reports of alleged abuse reported, 46.9% (274) involved continuing care facilities, 28.1% (164) involved persons with developmental disabilities settings, 9.8% (57) involved acute care facilities, 7.0% (41) involved seniors' lodges, 0.5% (3) involved women's shelters and 7.7% (45) involved other agencies/facilities that are not in the above categories.

Agency/Ministry Responsibility	# of Reports					
	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Regional Health Authorities/H&W	69	101	85	117	372	63.7%
PDD/Community Development	47	38	38	41	164	28.1%
AADAC/H&W	1	1	1	0	3	0.5%
Alberta Mental Health Board/H&W	1	0	0	0	1	0.2%
Management Bodies/Alberta Seniors	13	9	7	12	41	7.0%
Child and Family Services Authorities/CS	3	0	0	0	3	0.5%
Total	134	149	131	170	584	100.0%

See Part II figure 1 for further breakdown by organizational structure

COMPARISONS OVER THREE FISCAL YEARS:

The number of reports has gradually increased with 499 in 2000/01, 542 in 2001/02 and 584 in 2002/03. The greatest percentage of reports have been from:

Type of facility	2000/01	2001/02	2002/03
Hospitals and Nursing Homes	69.7%	56.5%	63.7%
Persons with Developmental Disabilities settings	19.6%	29.1%	28.1%
Lodges	7.2%	10.7%	7.0%

TYPES OF ALLEGED ABUSE:

Types of Abuse	# of Reports					
	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Physical	45	61	31	36	173	23.5%
Emotional	75	81	90	124	370	50.2%
Inappropriate medications	2	1	9	4	16	2.2%
Sexual	13	8	6	7	34	4.6%
Financial	11	8	12	11	42	5.7%
Neglect	29	36	17	19	101	13.8%
Total	175	195	165	201	736	100.0%

See Part II figure 2 for individual breakdown by organizational structure

TYPES OF ALLEGED ABUSERS:

Alleged Abusers	# of Reports					
	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Service Provider	95	99	81	111	386	66.1%
Client	23	32	33	40	128	22.0%
Family	13	11	10	14	48	8.2%
Other (volunteers/visitors/non-family)	3	7	7	5	22	3.7%
Total	134	149	131	170	584	100.0%

See Part II figure 3 for further breakdown by organizational structure

TYPES OF INVESTIGATORS:

Investigators	# of Investigations					
	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Fiscal Year	
					Total	%
Contracted Investigators	113	128	108	159	508	86.1%
Professional Colleges*	8	10	11	3	32	5.4%
Police	11	3	5	2	21	3.5%
Other bodies (MHPAO)	1	0	0	0	1	.2%
Not Investigated	5	8	9	6	22	4.8%
Total	138**	149	133***	170	590	100.0%

* Investigated by Alberta Association of Registered Nurses (4), College of Licensed Practical Nurses (23), College of Physicians and Surgeons (5)

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

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

AGES OF ALLEGED VICTIMS:

Indicative of other quarters, during the period of January 1 to March 31, 2003, 102 of the 170 reports or 60% of the reports made to the reporting line involved clients over the age of 65 years. According to the following age categories, the percentage of reports involved the following age categories:

Age Categories < 65 years of age*	% of Reports	Age Categories > 65 years of age**	% of Reports
18 - 25	5.3 %	66 - 70	3.5%
26 - 35	5.8%	71 - 75	6.5%
36 - 45	12.3%	76 - 80	11.7%
46 - 55	7.6%	81 - 85	14.1%
56 - 65	8.8%	86 - 90	10.6%
		91 - 95	11.2%
		> 95	2.3%

