

ANNUAL REPORT 2005-06



Protection for Persons in Care

Alberta
Seniors and
Community Supports

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Protection for Persons in Care Act

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Profile

The Protection for Persons in Care office operates under the authority of the *Protection for Persons in Care Act*, which came into effect January 5, 1998. The office is responsible for receiving complaints of abuse, ensuring complaints are investigated, making decisions in response to an investigator's recommendations, and providing education and promoting awareness of abuse, prevention of abuse, and the requirements of the *Protection for Persons in Care Act*.

The office addresses complaints of abuse involving adults receiving services in government-funded care facilities. This includes agencies such as seniors' lodges, nursing homes, hospitals, assisted/supportive living facilities, women's shelters, homeless shelters, group homes, residential alcohol and drug abuse treatment centres, and other places that provide special care, including many agencies that receive funding through the Persons with Developmental Disabilities community boards.

Highlights of the Year

The main highlight in 2005-06 occurred as a result of the recommendations of the Alberta Ombudsman. To ensure that investigations completed by Protection for Persons in Care are administratively fair, significant changes were made to the complaints and investigation processes.

The following procedural changes were implemented for complaints received as of June 1, 2005:

- a) After a report of abuse is received, a letter is sent to the complainant, confirming that Protection for Persons in Care has jurisdiction to respond to the complaint. The letter also clarifies the details of the allegation(s) that will be investigated.
- b) After being notified by telephone, written notice of the complaint is provided to the agency.
- c) A letter is provided to the person named as the alleged abuser, if his/her identity is known, and includes the details of the complaint that will be investigated.
- d) Every person named as an alleged abuser has the opportunity to participate in an interview with the investigator, either personally or by telephone. The alleged abuser may also participate in the investigation by providing a signed, written statement.
- e) Once an investigation is complete, and prior to the decision of the Ministry, Protection for Persons in Care provides the alleged abuser, the complainant, the agency representative, the alleged victim, and/or the guardian/agent, with a *Summary of the Investigation Report*. The report summarizes the key information gathered during the investigation and includes recommendations from the investigator. This ensures that the relevant affected parties are aware of information that would be considered in making a decision.

- f) All relevant parties have the opportunity to respond to the *Summary of the Investigation Report* by providing their written comments to Protection for Persons in Care within 30 days.
- g) After the 30-day response period, all responses are reviewed and a decision is made. All relevant parties are notified of the decision.

In general, the response to the changes has been positive; however, feedback (from satisfaction surveys, phone calls, and correspondence) indicates that the revised processes have had a major impact on the time it takes to complete the entire process.

Another highlight occurred in October 2005, when the Minister appointed Dr. Neil Brown, MLA Calgary-Nose Hill, to advise the Minister on matters related to the legislative review of the *Protection for Persons in Care Act*. Dr. Brown reviewed the input obtained from Albertans during the consultation process (2003 and 2004) and the report and recommendations made by the former Legislative Review Committee (2003). Dr. Brown is examining options and implications of possible legislative amendments to the Act. It is anticipated that Dr. Brown will submit his report and recommendations to the Minister in the fall of 2006. The *Protection for Persons in Care Act* is scheduled for amendments in spring 2008.

Summary of Reports of Abuse

In 2005-06, Protection for Persons in Care received 530 reports of abuse, four percent less than received in 2004-05. The reduction in overall reports of abuse is attributed to slightly fewer reports received involving clients served by Regional Health Authorities. During the 12-month period, Protection for Persons in Care received an average of 44 complaints per month. March had the highest number of reports (59) and August had the lowest (27).

Since 2000-01, the Protection for Persons in Care office has dealt with 3,385 reports of abuse, an average of 564 per year. Chart 2 shows a steady growth in reports received by Protection for Persons in Care, peaking in 2003-04 with 676 reports and then substantially dropping in 2004-05 with a further reduction in 2005-06. The peak in 2003-04 is attributed to greater awareness by the public and agencies resulting from activities associated with the legislative review of the *Protection for Persons in Care Act* over the two-year period from 2002 to 2004.

