

QUARTERLY REPORT
OF
REPORTED ALLEGATIONS
PROTECTION FOR PERSONS IN CARE
JULY 1, 2003 – SEPTEMBER 30, 2003

**To report an allegation of abuse call:
Reporting Line (toll free) at 1-888-357-9339
Fax at (780) 415-8611**

For more information about Protection for Persons in Care contact:

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Email edith.baraniecki@gov.ab.ca

REPORTED ALLEGATIONS
Second Quarter 2003 - 2004 (July 1 - September 30, 2003)

During this quarter, 195 reports were received by the Protection for Persons in Care (PPC) reporting line, one of the largest numbers of reports received in a three-month period. There was a marked increase in the number of allegations from the lodge settings.

TYPES OF AGENCIES

Agency/Ministry Responsibility	1 st Quarter	2 nd Quarter	Total	Fiscal Year %
Regional Health Authorities/H&W	79	102	181	56.7%
PDD/Community Development	34	63	97	30.4%
Management Bodies/Alberta Seniors	8	29	37	11.6%
Children's Services	3	1	4	1.3%
Total	124	195	319	100.0%

See figure 1 (Page 4) for further breakdown by organizational structure

TYPES OF ALLEGED ABUSE

Types of Abuse	1 st Quarter	2 nd Quarter	Total	Fiscal Year %
Physical	30	42	72	19.0%
Emotional	77	133	210	55.2%
Inappropriate medications	4	4	8	2.1%
Sexual	17	7	24	6.3%
Financial	4	17	21	5.5%
Neglect	16	29	45	11.9%
Total	148	232	380	100.0%

See figure 2 (Page 5) for individual breakdown by organizational structure

TYPES OF ALLEGED ABUSERS

Types of Alleged Abusers	1 st Quarter	2 nd Quarter	Total	Fiscal Year %
Service Provider	67	119	186	58.3%
Client	42	45	87	27.3%
Family	7	18	25	7.8%
Other (volunteer/visitors/non-family)	8	13	21	6.6%
Total	124	195	319	100.0%

See figure 3 (Page 6) for further breakdown by organizational structure

TYPES OF FACILITIES WHERE ALLEGED VICTIMS RESIDE

Type of Facility	1 st Quarter	2 nd Quarter	Total	Fiscal Year %
Auxiliary/Nursing Homes	68	76	144	45.1%
Acute Care	10	17	27	8.5%
Assisted Living	1	4	5	1.6%
Personal Care Homes	0	5	5	1.6%
PDD Facilities	34	63	97	30.4%
Lodges	8	29	37	11.6%
Women's Shelters	3	1	4	1.2%
Total	124	195	319	100.0%

TYPES OF INVESTIGATORS

Types of Investigators	1 st Quarter	2 nd Quarter	Total	Fiscal Year %
Contracted Investigators	116	184	300	93.7%
Professional Colleges*	2	4	6	1.9%
Police	2	5	7	2.2%
Other bodies	0	0	0	0.0%
Not Investigated**	4	3	7	2.2%
Total***	124	196	320	100.0%

* During the 2nd Quarter, reports were referred to the College of Physicians and Surgeons (3) 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 abuse when no actual harm occurred.

