

QUARTERLY REPORT
OF
REPORTED ALLEGATIONS
PROTECTION FOR PERSONS IN CARE
APRIL 1, 2003 – JUNE 30, 2003

To report an allegation of abuse call the Reporting Line (toll free) at 1-888-357-9339 or fax to (780) 415-8611

If you require information on the Protection for Persons in Care Legislative Review or to obtain a copy of the report and questionnaire due November 14, 2003 view Community Development's Web site at www.cd.gov.ab.ca or call (780) 415-8617 or email PPCLegReview@gov.ab.ca

If you would like more information about Protection for Persons in Care contact:
Edith Baraniecki, Director, Protection for Persons in Care by phone at (780) 427-0552, Fax at (780) 415-8611 or email to edith.baraniecki@gov.ab.ca

REPORTED ALLEGATIONS: First Quarter 2003 - 2004 (April 1 - June 30, 2003)

During this quarter, 124 reports were received by the Protection for Persons in Care (PPC) reporting line, which is a 27% decrease from the last quarter.

Agency/Ministry Responsibility	1 st Quarter	Fiscal Year %
Regional Health Authorities/H&W	79	63.7%
PDD/Community Development	34	27.4%
AADAC/H&W	0	0.0%
Alberta Mental Health Board/H&W	0	0.0%
Management Bodies/Alberta Seniors	8	6.5%
Child and Family Services Authorities/CS	3	2.4%
Total	124	100.0%

See figure 1 Page 3 for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE:

Types of Abuse	1 st Quarter	Fiscal Year %
Physical	30	20.2%
Emotional	77	52.0%
Inappropriate medications	4	2.7%
Sexual	17	11.4%
Financial	4	2.7%
Neglect	16	10.9%
Total	148	100.0%

See figure 2 Page 4 for individual breakdown by organizational structure

TYPES OF ALLEGED ABUSERS:

Types of Alleged Abusers	1 st Quarter	Fiscal Year %
Service Provider	67	54.0%
Client	42	33.9%
Family	7	5.6%
Other (volunteer/visitors/non-family)	8	6.5%
Total	124	100.0%

See figure 3 Page 5 for further breakdown by organizational structure

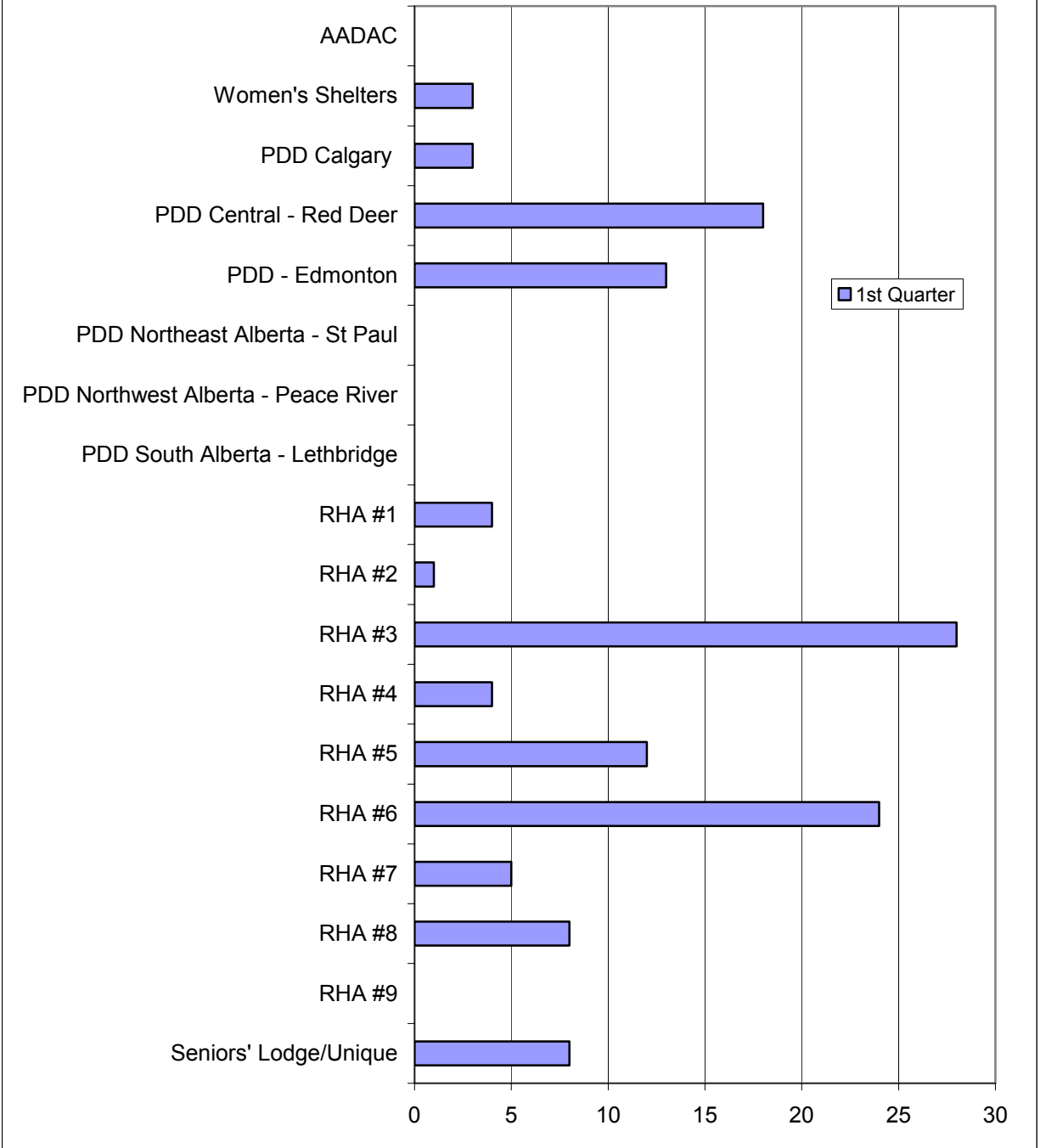
TYPES OF INVESTIGATORS:

Types of Investigators	1 st Quarter	Fiscal Year %
Contracted Investigators	116	93.6%
Professional Colleges*	2	1.6%
Police	2	1.6%
Other bodies (MHPAO)	0	0.0%
Not Investigated**	4	3.2
Total	124	100.0%

*Referred to College of Physicians and Surgeons (1) and the College of Licensed Practical Nurses (1)

**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
Number of Reports
April 1, 2003 to June 30, 2003**



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, 2003 to June 30, 2003**

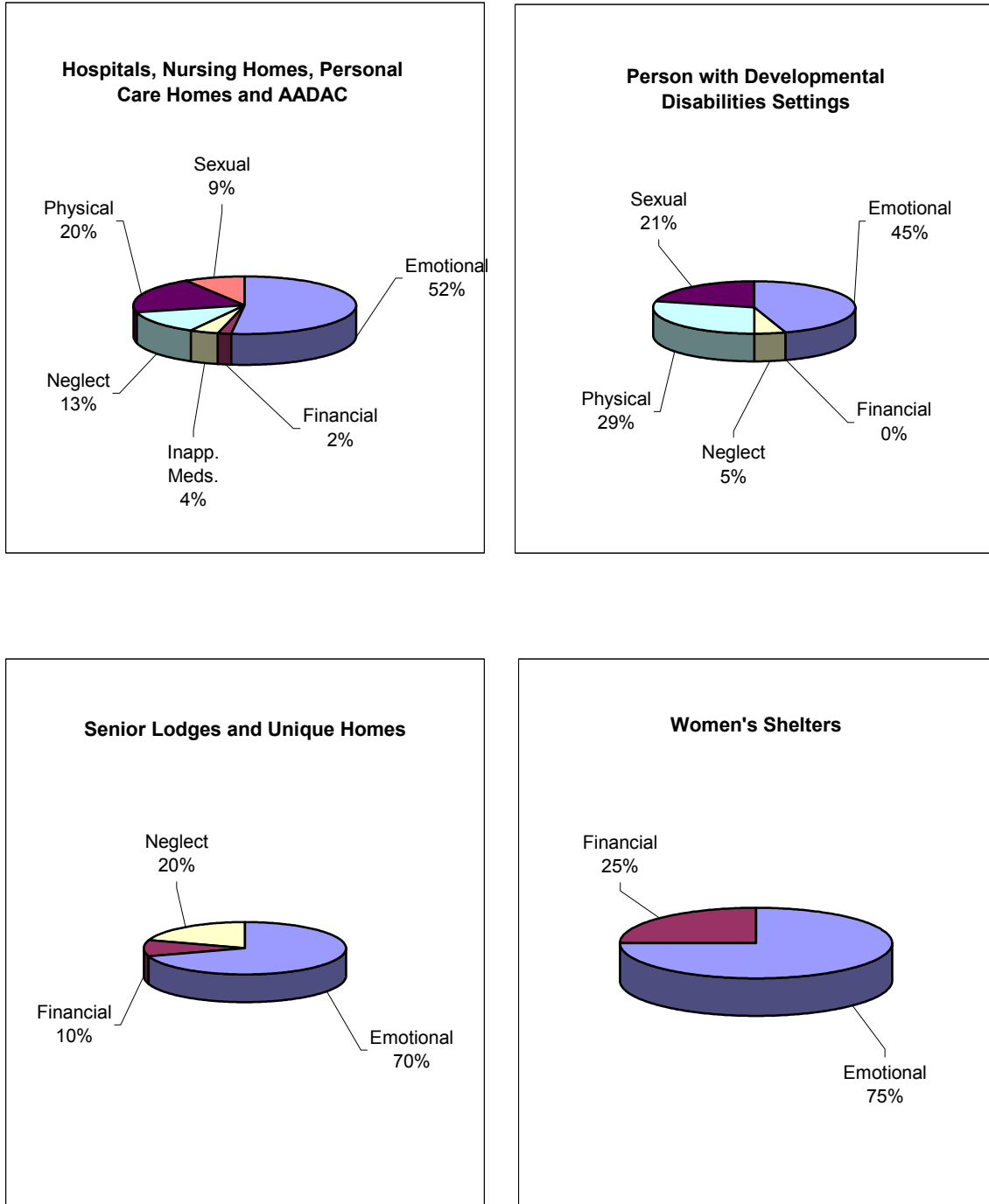


Figure 2

**Protection for Persons In Care
Categories of Alleged Abusers by Care Setting
April 1, 2003 to June 30, 2003**

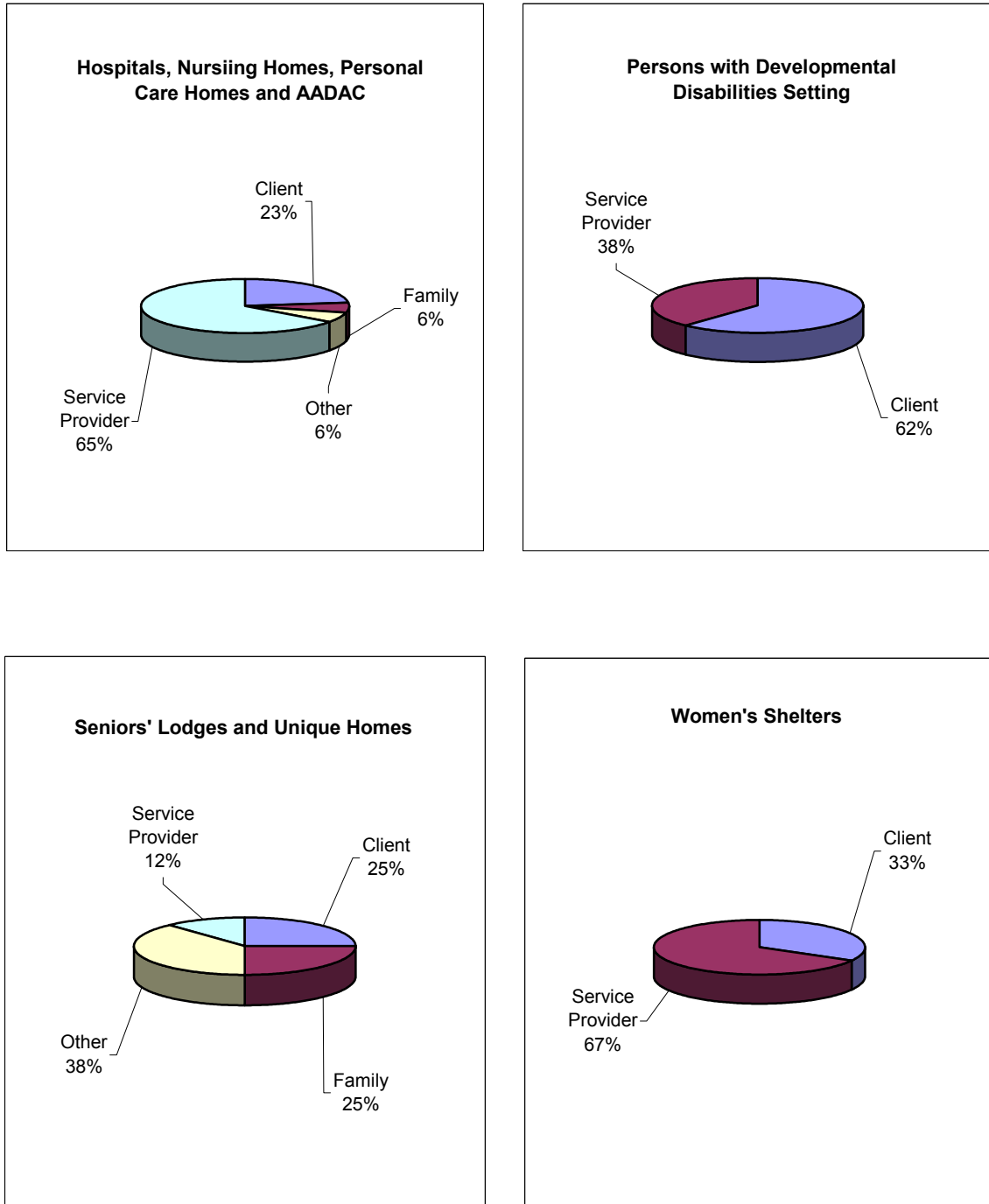


Figure 3

COMMON THEMES ARISING OUT OF INVESTIGATIONS

The purpose in sharing these themes is to assist agencies/facilities in being proactive in their education and communication endeavors. Where investigations have been concluded, the recommendations have been included.

Incidents related to toileting residents:

- In several reports, it was noted that service providers specifically told residents that they were to use their incontinent products rather than the service provider assisting with toileting the residents when the residents requested to go to the bathroom.
- Incidents of service providers not changing or toileting residents properly included service providers telling the residents that they were too busy to change them; advising the resident they would not toilet the resident again because they had done so recently; locking the bathroom door to prevent the resident from entering the bathroom at night; requesting the resident to stand up because the service provider would not change the resident in bed; and “smacking” the resident’s buttock and telling the resident not to use the incontinent product because the resident had been changed three times already.