* divided into 10 year ranges

** divided in 5 year ranges

PROTECTION FOR PERSONS IN CARE

PART II

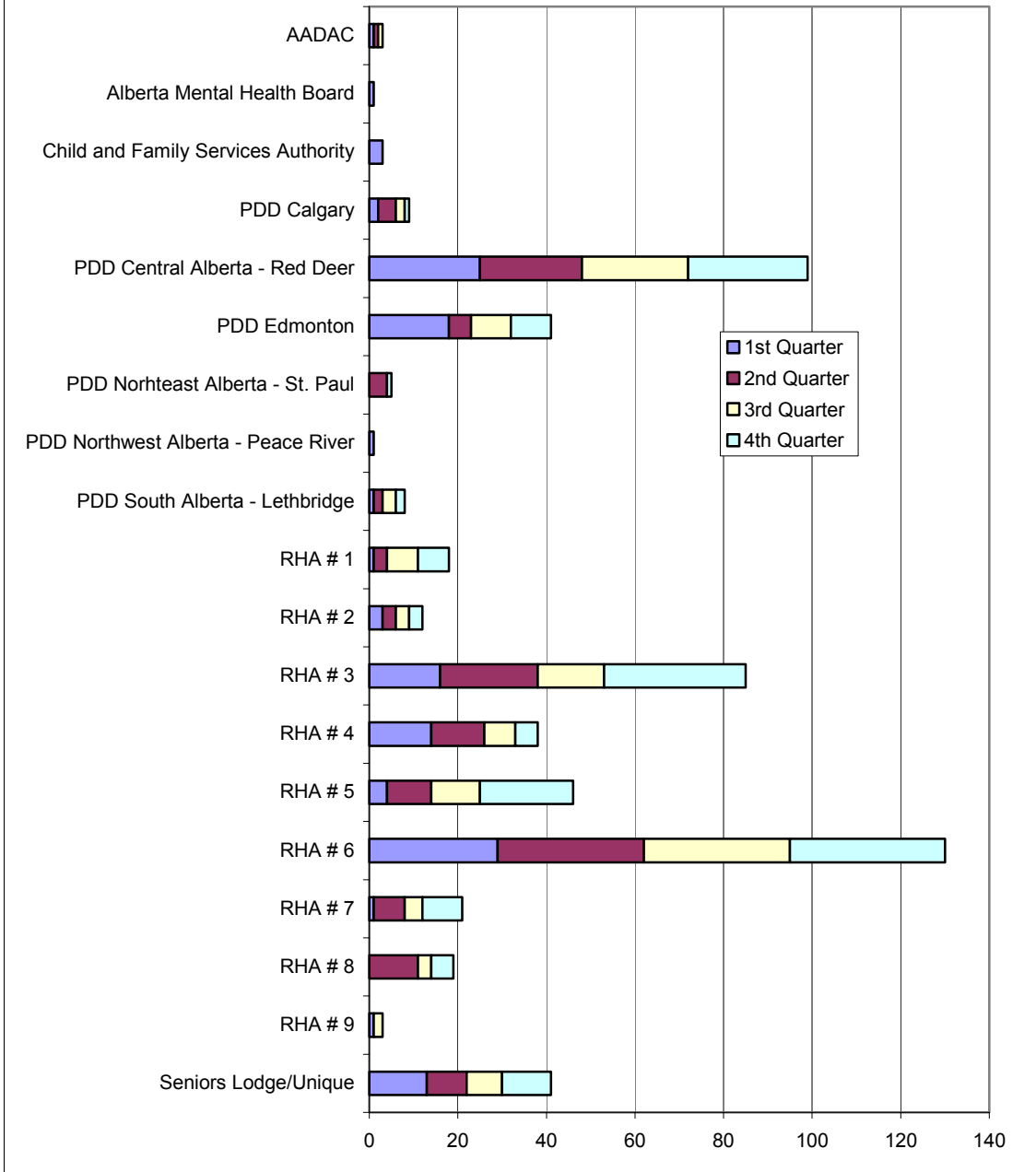
SUMMARY GRAPHS AND CHARTS OF REPORTED CASES

April 1, 2002 – March 31, 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 - March 31, 2003 (12 months)



