

ANNUAL REPORT  
2003/2004

On the Activities of  
Protection for Persons in Care

April 1, 2003 – March 31, 2004



**Protection for  
Persons in Care**

**A PROGRAM OF**

**ALBERTA  
COMMUNITY  
DEVELOPMENT**

**PROTECTION FOR PERSONS IN CARE**

**PART I**

**COMPLAINTS OF ABUSE**

**APRIL 1, 2003 – MARCH 31, 2004**

## PROTECTION FOR PERSONS IN CARE

### REPORTED ALLEGATIONS: April 1, 2003 - March 31, 2004

#### NUMBER OF REPORTS:

In the fiscal year, the largest number of reports (47.3% or 320 reports) involved continuing care facilities, followed by Persons with Developmental Disabilities (PDD) settings and seniors' lodges. There was also an increase in the number of reports from acute care hospitals.

Agency/Ministry Responsibility	# of Reports					
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Fiscal Year	
					Total	%
Regional Health Authorities/H&W	79	102	107	129	417	61.7%
PDD/Community Development	34	63	40	45	182	27.0%
Management Bodies/Alberta Seniors	8	29	20	16	73	10.8%
Children's Services	3	1	0	0	4	.5%
<b>Total</b>	<b>124</b>	<b>195</b>	<b>167</b>	<b>190</b>	<b>676</b>	<b>100.0%</b>

See Part II, Figure 1 for further breakdown by organizational structure

#### COMPARISONS OVER FOUR FISCAL YEARS:

The number of reports has steadily increased from 499 in 2000/01, to 542 in 2001/02, to 584 in 2002/03 and to 676 in 2003/04. This represents a 35% increase over the four reporting years.

Type of Facility	2000/01	2001/02	2002/03	2003/04
Hospitals and Nursing Homes	348	306	372	417
Persons with Developmental Disabilities settings	98	158	164	182
Lodges	36	55	41	73
Others	17	23	7	4

#### TYPE OF ALLEGED ABUSE:

Type of Abuse	# of Reports					
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Fiscal Year	
					Total	%
Physical	30	42	47	42	161	19.0%
Emotional	77	133	98	119	427	51.0%
Inappropriate medications	4	4	1	4	13	2.0%
Sexual	17	7	15	11	50	6.0%
Financial	4	17	19	20	60	7.0%
Neglect	16	29	38	43	126	15.0%
<b>Total</b>	<b>148</b>	<b>232</b>	<b>218</b>	<b>239</b>	<b>837</b>	<b>100.0%</b>

See Part II, Figure 2 for individual breakdown by organizational structure

#### TYPE OF ALLEGED ABUSER:

Alleged Abuser	# of Reports					
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Fiscal Year	
					Total	%
Service Provider	67	119	101	136	423	62.5%
Client	42	45	41	33	161	23.8%
Family	7	18	20	15	60	9.0%
Other (volunteers/visitors/non-family)	8	13	5	6	32	4.7%
Total	124	195	167	190	676	100.0%

See Part II, Figure 3 for further breakdown by organizational structure

### **TYPE OF INVESTIGATOR:**

Investigator	# of Investigations					
	1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Fiscal Year	
					Total	%
Contracted Investigators	116	184	147	161	608	90.0%
Professional Colleges	2	4	6	6	18	2.6%
Police	2	5	3	13	23	3.2%
Not Investigated	4	3	11	11	29	4.2%
Total**	124	196	167	191	678	100.0%

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

### **AGES OF ALLEGED VICTIMS:**

During the period of April 1, 2003 to March 31, 2004, 371 of the 676 (54.8%) of the reports made to the reporting line involved clients over the age of 65 years.