*** A file maybe investigated by more than one type of investigator.

**Protection for Persons in Care
Number of Reports
April 1, 2003 to September 30, 2003**

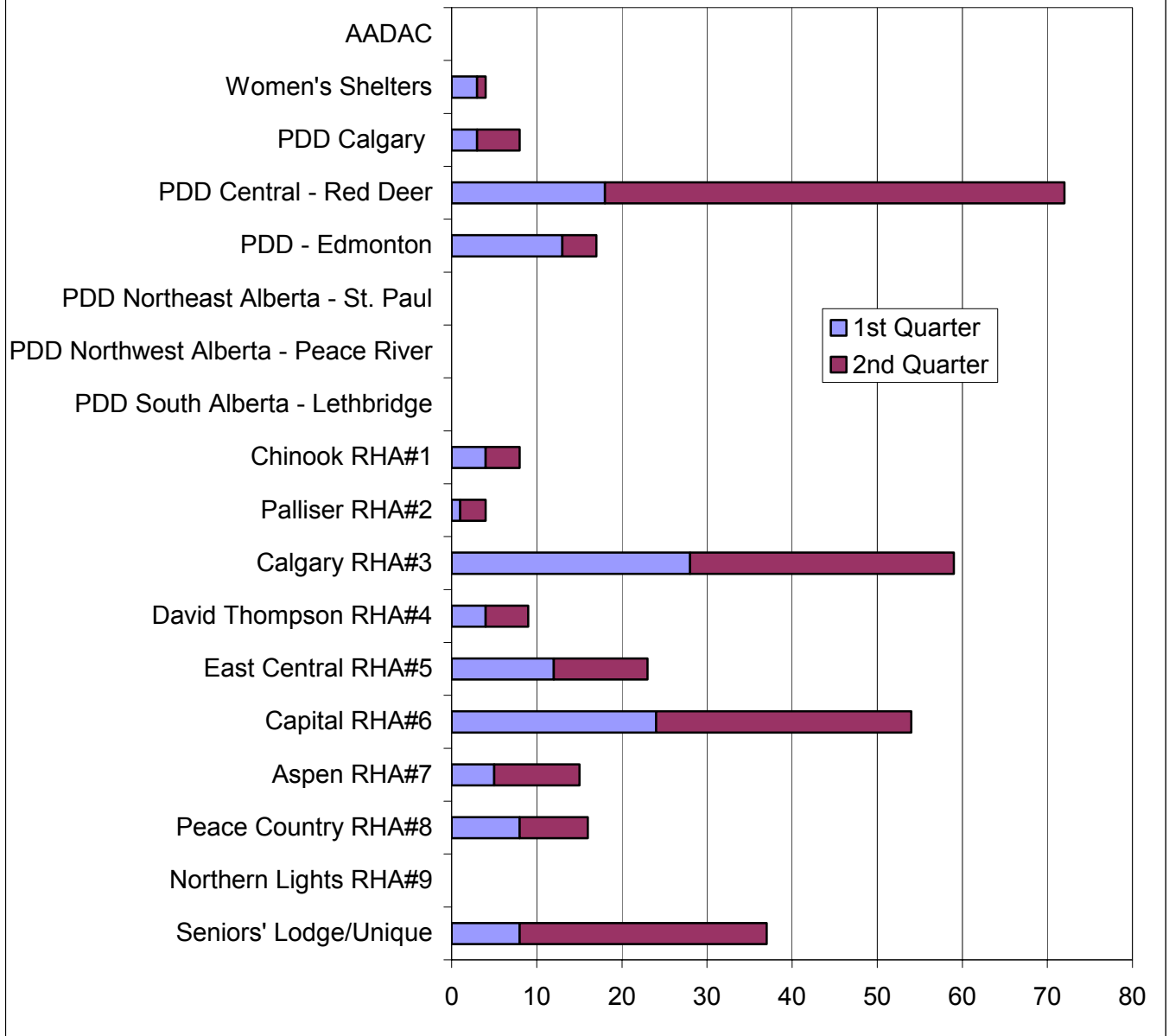


Figure 1

**Protection for Persons in Care
Types of Alleged Abuse by Care Setting