Please note: This graph is reflective of the new RHA boundaries effective April 1, 2003

Figure 1

**Protection for Persons in Care
Types of Alleged Abuse by Care Setting
April 1, 2002 to March 31, 2003**

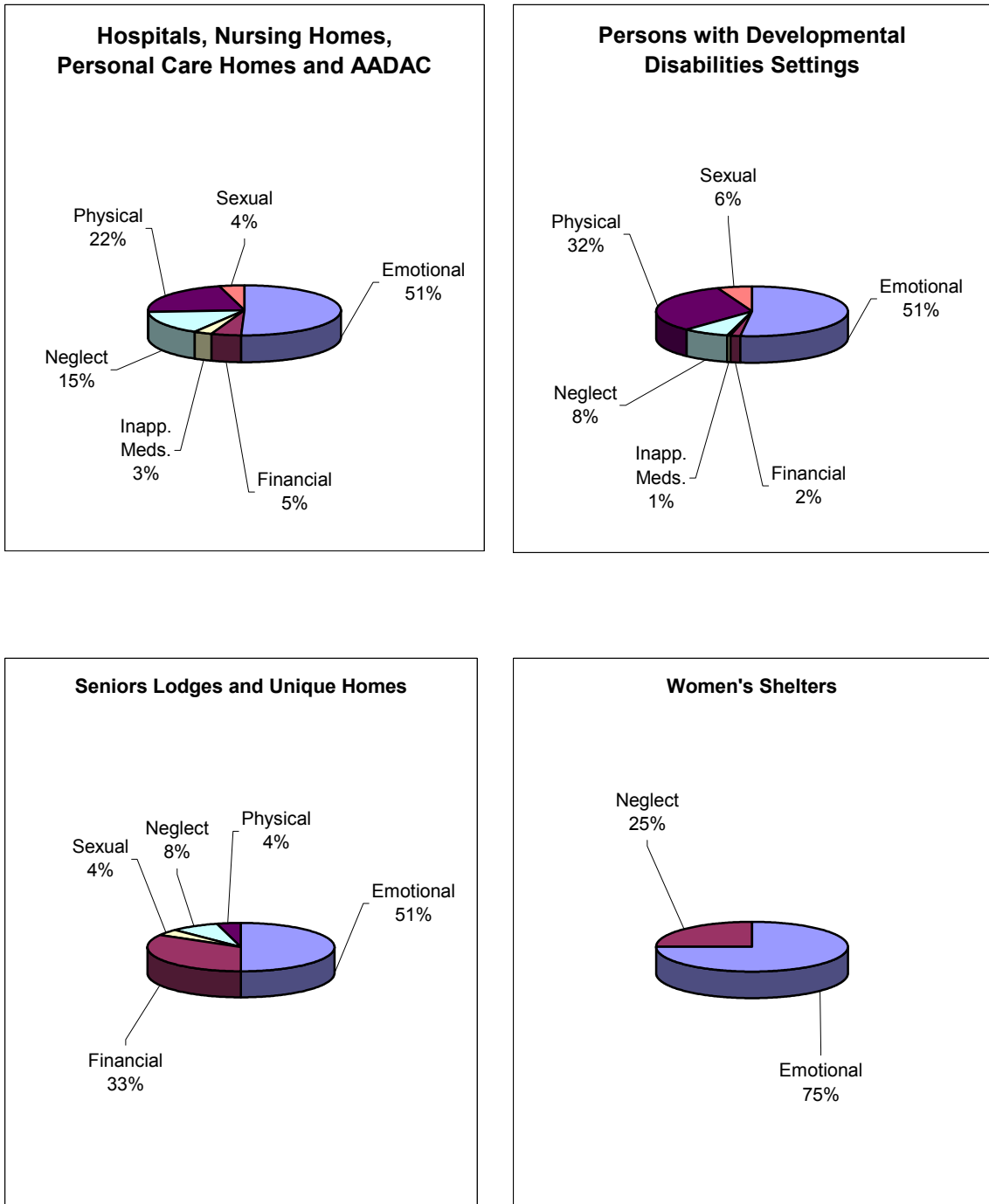


Figure 2

**Protection for Persons In Care
 Categories of Alleged Abusers by Care Setting
 April 1, 2002 to March 31, 2003**

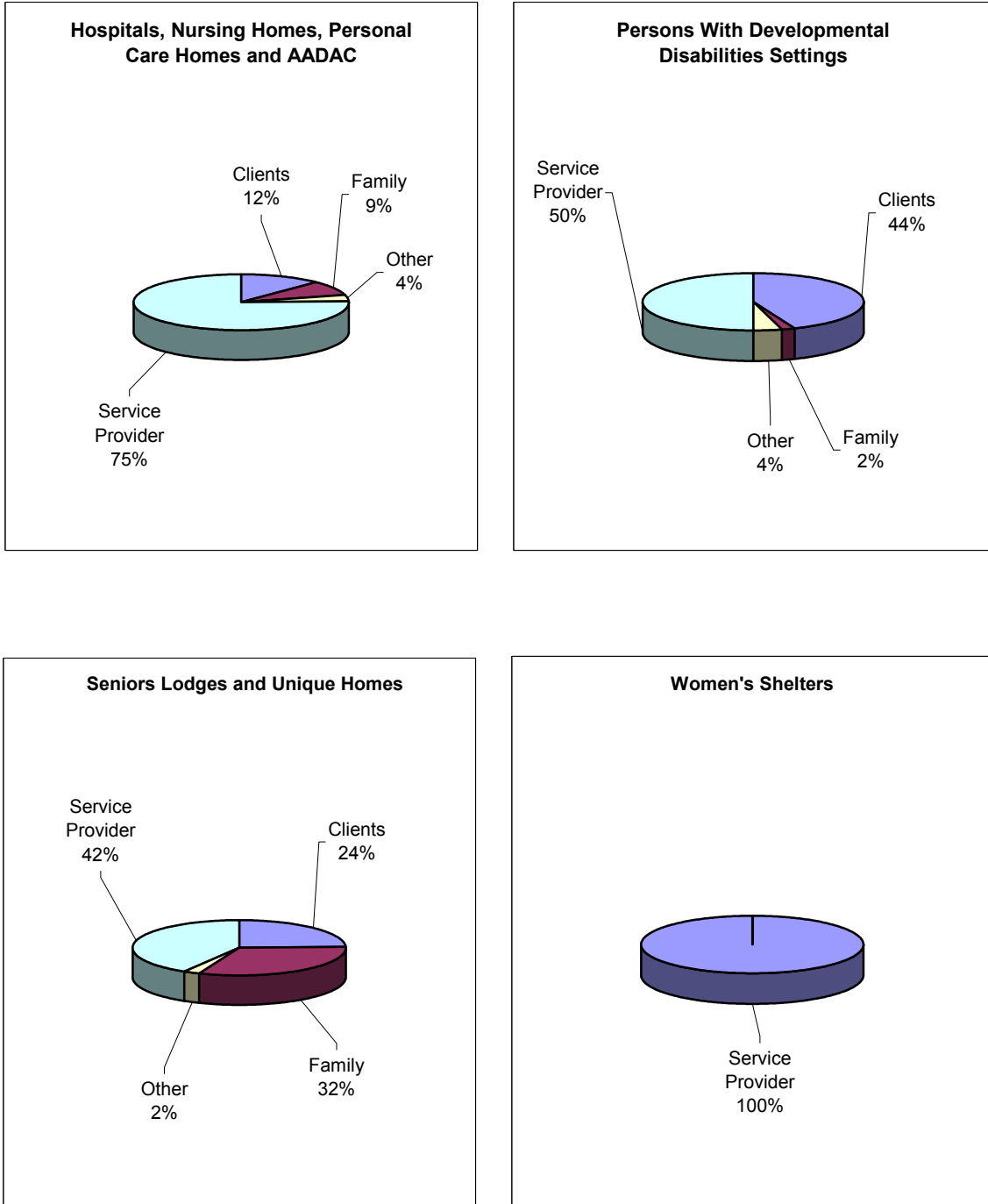


Figure 3

PROTECTION FOR PERSONS IN CARE

PART III

INVESTIGATION OUTCOMES AND RECOMMENDATIONS

FROM CASES REPORTED

April 1, 2002 – MARCH 31, 2003

INVESTIGATION OUTCOMES AND RECOMMENDATIONS

INVESTIGATION RESULTS FOR FILES CLOSED - April 1, 2002 – March 31, 2003:

- During this twelve-month period, all of the 584 cases investigated were closed. 64% of the cases were dismissed as unfounded or due to insufficient evidence.
- 68% of reports involving allegations of abuse in seniors' lodges were dismissed; 70% of the allegations regarding Persons with Developmental Disabilities (PDD) services were dismissed, and 60% of reports in facilities governed by regional health authorities were dismissed.
- 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*, recommendations are made in an effort to assist facilities in preventing similar incidents.

RECOMMENDATIONS RELATED TO HUMAN RESOURCES:

- During this twelve-month period there were 112 reports involving an employee/service provider as an alleged abuser where some type of disciplinary action was taken. The action taken by the facility/agency included: termination in 39 reports, staff resignation in 13 reports, and various forms of discipline in the remaining reports. There were two reports in which the investigators recommended the facility consider disciplinary action.
- In one case, the professional association's finding was that unprofessional conduct and unskilled practice occurred and it ruled that its member must attend workshops before being reinstated.
- During the previous fiscal year, 2001 to 2002, there were staff terminations in 24 reports and staff resignation in 9 reports.

RECOMMENDATIONS RELATED TO OFFENSES UNDER THE *ACT*

- Five investigation reports, involving 11 files, were forwarded to a Crown Prosecutor for review in relation to section 12 – making a complaint under the *Act* knowing it to be false.
- Four investigation reports, involving 10 files, were forwarded to a Crown Prosecutor for review in relation to section 2(1) – failure to report abuse. Two of these cases were referred to the police for further investigation.
- While Crown Prosecutors are under no obligation to report back to Protection for Persons in Care, for some of the cases where they have reported to Protection for Persons in Care, they indicated that the six month time limitation for laying charges for special offenses had already lapsed.

PROTECTION FOR PERSONS IN CARE

PART IV

CASE SUMMARIES

APRIL 1, 2002 – MARCH 31, 2003

CASE SUMMARIES OF COMMON THEMES ARISING OUT OF INVESTIGATIONS:

Among the types of cases investigated during the fiscal year, allegations involving security guards as alleged abusers, paid companions as alleged abusers, and transportation issues are highlighted. The purpose in sharing these case studies is to assist agencies/facilities in being proactive in their education and communication endeavors.

SECURITY PERSONNEL NAMED AS THE ALLEGED ABUSERS:

The purpose in highlighting these cases involving security guards is that facilities do rely on security guards to provide constant observation of clients in emergency and/or mental health situations; however, there is not always clear lines of responsibility or adequate supervision and education regarding the duties expected of the security guard. The third case indicates that sometimes it is a perception issue regarding how the security guard handled the client.

Case #1:

Allegation: A male security guard, while providing constant observation, tucked a blanket around the patient, asked for her phone number, and rubbed his hand up one of her legs causing the patient to be uncomfortable with his behaviour.

Investigation: The facts gathered indicated that an incident occurred between the patient and the security guard causing the patient to be emotionally upset.