# **PROTECTION FOR PERSONS IN CARE**

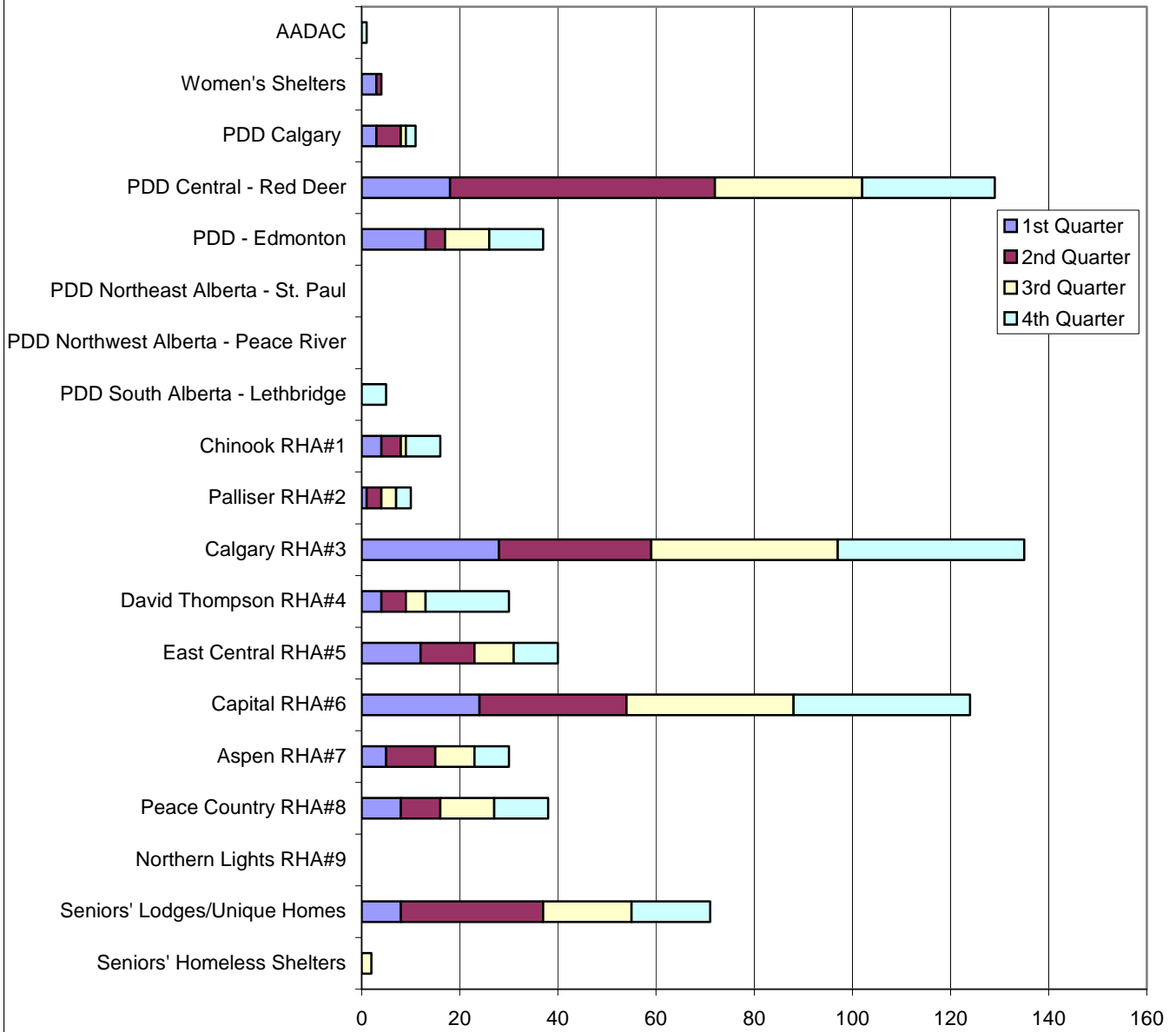
## **PART II**

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

**April 1, 2003 – March 31, 2004**

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

## Protection for Persons in Care April 1, 2003 - March 31, 2004 Number of Complaints



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 March 31, 2004**

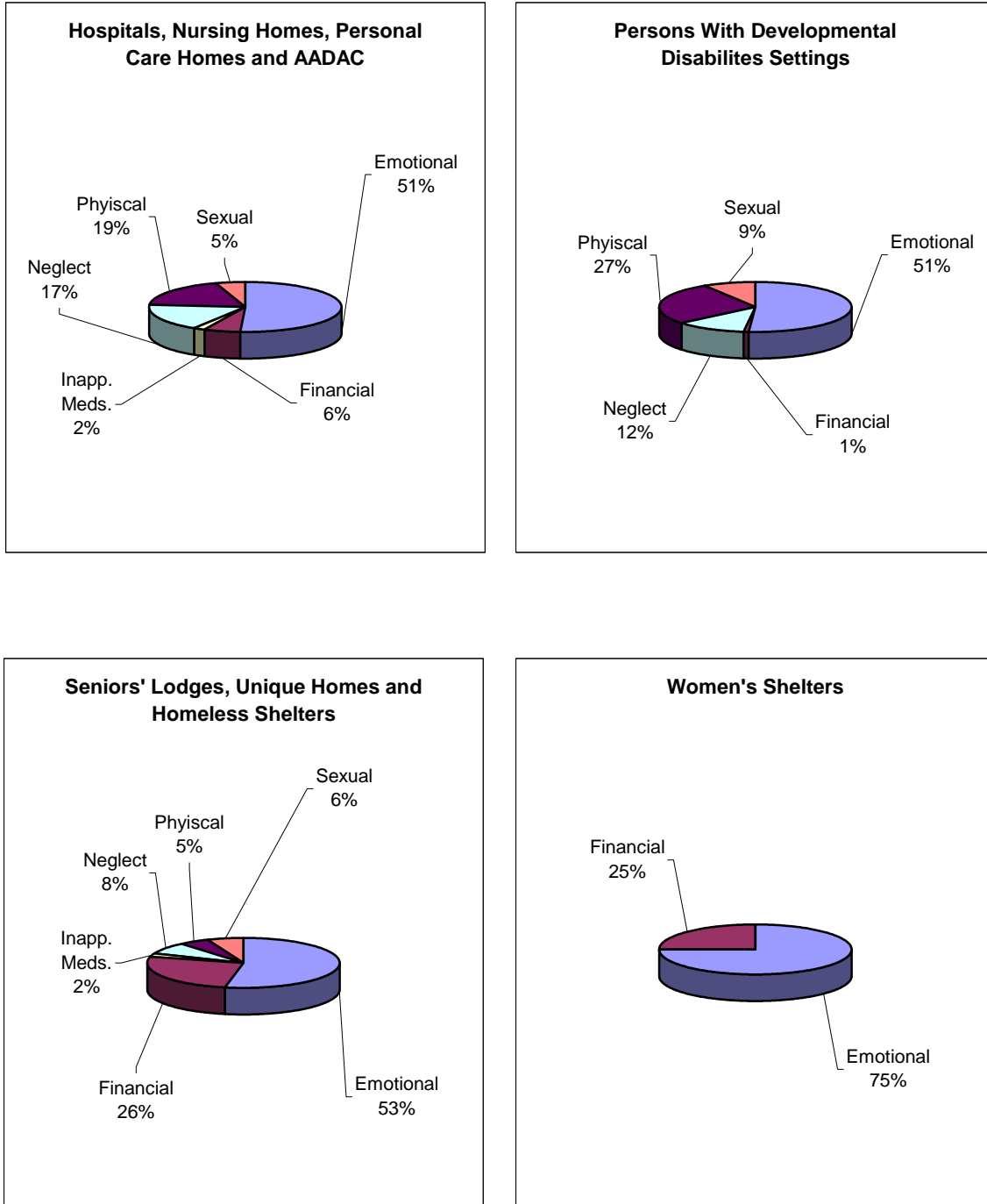


Figure 2

**Protection for Persons In Care  
Categories of Alleged Abusers by Care Setting  
April 1, 2003 to March 31, 2004**

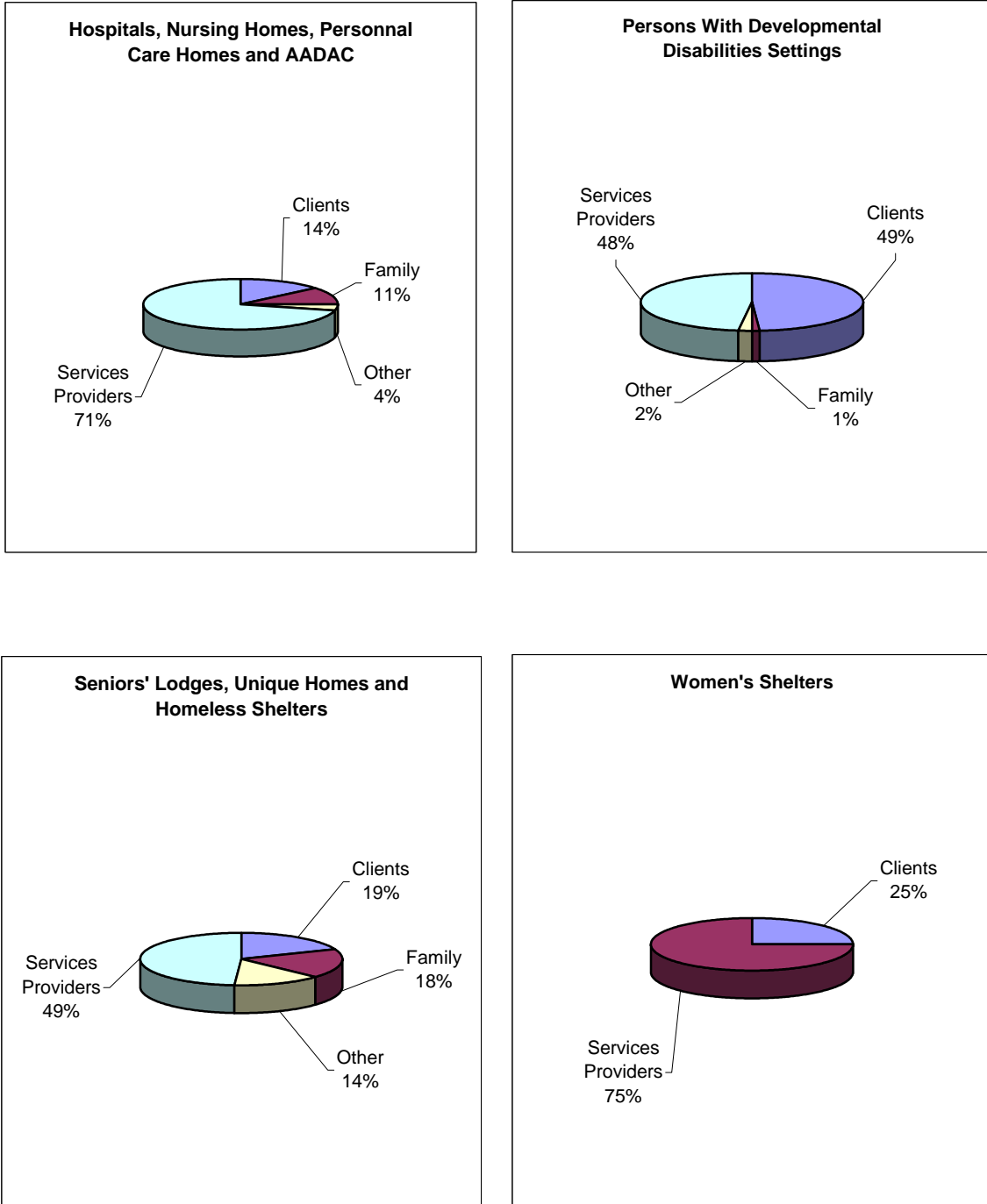


Figure 3

**PROTECTION FOR PERSONS IN CARE**

**PART III**

**INVESTIGATION OUTCOMES AND RECOMMENDATIONS**

**FROM CASES REPORTED**

**April 1, 2003 – MARCH 31, 2004**

## **INVESTIGATION OUTCOMES AND RECOMMENDATIONS**

### **INVESTIGATION RESULTS FOR FILES CLOSED - April 1, 2003 – March 31, 2004:**

- During this