Chart 1

Monthly Reports 2005-06

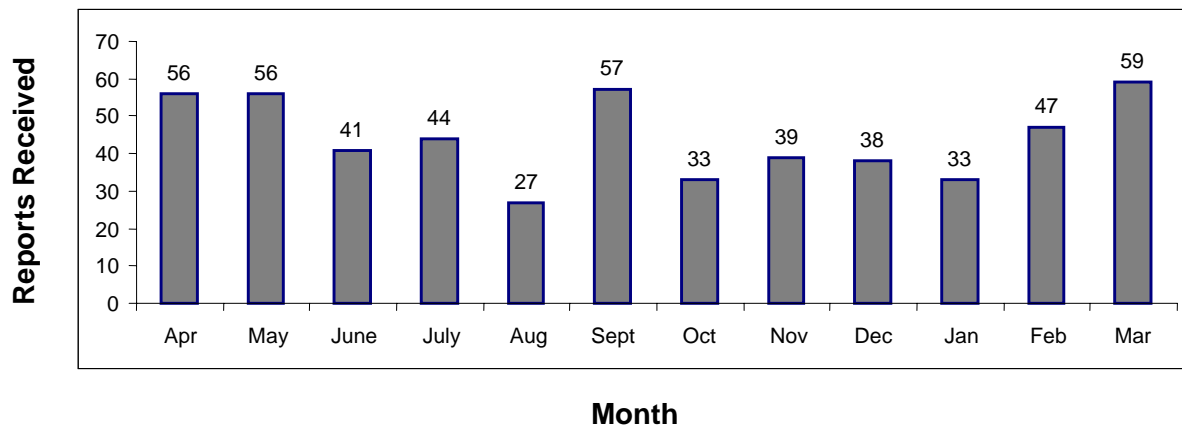
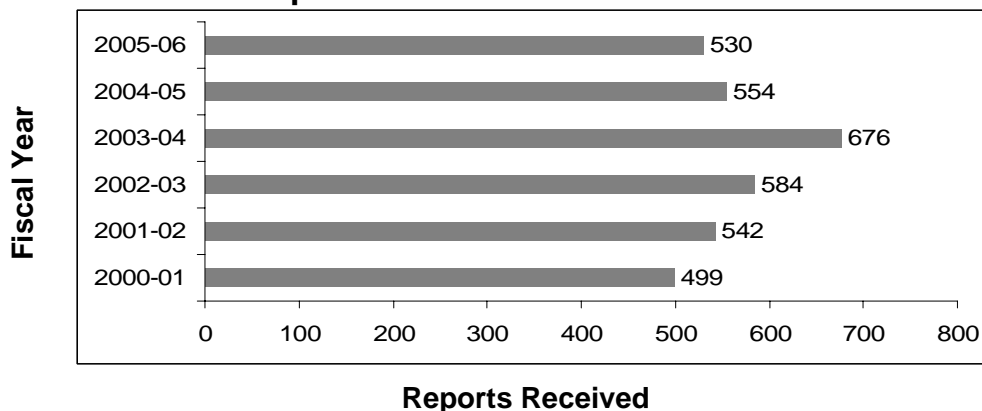


Chart 2

Total Reports Received 2000-01 to 2005-06



Reports by Ministry and Regional Authority

Agencies and facilities that fall under the responsibility of Alberta Health and Wellness accounted for 72 percent of all reports received in 2005-06. Twenty seven percent of the reports related to agencies that are under Alberta Seniors and Community Supports. One report involved a facility under the responsibility of Alberta Children's Services.

The most significant change from the previous fiscal year is that fewer reports were received involving agencies under Alberta Health and Wellness. In 2004-05, a total of 407 reports were received involving health-related facilities, whereas in 2005-06, only 382 reports were received. There was an increase in reports related to homeless shelters, from two in 2004-05, to nine in 2005-06.

Table 1
Total Reports by Ministry and Regional Authority

Health and Wellness	Regional Health Authority	2005-06 Reports	2004-05 Reports
	RHA #1 Chinook	8	22
	RHA #2 Palliser	14	19
	RHA #3 Calgary	87	100
	RHA #4 David Thompson	44	35
	RHA #5 East Central	20	26
	RHA #6 Capital	156	147
	RHA #7 Aspen	25	12
	RHA #8 Peace Country	20	44
	RHA #9 Northern Lights	4	0
	Regional Health Authorities total	378	405
	Alberta Alcohol and Drug Abuse Commission	4	2
	Ministry Total	382	407
Seniors and Community Supports	Persons with Developmental Disabilities (PDD) Community Boards		
	Northeast Community Board	2	1
	Northwest Community Board	0	1
	Edmonton Community Board	13	17
	Central Community Board	61	65
	Calgary Community Board	11	4
	South Community Board	3	7
	PDD total	90	95
	Seniors' Lodges	48	48
	Homeless Shelters	9	2
	Ministry Total	147	145
Children's Services	Women's Shelters	1	1
	Ministry Total	1	1

Complaints by Type of Abuse

Complaints by type of abuse are greater than total reports because one report may involve multiple allegations and/or more than one type of abuse. In 2005-06, the 530 reports received by Protection for Persons in Care involved 818 complaints of abuse (as identified by types of abuse in Table 2).

Emotional harm continues to be the most common type of abuse reported (50 percent of all complaints), followed by bodily harm (24 percent), failure to provide the necessities of life (18 percent), sexual contact (3 percent), inappropriate medication administration (3 percent), and financial abuse (2 percent).

There was a significant increase in the number of complaints of "bodily harm," from 157 complaints in 2004-05 to 192 complaints in 2005-06. The number of complaints of "inappropriate medication administration" increased from 15 complaints in 2004-05 to 23 in 2005-06. There was a reduction in the number of complaints involving "sexual contact, activity or behaviour," from 36 complaints in 2004-05 to 27 complaints in 2005-06.