Recommendations: 1) That the facility consider reviewing its contract with the security company to ensure the contract includes the expected professional behaviour/conduct on the part of its members, and consequences if professionalism is not maintained; 2) That the facility review the security company's policies relating to assigning a male security guard to conduct constant observation of female patients, especially between the hours of 8 P.M. and 8 A.M.; 3) That the facility consider reviewing the duties of security supervisory personnel in relation to accountability for security guards providing constant observation for patients in the facility; and 4) That the facility review the frequency of staff documentation regarding attending to a patient on constant observation.

The Ministry approved these recommendations.

Case #2:

Allegation: When a patient was admitted under the *Mental Health Act* at an acute facility, security guards punched the patient on the left side of his head. A security guard pinned the patient down and put him in a headlock. The security guards banged on the window and made faces at the patient, laughed and called him names. They told the patient to go ahead and kill himself. The patient spit on the security guard and was charged.

Investigation: Due to the criminal nature of this allegation, the matter was turned over to the local police for investigation.

Case #3:

Allegation: A security guard tightly handcuffed a patient who was admitted to the emergency department under the *Mental Health Act*, causing the patient to sustain swollen hands, redness and bruising to his wrists.

Case #3 (Cont.)

Investigation: The surveillance video confirmed that the patient was handcuffed. Surveillance showed that the patient was checked numerous times by various security/nursing staff and given blankets and his jacket for warmth. The video showed the patient hanging over the bench with his body weight pulling against the handcuffs. The patient appeared agitated and restless for most of the night. He was given breakfast and escorted outside to have a cigarette. The facility policy allows security personnel to use mechanical restraints on a temporary basis for patients who pose a threat to themselves or others. The policy requires security personnel to keep a restrained patient under surveillance and remove the handcuffs if required.

Recommendation: The allegation of intentionally causing bodily harm be dismissed due to insufficient evidence.

The Ministry approved this recommendation.

PAID COMPANIONS NAMED AS ALLEGED ABUSERS:

The purpose in highlighting these cases involving paid companions is that at times companions are hired and paid by families and/or guardians to provide companionship (not care) to the resident. Often facilities do not have policies in place to identify the role, responsibilities and accountabilities of the paid companions. As well, paid companions are often not included in educational training sessions such as managing difficult people and prevention of abuse.

Case #1:

Allegation: One of the two paid companions (PC) yelled at the resident, told the resident she was stupid and that the resident did not appreciate the PC.

Investigation: A witness heard the PC tell the resident to “behave and stop acting so stupid.” This witness said the resident has come several times to the witness and said, “She’s mean to me. She’s mean to me.” A second witness said the PC has said to the resident, “if you don’t be good, I’ll go and tell (son’s name) and he will be mad at you.” The resident’s son (guardian) said that he was aware that the PC had a rough nature but was unaware she was abusive. The son said the facility has spoken to him on many occasions regarding the roughness of the PC. The son said he has no formal contract with either of the PCs which states the duties that are expected. The son said he did want the PCs to keep his mother busy, as he believes that activity will slow down the advancement of her dementia. The PC said that if telling the resident that she “is crazy” is abusive, then she “supposes she is guilty.” The PC said the resident is a very manipulative person who yells and screams incessantly and after three or four hours of hearing this, she (PC) gets tired of it.

Recommendations: 1) That the facility hold a care conference with the resident’s family and PCs to discuss the resident’s care needs and incorporate socialization activities into the care plan; 2) That the facility social worker meet with the resident’s son and assist him in drafting a set of guidelines for the companions, which would set out expectations for their continued employment; 3) That the facility provide an inservice regarding dementia and techniques for handling resident behaviours for all staff, and paid companions; and 4) That the facility, being responsible for resident safety, consider having the social worker meet with the PC and speak to her regarding positive reinforcement and behaviours she could use with the resident.

The Ministry approved the recommendations.

Case #1 (Cont.)