July 1, 2003 to September 30, 2003**

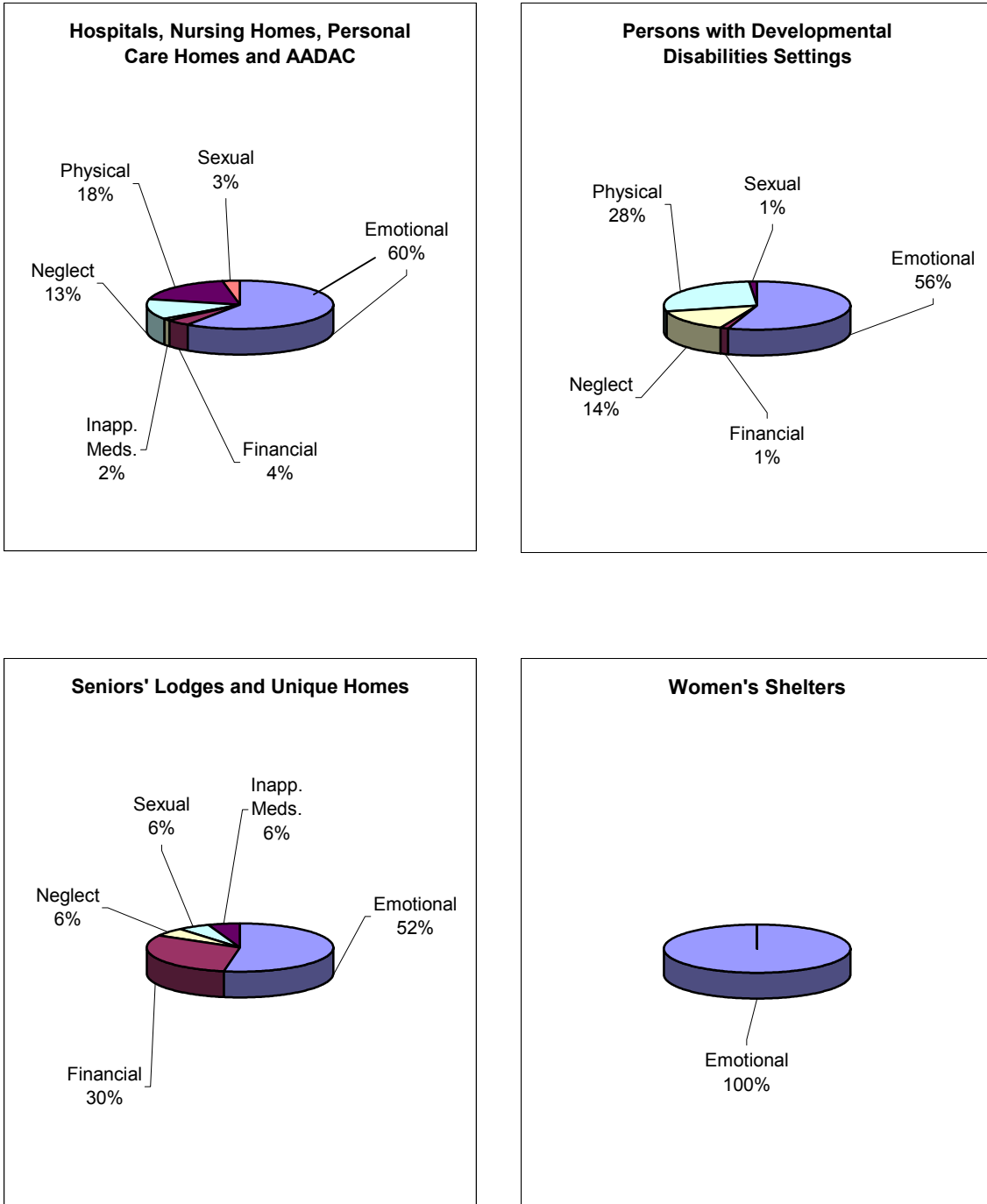
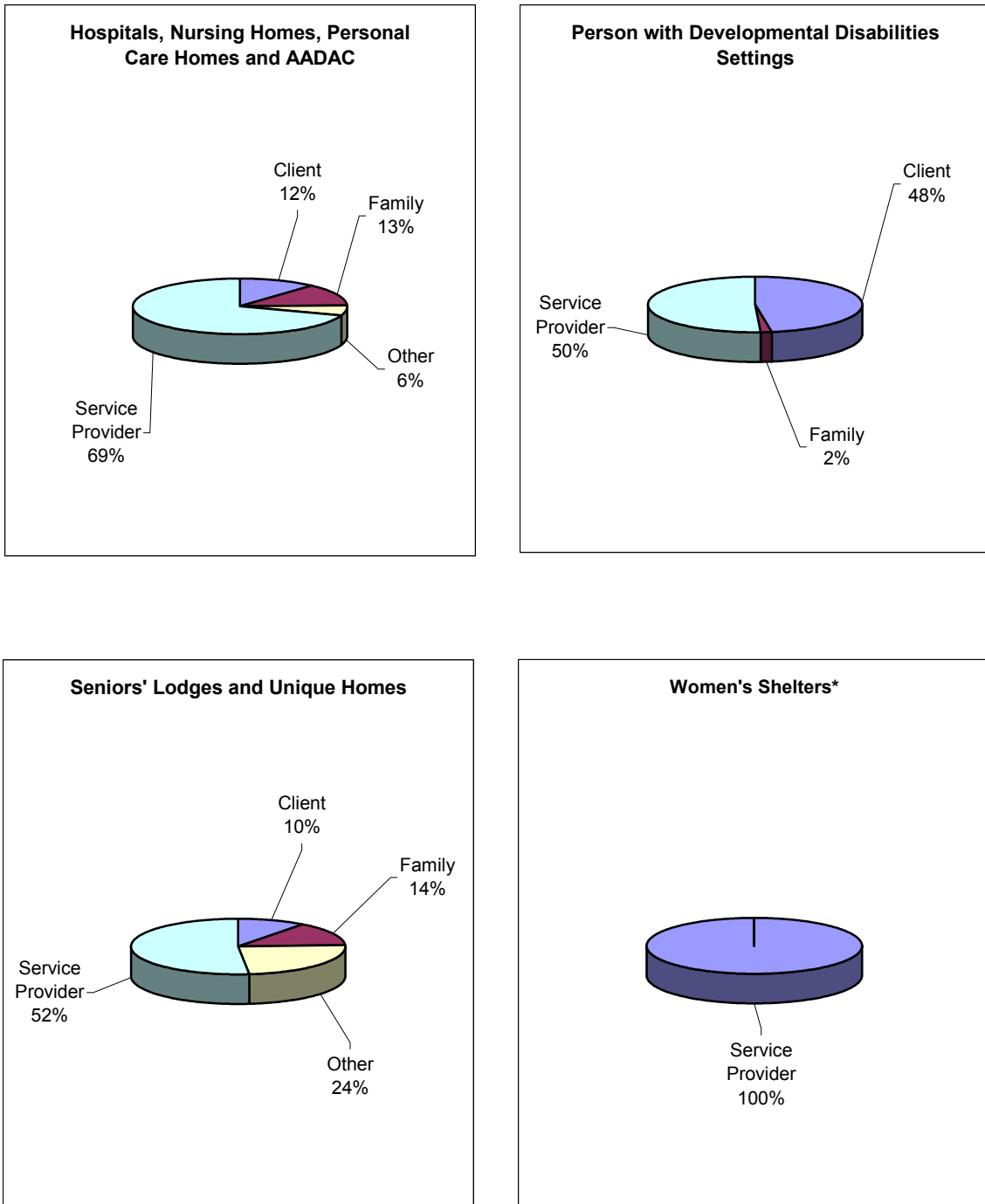