Table 2
Types of Abuse Complaints

Types of Abuse	2005-06		2004-05	
	Actual	Percentage	Actual	Percentage
Emotional harm	412	50%	403	52%
Bodily harm	192	24%	157	20%
Failing to provide the necessities of life without a valid consent	145	18%	148	19%
Sexual contact, activity or behaviour	27	3%	36	5%
Inappropriate medication administration	23	3%	15	1%
Misappropriating money or possessions	19	2%	20	3%
	818	100%	779	100%

Distribution of Complaints Received by Type of Abuse

Table 3 shows complaints received by type of abuse and across the various types of facilities or settings. As in previous years, complaints of emotional harm continue to be the most prevalent across all facility types.

Table 3

Distribution of Complaints Received by Type of Abuse

	Emotional Harm	Bodily Harm	Failing to Provide the Necessities of Life	Sexual	Financial	Inappropriate Medication
Nursing Homes and Auxiliary Hospitals	203	103	94	13	6	16
Persons with Developmental Disabilities Settings	65	49	9	5	3	1
Acute Care Hospitals	49	18	22	2	2	6
Seniors' Lodges	47	7	7	1	5	0
Personal Care Homes	18	8	3	1	2	0
Assisted/Supportive Living	15	3	10	0	0	0
Homeless Shelters	9	0	0	1	0	0
Other (e.g. Family Care Homes, Approved Homes, Drop-In Centres)	1	4	0	2	1	0
AADAC	4	0	0	2	0	0
Women's Shelters	1	0	0	0	0	0

Investigations

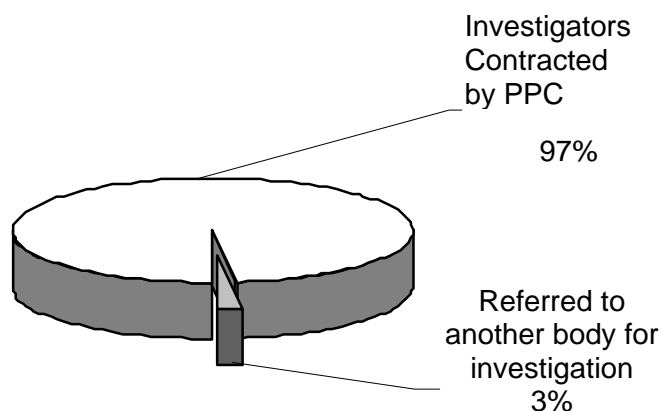
Of the files closed in 2005-06, investigators contracted by Protection for Persons in Care (PPC) conducted 97 percent of all investigations. The average time taken for a contracted investigator to conclude an investigation was 35 days. No investigations were conducted by staff of the Protection for Persons in Care office.

Of the 530 reports received, PPC referred a total of 29 files to another body for investigation. Of these, 15 reports were referred to the police, two were referred to the Office of the Mental Health Patient Advocate (OMHPA), and 12 were referred to a professional association.

Of the 12 reports referred to a professional association, eight were sent to the College of Physicians and Surgeons of Alberta, three to the College of Licensed Practical Nurses of Alberta (CLPNA), and one to the Alberta College of Social Workers. At year-end, seven of the files referred to a professional association remain open, and one file referred to the OMHPA remains open.

One investigation conducted by the CLPNA, in response to a report made in 2003-04, was closed this year. Two other files, investigated by the OMHPA, were carried forward from 2004-05, and both were closed this year.

Chart 3
Investigators Appointed
Based on Closed Files



Outcomes of Abuse Complaints Based on Closed Files

The files closed in 2005-06 involved 566 complaints. Of these, 77 percent were dismissed because they were unfounded or evidence was insufficient, and 23 percent were upheld. The *Protection for Persons in Care Act* also enables complaints to be dismissed because the complaint was made without reasonable and probable grounds; however, in 2005-06, no complaints were dismissed for this reason.

Most investigations have resulted in recommendations being made to the agency/facility to address concerns identified or to prevent similar incidents from happening in the future. Even if a complaint is dismissed, the investigation reveals that an incident did occur and that the complaint had merit.

Table 4 provides a breakdown of the complaints dismissed and not dismissed by the type of abuse investigated.

Table 4
Outcomes of Abuse Complaints by Type of Abuse
Based on Closed Files

Type of Abuse	Dismissed	Not Dismissed
Emotional Harm	72%	28%
Bodily Harm	87%	13%
Failure to provide the necessities of life	84%	16%
Misappropriating money or possessions	73%	27%
Sexual contact/activity	42%	58%
Inappropriate Medications	93%	7%

Recommendations Arising from Investigations

The majority of investigations completed include recommendations made by the investigator. The recommendations are intended for the agency and focus on preventing similar incidents from occurring in the future, emphasizing prevention, safety, and improvements in processes and practices.

As in previous years, many investigators recommended staff education and training. *Supportive Pathways* is a comprehensive program that educates health care workers about dementia and how to care for individuals who have Alzheimer's disease or other related dementias. This year, a common recommendation was that some of the health workers involved in abuse complaints participate in the *Supportive Pathways* program if they had not done so already.

Some of the recommendations arising from investigations in seniors' lodges and some nursing homes were related to substitute decision-making. In these cases, the recommendations addressed guardianship, personal directives, and enduring powers of attorney.