- Recommendations included that the facility review its toileting times, the agency considers reviewing the client’s support plan to determine if it warrants updating/revision or incorporation of any additional procedures related to incontinence, and the facility monitor the performance of the service provider and take immediate steps to ensure residents do not experience harm.

Incidents where residents were threatened with going to a nursing home:

- There were at least two reports where service providers in a lodge and in a designated/assisted living facility yelled at and threatened the resident with being sent to a nursing home.
- Recommendations included that the facility provide the service providers with one-on-one training sessions regarding using more acceptable interaction skills; a specific timeframe to learn and utilize these skills, and track the service provider’s behavior following the sessions; and that facility managers speak with staff about using the term “nursing home” as a threat when speaking with residents in designated/assisted living facility.

Incidents involving call bell response times:

- There were several incidents reported regarding the response times to call bells. Some involved residents requesting assistance after toileting and having to wait over an hour. During the gathering of the facts, service providers indicated to the investigators that they were too busy to answer all the calls, as they were required to carry out higher priority duties.
- Recommendations were made that the facilities review their call bell response times and endeavor to improve the response times.

Incidents involving communication through Unit Clerks:

- There were several incidents reported where the Unit Clerk (UC) was put in the position of being the major communication link between staff and the Care Manager (CM), which resulted in an inappropriate shift of communication responsibilities away from professional staff. In one incident, the UC had the resident