Figure 2

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



* Reflects one case only
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.

Incidents where service providers failed to report incidents of abuse to the reporting line:

There were several reports of alleged abuse of clients where the service providers failed to report the abuse to the Protection for Persons in Care (PPC) reporting line. In one incident the facility manager was aware of an alleged abuse for one month but failed to report the incident. In another incident it was revealed that several staff and family members were aware of the inappropriate actions of the alleged abuser but did not report the incidents internally nor to the PPC reporting line. In another incident, several service providers, including a registered nurse and a physician, were aware of spousal abuse but did not report the matter.

These cases were forwarded to the Crown Prosecutor's Office for failure to report abuse.

Among the recommendations to the facilities were:

- take disciplinary action against the facility manager for failing to report;
- instruct staff to intervene and stop any observed abuse towards a resident, regardless of who the alleged abuser is, and report immediately to the manager so the situation can be dealt with appropriately;
- ensure that all staff understand that their primary responsibility is to protect the resident and stop abuse from occurring, regardless of what a physician may tell them;
- schedule and monitor a spouse's visits with a resident in an open area preferably at other times than mealtimes, which are when the abusive actions were occurring, and advise the resident's spouse that his behaviour is abusive and will no longer be tolerated and, if it continues, the spouse will be removed/banned from the building.

Incidents involving family member/friend conflicts:

There were several incidents of alleged emotional abuse caused by family members reported during this reporting period. Most of these reports involved lack of communication between family members and/or are related to financial matters.

With Protection for Persons in Care, as with facilities, find these cases very challenging. Neither the facilities nor Protection for Persons in Care can deal effectively with this type of abuse. The *Protection for Persons in Care Act* was not intended to be the legislation for dealing with family matters. Facilities are encouraged to develop strategies to deal with the discord and to consider looking for opportunities to assist residents and family members in facilitating discussions in an effort to improve the well being of the resident affected by the family discord.

Incidents where residents were subjected to non-consensual sexual contact, activity or behaviour:

There were several reports of incidents involving residents being sexually abused by other residents, service providers or visitors.

- 1) A nursing attendant (NA) was alleged to have made inappropriate sexual comments and physically manipulated the resident's male anatomy while providing care. The resident is now deceased. The NA was terminated from her position.
- 2) The NA (who is the same NA as in #1 above) made inappropriate sexual comments to a male resident while providing care. The resident did not want the incident referred to the police. The NA was terminated from her position.
- 3) Over a period of nine weeks, a male resident in a lodge setting touched a female resident in a sexual manner without her consent. The investigator contacted the police who advised that they would not investigate the matter as the female resident and her family were not in favor of pressing charges. The male resident was evicted from the lodge.
- 4) One male resident in a group home sexually touched another male resident. The facility has taken preventive action by supervising all visits between the residents and not allowing the alleged abuser to be alone with other male residents.
- 5) A male resident in a long term care setting was observed fondling a female resident. This was the third incident involving the male resident. The facility put measures in place to monitor the male resident until he was transferred to another facility.
- 6) A male visitor inappropriately touched a female resident. No staff person confronted the male visitor or removed him from the area. Staff did not ensure that the male visitor left the building or that he did not enter any other resident's room. The male visitor is now prohibited from visiting. An in-service was held with staff regarding preventing and managing abuse. It was recommended that the facility counsel staff regarding their failure to adequately protect the female resident.

Clarification regarding Protection for Persons in Care's jurisdiction to investigate:

Over the last several months there appears to be confusion as to when Protection for Persons in Care has jurisdiction to investigate allegations of abuse. PPC Bulletin Number 7: *Jurisdiction – Protection for Persons in Care* January 2004 has been developed to provide clarification and add further explanation.

The *Protection for Persons in Care Act* (the *Act*) enables complaints of alleged abuse to be investigated for clients, only when several conditions have been met. The conditions are:

- 1) The client is an adult.
- 2) The client receives services from an agency.
- 3) The agency that provides the services is an "agency" as defined in the *Act*.
- 4) The alleged abuse arose in the context of the client receiving services from the agency.
- 5) The complainant has reasonable and probable grounds to believe and believes that there is or has been abuse against a client (refer to PPC Bulletin Number 1 – *Duty to Report Updated May 2002*).

Protection for Persons in Care has no jurisdiction to accept complaints or conduct investigations unless *all five conditions* are met.