Recommendations common to some of the investigations in nursing homes and in settings funded by Persons with Developmental Disabilities community boards involved supporting clients and managing difficult behaviours. The need for arranging psycho-geriatric assessments or conducting behavioural assessments, appropriate use of restrictive procedures, and the development of individual support plans were among the recommendations made.

In 2005-06, there were recommendations made that the health professional involved in the allegation be referred to his/her professional association for a review of his/her practice if the facility had not already taken this action. Twelve such recommendations for referral to a professional association related to registered nurses.

In response to the allegations of abuse, 32 staff resigned or had their employment with the facility/agency terminated. Of these, eight were registered nurses, eight were personal care attendants, and seven were nursing attendants. The others included a licensed practical nurse, a social worker, a housekeeper, and support workers/aides. In one case, a volunteer had their services terminated.

Types of Persons Named or Identified as Alleged Abusers

In all settings, and consistent with previous years, the majority of persons identified as alleged abusers are service providers. Within Persons with Developmental Disabilities settings, a significant portion of the complaints (45 percent) involved other clients/residents named as alleged abusers.

Table 5
Types of Alleged Abusers

Type of Alleged Abuser	2005-06		2004-05	
	Actual	Percentage	Actual	Percentage
Service Provider	399	75.3%	408	73.6%
Client/Resident	86	16.2%	99	17.9%
Family	27	5.1%	32	5.8%
Other	18	3.4%	15	2.7%
	530	100%	554	100%

Note:

"Other" refers to volunteers, visitors, non-family members, and other third parties.

Table 6
Types of Alleged Abusers by Facility Type

Facility Type	Service Provider	Client/Resident	Family	Other
Regional Health Authority Facilities and AADAC	82%	9%	5%	4%
Persons with Developmental Disabilities Settings	51%	45%	1%	3%
Seniors' Lodges and Homeless Shelters	65%	21%	11%	3%

Note:

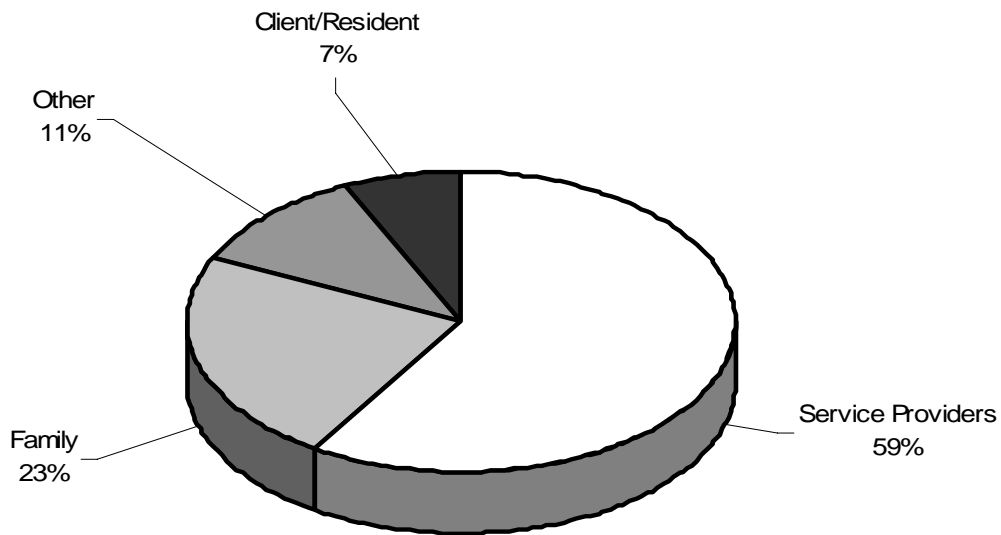
Women's Shelters had one report involving a service provider as the alleged abuser.

Types of Complainants

The majority (59 percent) of all complainants were service providers, such as agency employees. Of the service providers, 48 percent were management and 52 percent were non-management.

Family members represented 23 percent of all complainants, while seven percent were clients/residents. The remaining 11 percent of complainants were people such as volunteers, visitors, and other third parties.