Facility Response: The facility social worker met with the PC but the PC indicated she was not willing to change the way she spoke to the resident. The social worker met with the son to assist in drawing up a contract with expectations for the PC's continued employment but he chose not to pursue the contract. The facility is currently creating a brochure for family members regarding hiring private companions. Inservices on dementia and handling resident behaviours are planned and PCs will be invited to attend. In addition, a notice will be put in the monthly newsletter inviting families, companions and volunteers to attend these inservices. The facility will be more assertive in the future in PC/family situations where resident care is a concern.

Case #2:

Allegation: A paid companion (PC) slapped a long term care resident.

Investigation: Witnesses indicated that they heard a slap and inquired about the slap by speaking to the PC and the resident. The PC denied she slapped the resident but said instead that the resident slapped her. The resident said he had no memory of being hit by the PC; he showed how he slapped the PC in another incident. No staff checked the resident for injury.

Recommendations: 1) That the allegation be dismissed due to insufficient evidence; 2) That the facility ensure that when staff suspects a resident has been abused, that the resident be checked for injury and 3) That the facility review/revise its policy and procedures concerning PC to include the process to be used when a companion is named as the alleged abuser.

The Ministry approved the recommendations.

Facility Response: Checking for injury is an expectation and is in policy. The policy regarding paid companions is under review.

INCIDENTS INVOLVING TRANSPORTATION OF CLIENTS:

The purpose in highlighting these cases involving transportation of clients is that staff are not always fully informed or aware of the behaviours of the clients in particular during transportation. Another issue identified was staff riding together in the front seat leaving clients seated together in the other seats.

Case #1:

Allegation: A male client slapped a female client on the face and used profanity directed at her when they were in a vehicle on a trip to the drugstore.

Investigation: The male client sat in the front passenger seat and two female clients sat in the back seat. Unknown to the staff person, the female client's file revealed that she gets upset if she cannot sit in the front of the van when on trips. On the return trip, the female client rushed to the front seat, displacing the male client from his front seat. The male client was required to sit in the back seat on the way back and became agitated and began striking the female client in front of him with a rolled up newspaper. Upon returning to the home, the male client continued to hit with the newspaper and used profanity against the female client. Neither staff had been orientated to the clients in this home and had not spoken to home staff prior to the incident. The agency has implemented a plan seeking the clients' agreement, before the trip, to take turns sitting in the front seat.

Case #1 (Cont.)

Recommendations: 1) That the allegation be dismissed due to insufficient evidence; 2) That the facility ensure staff follow the protocols that have been created regarding seating arrangements for clients when being transported in vehicles; 3) Ensure pertinent information is documented and reviewed regarding past transportation experiences of clients; 4) Ensure new staff are adequately trained to anticipate and respond to possible difficulties with clients; and 5) Ensure the casual/relief binder containing information that new staff should know when working alone with clients is updated and reviewed by staff.

The Ministry approved the recommendations.

Case #2:

Allegation: While riding in a vehicle, one client (#1) “clawed” the back of another client’s (#2) neck, causing several scratches to the client’s neck.

Investigation: Two staff, both sitting in the front seat, took two clients for a drive to the lake. One client sat behind the other in the two back seats of the van. They had stopped on route to get pop. Client #1 tried to take client #2’s pop. Client #1 is known to have a behaviour compulsion to drink excessive amounts of fluids. A facility staff person said the use of liquids, including pop, in the van is not permitted and that two staff, both in the front seat, is unusual and unnecessary. The decision to take clients out of town also required prior approval. Documentation supported the above transportation policies and approved restrictive procedures for client #1 regarding restricting/controlling access to liquids.

Recommendations: That the allegation be dismissed due to insufficient evidence of intent to harm on the part of client #1 but that the facility consider disciplinary action for breach of policy with respect to the two staff members.

The Ministry approved the recommendations.

Case #3:

Allegation: A male client inappropriately touched a female client on the breast while riding on the Disabled Adult Transportation System (DATS) bus.