listed as requiring a flu vaccine however the Registered Nurse (RN) discovered that she had given the resident the flu vaccine in error. The RN told the UC to inform the CM of the error in the morning. In another incident, the RN relayed concerns about a medication error to the UC and did not chart or relay the error to the oncoming shift RN. In an incident involving the transfer of a resident from a nursing home to an acute care hospital for a biweekly medical treatment, the Unit Clerk was relied upon to communicate appointment changes, resulting in the resident being left unattended and disorientated.
- Recommendations arising out of these incidents included that facilities review the role of the UC in the administration of medications, review the policies and procedures for medication administration and ensure the service providers are aware of them. Facilities should also ensure that service providers document incidents within an appropriate timeframe and know that relying on verbal communication is not sufficient. Facilities should initiate discussions with the Regional Health Authorities and other stakeholders to ensure specific policies are established with respect to accountability and responsibility for patients/residents as they move between facilities for treatment.

Incidents involving night shift in community group home settings:

- There were several reports involving sleep staff or night shift staff in group home settings not being attentive to client needs at night.
- Recommendations for agencies included:
 - Consider establishing routine supervision of the night staff position and provide feedback to the night staff on an ongoing basis.
 - Conduct regular performance reviews of individuals working the night staff position.
 - Review and update the position description of the night staff position to ensure it reflects expectations related to the provision of client care as the needs of clients change.