Chart 4
Types of Complainants

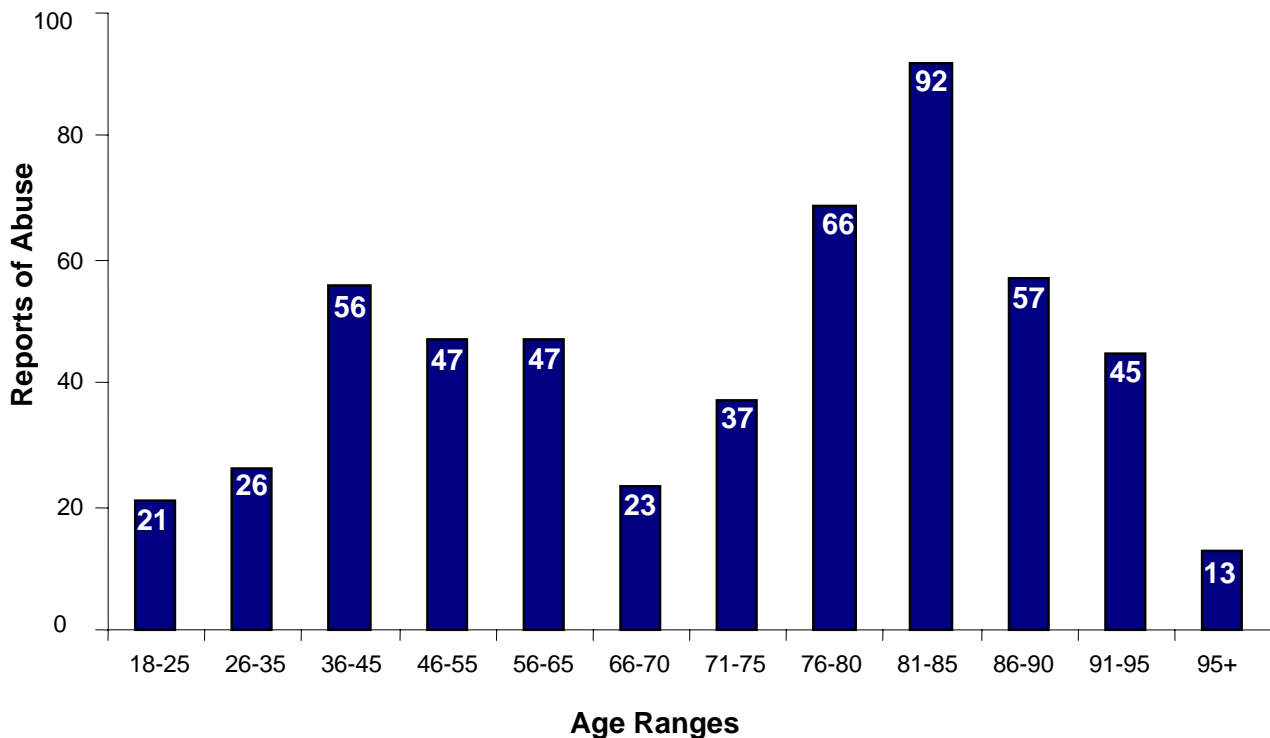


Characteristics of Alleged Victims: Age and Gender

Sixty-three percent of alleged victims were over 65 years old and 37 percent were under 65 years old. Of the alleged victims over 65 years old, the majority were between the ages of 76 and 90 years. Most complaints involved alleged victims between the ages of 81 and 85 years. The fewest complaints related to alleged victims in the youngest category (18 to 25 years) and the eldest category (96 to 100 years).

Overall, a higher percentage of females (60 percent) are alleged victims compared to males (40 percent). Of the females, 32 percent were between the ages of 18 and 65 years, and 68 percent were 66 years and older. Of the males, 45 percent were between the ages of 18 and 65 years, and 55 percent were 66 years and older.

Chart 5
Age of Alleged Victims



Information, Awareness, and Education

Protection for Persons in Care continues to operate a toll-free telephone information and reporting line (1-888-357-9339), which operates during business hours. In 2005-06, Protection for Persons in Care received 3,315 telephone calls. In addition to receiving complaints of abuse, Protection for Persons in Care refers callers to other jurisdictions such as law enforcement agencies, other government departments, and community service organizations.

Protection for Persons in Care distributed 24,392 brochures and 536 posters to facilities, service providers, and the public to raise awareness of the act and the toll-free reporting line.

Twenty-nine information sessions were provided across the province for various audiences, including student groups and facility/agency staff. These sessions were attended by 1,070 participants.

The sessions, some of which occur at regular intervals throughout the year, were provided to the following groups:

- Alberta Health and Wellness, continuing care leaders
- Calgary Health Region
- Excel Society Frontier Program
- Nightingale Academy (Nursing Attendant program)
- Norquest College
- Regional Patient Concerns Resolution Managers
- Salem Manor Nursing Home
- Tender Ties, NAIT (Aboriginal Nursing Attendant program)
- Urban Manor
- University of Calgary nursing students
- Interdisciplinary Gerontology Conference on Abuse Awareness and Prevention
- Supportive Living workshop
- *Breaking the Silence: There's no excuse for Elder Abuse*, organized by the Jewish Family Service Calgary and The Action Group on Elder Abuse
- Seniors Services workshop
- Veiners Senior Centre workshop

Satisfaction Surveys

During 2005-06, three satisfaction surveys were completed to determine satisfaction with specific aspects of the complaint reporting and investigation process.

Survey I, Complainant Satisfaction Survey

Survey I, referred to as the *Complainant Satisfaction Survey*, was distributed to all complainants who reported abuse from January 4, 2005, to May 31, 2005. Each time a file was closed, Protection for Persons in Care mailed the survey to all complainants, with a stamped, self-addressed envelope. Complainants were asked to return the survey to Protection for Persons in Care, by mail, within 30 days.

Protection for Persons in Care mailed out 272 surveys, and 86 completed surveys were returned, resulting in a response rate of 32 percent.