twelve-month period, three cases remain open and are being investigated by professional associations. Of the closed cases, 60% were dismissed as unfounded or due to insufficient evidence.
- 75% of reports involving allegations of abuse in seniors' lodges were dismissed; 51% of the allegations regarding Persons with Developmental Disabilities (PDD) settings were dismissed; and 61% 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 117 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 45 reports, staff resignation in 17 reports, and various forms of discipline in the remaining 55 reports. There were 17 reports in which the investigators recommended that the facility consider disciplinary action.
- There were 18 reports investigated by professional associations. Of the 15 closed reports, there was no evidence that abuse occurred.
- During the previous fiscal year, 2002 to 2003, there were staff terminations in 39 reports and staff resignations in 13 reports.

### **RECOMMENDATIONS RELATED TO OFFENCES UNDER THE ACT:**

- Six investigation reports involving eight 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.
- Three investigation reports were forwarded to a Crown Prosecutor for review in relation to Section 2(1) – failure to report abuse.
- 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 back to Protection for Persons in Care, they indicated that there was not enough evidence for laying charges related to the special offences.

**PROTECTION FOR PERSONS IN CARE**

**PART IV**

**COMMON THEMES ARISING OUT OF INVESTIGATIONS**

**APRIL 1, 2003 – MARCH 31, 2004**

## **COMMON THEMES ARISING OUT OF INVESTIGATIONS:**

The purpose of sharing these themes is to identify some of the common issues arising from complaints and investigations to enable agencies/facilities to become more proactive in their prevention initiatives.