Investigation: The male client usually sits in front of the female client, who boards the bus first. The female client’s singing along to her “Walkman” bothers the male client. An altercation occurred upon arrival at the facility. The male client admitted to touching the female client but said he now sits at the back of the bus. The male client has been the subject of a similar allegation in the past and a risk assessment determined that he was to have one-to-one supervision. A previous suggestion that the male client be escorted by an attendant while on the public transit bus has not been implemented.

Recommendations: 1) That the agency, in collaboration with the service providers and the male client’s guardian, revisit the idea of having the male client travel by public transportation with an attendant when female clients are present; 2) Explore counseling for the male client to assist in his relationships with females; and 3) Review the practice of permitting the male client to be with female clients while unsupervised at the work site.

The Ministry approved the recommendations.

Case #3 (Cont.)

Agency Response: DATS ensures the male client is seated away from female clients and that no female client is at risk. If this does not work, another transportation method will be used. The male client has been moved to a smaller work site thus providing closer supervision. The male client is in counseling and will have a medication review.

Case #4:

Allegation: While on a day trip in a van, one client hit another client on the back and face, knocking the client's glasses off and breaking them.

Investigation: One client (#1) became extremely agitated, kicking the other client (#2), the staff, and the van windows. Client #1 has a history of behavioural problems, with violent aggression towards other clients and staff in the past. The two staff called the facility to get advice on what to do but they did not receive a call back from the on-call worker. The facility has instituted new procedures to be implemented when taking clients on day trips. These include taking along medications, cell phones and emergency procedures.

Recommendations: That the allegation of intentionally causing bodily and emotional harm be dismissed due to lack of evidence of intent to cause harm and that the facility reviews its failure to reply to the phone response and take discipline action if necessary. That the facility considers relocating client #1 to the behavioural unit in the interim before her move to a group home.

The Ministry approved the recommendations.

Facility Response: Client #1 continues to reside in the facility, which is considered the best location for her at the present time. She has had modifications to her behavioural plan. Attendance to phone calls in sensitive situations has been reviewed with all staff.

PROTECTION FOR PERSONS IN CARE

PART V

ADMINISTRATION

Protection For Persons in Care Branch Mailing Address

Any written correspondence to the Protection for Persons in Care Branch, such as the 90 day responses to the recommendations or requests for brochures and posters should be made to:

**Protection for Persons in Care Branch
Community Supports Systems Division
Alberta Community Development
Station M, Box 476
Edmonton, Alberta T5J 2K1**

The fax number is (780) 415-8611 and the toll free reporting number is 1-888-357-9339.

Educational Resources

During this fiscal year, over 25,000 brochures and over 650 posters were distributed on request. In addition, over 2,000 Quarterly Reports were distributed. Throughout the year, presentations were given to over 600 participants with the vast majority being nursing attendant students.

Legislative Review

The *Protection for Persons in Care Act* Legislative Review Committee has provided the Honourable Gene Zwozdesky, Minister of Community Development, with its report and recommendations. The report was released on September 17, 2003 for further feedback. If you would like a copy of the report and questionnaire contact the Protection for Persons in Care Legislative Review office by email at PPCLegReview@gov.ab.ca or by phone at (780) 415-8617 in Edmonton or toll free at 310-0000, then (780) 415-8617. **Questionnaires must be received no later than November 14, 2003.** The report and the questionnaire are also on the Community Development Web site: www.cd.gov.ab.ca

Future Reports

The mailing of Quarterly Reports on the activities of Protection for Persons in Care will be discontinued. However, statistical information on incoming reports and information on common themes will be posted on a quarterly basis on Community Development's Web site at www.cd.gov.ab.ca under Helping Albertans/Protecting Persons in Care. An Annual Report will be published and sent to the current quarterly report mailing list. If you do not have access to the Internet or would like copies of the reports contact:

Edith Baraniecki, Director, Protection for Person in Care
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