Survey II, All Respondents Satisfaction Survey

Survey II, referred to as the *All Respondents Survey*, was created by Protection for Persons in Care as a result of the changes to the complaints and investigation process on June 1, 2005. Survey II was intended for all relevant parties involved in the complaint and investigation process and applied to files opened from June 1, 2005, to files closed as of January 13, 2006.

For Survey II, Protection for Persons in Care mailed surveys to individuals most affected by the investigation, including complainants, alleged victims, alleged abusers, agency/facility representatives, and guardians/agents of alleged victims and alleged abusers, if applicable. A self-addressed, stamped envelope was provided. Respondents were requested to send the completed survey back to Protection for Persons in Care, by mail or fax, within 30 days.

A total of 191 surveys were sent to potential respondents, and 56 surveys were returned, resulting in a response rate of 29 percent. Respondents were as follows:

- 63% complainants
- 18% guardians of the alleged victim or the alleged abuser
- 14% alleged abusers
- 1% alleged victims
- 4% unidentified

Survey III, Investigation Satisfaction Survey

Survey III, referred to as the *Investigation Satisfaction Survey*, is a project in which the Protection for Persons in Care office established a contract with Pivotal Research Inc. to conduct investigation satisfaction surveys in two phases. Phase 1, referred to as the baseline phase, applies to all files closed from January 15, 2006, to March 31, 2006. The same survey will be conducted in Phase 2, from April 1, 2006, to March 31, 2007.

In Phase 1, surveys were mailed to relevant parties involved in each investigation, along with a prepaid business reply envelope addressed to Pivotal Research Inc. Over a 72-day period, 274 surveys were distributed to alleged victims, alleged abusers, agency/facility representatives, and guardians/agents of the alleged victim and/or alleged abuser. Eighty-five surveys were completed and returned, resulting in a 31 percent response rate.

Respondents to the survey were:

- 40% agency/facility representatives
- 25% complainants
- 15% guardian/agent of alleged victims
- 14% alleged abusers
- 4% guardian/agent of the alleged abusers
- 2% alleged victims

Forty-five percent of those surveyed were involved in an investigation related to long-term care facilities, 29 percent were related to investigations in Persons with Developmental Disabilities settings, eight percent involved acute care hospitals, eight percent involved seniors' lodges, seven percent involved assisted/supportive living, and two percent involved other health facilities.

Survey I, II, and III Results

Generally, responses to all surveys indicated that respondents were satisfied with the investigators appointed by Protection for Persons in Care and with most aspects of the complaints management process. However, after the complaints management process changed on June 1, 2005, respondents indicated they were dissatisfied with the duration of time taken to complete the entire process.

Table 7
Highlights of Satisfaction Survey Results

Survey Categories	Survey I	Survey II	Survey III
Satisfaction with the investigator, e.g. acted professionally, courteously, clarified information	96%	98%	90%
Satisfaction with the time taken to complete the process	64%	41%	52%
Satisfaction with the information provided to the respondent after the investigation was completed	74%	84%	81%
Satisfaction with the focus of the recommendations arising from the investigation	65%	64%	71%
Overall satisfaction	N/A	73%	71%
Response Rate	32%	29%	31%

Note: N/A is recorded under Survey I indicating that there were no questions asked to determine respondents' overall satisfaction.

Protection for Persons in Care Office

Protection for Persons in Care has been a part of Alberta Seniors and Community Supports since November 2004. The office is led by a director who has overall responsibility for the branch, strategic direction, and budgeting.

The office is divided into two functional areas. The Prevention, Policy and Planning unit, which include a Manager and a Policy and Planning Consultant, addresses matters relating to policy, planning, legislation and regulation, business planning, and other related initiatives. The Operations unit, which includes a Manager, three Abuse Prevention Consultants, and three Administrative Support staff, handles the incoming abuse complaints, referrals, education, coordination of all aspects of investigations, and communication with complainants, agencies, and investigators.

The office contracts with investigators who are external to government and to the agencies that come under the jurisdiction of the *Protection for Persons in Care Act*. This ensures that all investigations are independent and objective. The contracted investigators are located in urban and rural areas across the province.

There are currently 24 investigators with differing backgrounds, such as law enforcement, nursing, social work, psychiatric nursing, and other professions. The investigators also have extensive knowledge in various fields, including criminology, rehabilitation, long-term care, acute care, mental health, persons with developmental and other disabilities, human resources, management, and education.

Concluding Statement

The year 2005-06 has been one of significant development for Protection for Persons in Care because of the modifications made to the complaints and investigation processes. Protection for Persons in Care appreciates the involvement and suggestions made by the Alberta Ombudsman, which prompted the changes to improve administrative fairness.

The investigations of abuse continue to reveal that most agencies are making gains in preventing abuse and that agencies are taking action to prevent future incidents. Protection for Persons in Care acknowledges the contributions of all individuals and organizations that help to prevent abuse of adult Albertans who receive government-funded services.

APPENDIX 1

Samples of Complaints, Investigations, and Recommendations

The following are samples of complaints made to Protection for Persons in Care and the findings and recommendations made or action taken by agencies.

Failure to provide the basic necessities of life and intentionally causing bodily harm

Complaint: It was alleged that staff left a toxic chemical cleaner at the resident's bedside and the resident ingested it.