### **Incidents alleging family members misappropriating residents' funds and failing to pay for residents' care:**

Allegations of financial abuse that involve family members misappropriating residents' funds tend to be a challenge for both agencies/facilities and Protection for Persons in Care (PPC). The *Protection for Persons in Care Act* (the *Act*) has jurisdiction to respond to complaints of abuse only if the allegation of abuse occurred within the context of the agency providing services to the resident. In many cases involving financial matters and third-parties such as family members, there is no direct connection to the agency, therefore, PPC cannot investigate due to lack of jurisdiction.

The *Act* requires that the complainant have reasonable and probable grounds to believe that the individual is intentionally misappropriating or illegally converting money or other valuable possessions. The *Act* was not intended to deal specifically with family disputes, debt collection, agency administrative issues, guardianship or trusteeship. Some of the complaints involving family members misappropriating money resulted in overdue payments and resident's accounts in arrears.

Agencies are encouraged to develop policy and processes to address payment of facility fees and matters that fall within the scope of substitute decision-making for personal and financial matters. Facilities should consider consulting with legal counsel to determine legal remedies and other options available to address matters of a financial nature where there is a concern involving a resident.

### **Incidents involving service providers who failed to change the residents' incontinent product:**

There were several complaints alleging that service providers failed to change or refused to change a resident's incontinent product. Recommendations arising from Protection for Persons investigations of these types of complaints included enhanced communication and training on the appropriate use of specific incontinent products, undertaking initiatives to enhance effective teamwork, review of staffing on various shifts and the need for increased supervision.

Agencies/facilities are encouraged to develop standard routines; clarify expectations regarding care to residents, clarify the duties of staff and arrange in-services related to specific product use.

### **Incidents alleging residents call bells were turned off and/or long delays occurred in responding to call bells:**

There were several incidents in which residents were left in situations without access to call bells or with call bells out of reach. Recommendations made to facilities to address these concerns included conducting independent reviews of shift care practices; assessing the environment, reviewing and adjusting staffing patterns, replacing the existing call bell system with an updated system (that cannot be turned off by taking the phone off the hook); and encouraging facilities to explore ways to further reduce response time.

### **Incidents involving service providers not completing incident reports:**

Several investigations revealed that service providers did not complete incident reports, and in some cases staff were instructed to complete incident reports but did not follow through. Most agencies have a policy related to completion of incident reports, but in some incidents the policy is not adhered to, and reports are not done or not fully completed in a timely manner.

Agencies are encouraged to remind staff to adhere to all aspects of incident reporting policy and ensure that all incidents of an unusual nature are documented. There are also issues with respect to notifying residents' family members/guardians of incidents. Service providers should review the processes of assessing residents who have received injuries and the need for follow-up with appropriate observation and intervention.

**PROTECTION FOR PERSONS IN CARE**

**PART V**

**ADMINISTRATION**

**EDUCATIONAL RESOURCES:**

During 2003 - 2004, over 25,000 brochures and over 800 posters were distributed on request. The reporting line received over 2,400 phone calls for clarification of the *Act*, referrals to other departments or jurisdictions, request for educational resources or to report alleged abuse of persons in care. Throughout the year, presentations were given to over 800 nursing attendant students, social workers and to Persons with Developmental Disabilities agency staff.

Protection for Person in Care staff attended the Alberta Long Term Care Association annual meeting and met on other occasions to discuss the *Act* and its relationship to other legislation.

### **FINANCIAL COSTS:**

This fiscal year, the cost of conducting Protection for Persons in Care investigations was approximately \$700,000. There are 20 investigators on contract in nine different geographical locations. The average cost of an investigation was \$1,341.00

### **LEGISLATIVE REVIEW:**

In summer 2003, the *Protection for Persons in Care Act* Legislative Review Committee provided the Honourable Gene Zwozdesky, Minister of Community Development, with its report and recommendations. This report was released on September 17, 2003, for further feedback. Responses to the Report are currently being reviewed.

### **PROTECTION FOR PERSONS IN CARE BRANCH MAILING ADDRESS:**

Written correspondence to the Protection for Persons in Care Branch, (including an agency's 90 day responses to recommendations or requests for brochures and posters) should be made to:

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

Toll free reporting number: **1-888-357-9339**  
Fax: **(780) 415-8611**  
Website: [www.cd.gov.ab.ca](http://www.cd.gov.ab.ca)  
Helping Albertans/Protecting Persons in Care