A family member visited the resident and saw a bottle of specialty tub and tile cleaner and a Styrofoam cup, half filled with a blue-green liquid, on the resident's bedside table. According to the family member, the cup had teeth marks on it so she believed the resident may have consumed the cleaner. The family member advised the director of care, and a registered nurse immediately assessed the resident. While the resident appeared to be pale, his vital signs were normal, he did not appear to be in any discomfort, nor did he demonstrate any signs that he had consumed a toxic substance; however, he was taken to an acute care hospital. A sample of the blue-green liquid in the cup was sent with him, as well as the empty chemical cleaner, which usually contains a clear purple solution.

The Material Safety sheet for the specialty tub and tile cleaner was reviewed and it was determined that there are no toxic side effects after ingestion. The physician at the acute care hospital said the tests showed no indication that the resident had ingested any toxic or harmful substance. The resident returned from the hospital and did not demonstrate any symptoms that he suffered any ill effects (if he had ingested the liquid).

Nobody was able to determine how the empty bottle got into the resident's room. Nursing staff are not trained in cleaning residents' rooms or in proper use of cleaning products. They are told to clean up spills/soils with paper towel, and the cleaning staff will disinfect the area later.

All staff interviewed confirmed that the resident had vomited during morning care, and they cleaned and changed the resident's bed and cleaned vomit off the floor, but they did not use cleaner, and they did not see a Styrofoam cup or cleaner at the resident's bedside. A housekeeper advised that she cleaned the resident's room the evening before the incident, but she did not leave any cleaning product in the resident's room.

An inventory was taken of the Housekeeper's cart shortly after the incident. A bottle of the cleaner and all other required cleaners were accounted for and on the

cart. The cleaning staff are expected to keep their cleaners underneath the top shelf of the cart while cleaning resident rooms. All cleaners are stored in the same size plastic spray bottles with differentiating labels. Cleaning staff use electronically locked machines in the main utility room to calculate and dispense solutions into the bottles.

Nursing staff usually use a disinfectant, which is blue/green in colour and not the specialty tub and tile cleaner. Both the disinfectant and the specialty tub and tile cleaner are kept in the utility room and not in the tub rooms. It is all staff members' responsibility to ensure that the utility rooms on each unit are kept closed with a sliding bolt at the top of each door.

One staff said that on a previous occasion, she saw the resident access the locked utility room and leave with a bottle of cleaning solution.

Recommendations: The investigator's recommendations were that facility management: (a) change the bolt action sliding locks on all unit utility rooms doors to a system that residents cannot open, (b) ensure cleaners kept in the tub rooms for ongoing use are locked in a cabinet, according to policy, and are inaccessible to residents, (c) ensure all staff members understand the importance of reporting potentially serious incidents, such as the resident accessing the utility room on a previous occasion, (d) alert all staff to the possibility that a resident, other than this resident, may have consumed the cleaner and may again access a cleaner given the opportunity for consumption in the future, (e) educate all housekeeping staff, according to existing policy, on appropriate labelling, storage, and use of all cleaning solutions available on the nursing units, and (f) ensure nursing staff notify housekeeping staff when cleaning and/or disinfecting is required on the unit.

Subjecting to non-consensual sexual contact, activity or behaviour

Complaint: The Resident Assistant (RA) touched a male resident in a sexual manner while providing care and asked the resident about his sexual contact with others.

The investigation revealed that one witness observed the RA applying cream to the resident's genitals without gloves, and when the RA finished with the resident's care, the RA made an inappropriate sexual comment to the resident. The witness told the RA not to talk to residents like that. A second witness advised that on other occasions, she has observed the RA lying on the resident's bed with her arm across the resident's shoulders, watching television.

A registered nurse advised that because many staff members told her about the RA's inappropriate sexual touching and behaviour, which took place over a six month period, the registered nurse monitored the RA closely. Prior to her employment being terminated, the RA was moved to work on a different unit and told not to visit the resident.

The director of care confirmed she was aware that some of the RAs do not always wear gloves when providing care, despite it being best practice to do so.

The RA said that she cared deeply for the resident and acknowledged that she did spend a great deal of time with the resident and had a very close relationship with the resident's family members. The RA said she did not always wear gloves when providing care to the residents, as there were times when the facility ran out of gloves. The RA denied that she had made a sexual comment towards the resident. According to the RA, she has never lain on the resident's bed, but has sat on the side of his bed while talking to him. The RA said that perhaps she had crossed a boundary when it came to caring for the resident, but adamantly denied that anything sexual had ever happened. The RA stated she was possibly guilty of unprofessional conduct, but that was all.

Recommendations: The investigator's recommendations were: (a) that the facility management direct all staff to wear gloves when providing care to a resident's genitalia and whenever exposure to blood and bodily fluids is probable, and (b) that the facility management inform all staff that making inappropriate comments to or about residents is unacceptable behaviour and appropriate action will be taken if this occurs.

Intentionally causing emotional harm

Complaint: A registered nurse (RN) was observed attempting to grab the resident from behind, and the RN slapped the resident on the face.

The resident is 89 years old and has dementia with severe cognitive impairment.

A staff person who witnessed the incident advised that, after supper, the resident was "grumpy" and was seen trying to kick another resident. The witness stated that the RN removed the resident from the situation and wheeled the resident to her room. According to the witness, the RN tried to calm the resident without success. The witness said she suggested moving the resident to another room to calm down, but the RN refused. According to the witness, the RN crouched down in front of the resident, held her hands and tried to talk to her. The witness stated that the resident became even more aggressive and then spat in the RN's face. In response, the RN let go of the resident's hands and slapped her once on the face. According to the witness, shortly after the incident, she noticed a red mark on the resident's face where she had been slapped.

The RN said she slapped the resident lightly after the resident spit in her face twice. The RN said the slap left no mark. The RN said she has had adequate training in dealing with aggressive residents and knew the best thing to do was to leave the resident alone to calm down; however, in this situation, she chose not to leave because the resident's roommate was ill and she felt she could not safely leave the resident alone with her sick roommate.

The RN documented in the resident's health record she "used her left hand in a slapping manner – non-intentional with no harm." Her recorded assessment was that there were "negative signs of injury."

The resident's nursing care plan specified that aggression and agitation exhibited by the resident was to be dealt with by: removing other residents from her immediate environment if she is angry; being sure the caregiver has her attention before speaking or touching; administering a medication (at bedtime); distracting the resident by taking her to the day room, encouraging her to look out the window, and talking to her about the sights outside; or redirecting her away from the area or situation.

Documentation confirmed that the RN received education at the facility about abuse, managing aggressive behaviour, the "STOP" program, *Supportive Pathways* dementia training, and that the RN signed the Resident Non-Abuse Pledge.

Action Taken by the Agency: The RN's employment was terminated, and the RN was reported to her professional association (College and Association of Registered Nurses of Alberta).

Intentionally causing bodily harm

Complaint: A support worker directed a client to walk to an outing rather than allowing him to take the bus.

The client has poor depth perception and often requires extra time and assistance walking on uneven ground. Staff who work with the client were generally aware that the client has "bad feet." Several staff stated it was a frequent occurrence for staff members to tell the client that, if he did not behave on the bus, he would have to walk; however, they never followed through and there was confusion among the staff as to whether it was an approved plan for the client.

A program coordinator stated that on the morning of the incident, the client was acting inappropriately on the bus. Staff asked the client to stop the behaviours, but the client continued to act inappropriately until the bus arrived at the facility. After lunch, the support worker informed the client that the two of them would walk to the afternoon activities because of the client's behaviour on the bus in the morning. It was not an approved procedure to make the client walk.

The support worker stated that on the bus in the morning, the client was being rude and she heard several staff members ask the client to get off the bus at the next stop and walk the remainder of the way to the facility but the client refused. At the time, the support worker believed the procedure of having the client walk when he misbehaved on the bus had been approved, although she now understands that it was restrictive. The support worker said she did not intend for the walk to be abusive and that she and the client talked and rested during the walk. According to the support worker, she did not hear until later that the client

complained of sore feet for approximately one and a half weeks following the incident.

The distance from the facility to the afternoon venue was 4.4 kilometres. The client denied having any problems as a result of the walk but agreed that it was a long way to walk; however, staff said the client "wants to please people with his answers" and rarely complains. The support worker was disciplined with a one-day suspension.

The client's key worker said she had proposed a plan to have the client go through a number of steps to address his inappropriate behaviours, which included having the client get off the bus to wait for the next bus or walk a short distance to another bus stop; however, there was no suggestion that the client should walk any significant distance because it is known that he has sore feet. Several staff had made similar suggestions but no plan had been developed or approved.

The facility policy, "Responding to Behaviours of Concern," states in part, "[The facility] is committed to the use of preventive and positive approaches to providing supports. Although it is preferable not to use restrictive procedures, it is acknowledged that at times it may be necessary. Policy procedure: a functional assessment will be completed, and an individualized Behaviour Support Plan will be developed for individuals who have behaviours of concern that pose a significant risk to the individual or others, and are likely to reoccur. Prior to the use of positive or restrictive procedures within a Behaviour Support Plan, staff must be trained in the implementation of the procedures and a qualified person must approve the Plan."

The facility's client manual lists several ways in which a client can report possible abuse; however, the Protection for Persons in Care reporting line number is not included.

Several staff stated that they are experiencing more stress than usual at the facility because the facility has increased services but is currently short-staffed, is involved in an accreditation process, and is undergoing renovations. Several staff also commented that there were "factions" within the staff and that team-building exercises might be beneficial and might improve client service delivery.

Recommendations: The investigator's recommendations were: (a) that the facility ensure long-standing or repetitive behaviours of concern exhibited by clients are addressed in a timely manner and that behavioural plans for clients are current, clearly documented, and communicated to all staff, (b) that the facility include the Protection for Persons in Care reporting line number in the client manual, and (c) that the facility develop a mechanism to obtain feedback from staff regarding issues that impact the quality of client care or staff morale and take positive steps to address concerns in a positive manner.