

September 3, 2014

Ms. Diane Mellott  
11, 974 Sutcliffe Road  
Victoria BC V8Y 1M8

Dear Ms. Mellott:

**Re: Director's Decision – Protection for Persons in Care (PPC) File #8308**

Your report of abuse received on April 29, 2014, was investigated under the *Protection for Persons in Care Act*, SA 2009, cP-29.1 (the Act). In accordance with section 15(1)(c) of the Act, I am providing you with a copy of the decision, as attached, following the investigation.

Please note that section 15(1)(d) of the Act indicates that the complainant, the service provider, the client and the individual involved have the right to appeal this decision. To appeal, a written notice of appeal must be submitted to the Appeals Secretariat office within 15 days after receiving the decision. A Notice of Appeal form is available on the PPC website at [www.health.alberta.ca/services/protection-persons-care.html](http://www.health.alberta.ca/services/protection-persons-care.html) or by calling the Appeals Secretariat office at 780-427-2709. The notice of appeal is to be mailed to: Appeals Secretariat, 6th Floor Centre West Building, 10035 108 Street, Edmonton, AB, T5J 3E1 (Fax: 780-422-1088). Further information on the Act is available at the above website or by calling 1-888-357-9339.

Sincerely,



Anita L. Sieben, Acting Director  
Protection for Persons in Care

Attachment



## DECISION RESPECTING PROTECTION FOR PERSONS IN CARE FILE #8308

*This decision is made pursuant to section 15 of the Protection for Persons in Care Act, SA 2009, cP-29.1 (the Act) regarding an allegation of abuse under the definition of an act or omission that results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without a valid consent, resulting in serious bodily harm, at Rutherford Heights Retirement Residence, Edmonton, reported on April 29, 2014, and investigated by a contracted investigator under the Act.*

### ALLEGATION

- [1] It was alleged that between January 21, 2014, and January 27, 2014, staff failed to assess and monitor the client who looked extremely unwell, had breathing difficulties, and did not attend all meals in the dining room. This resulted in the client's condition deteriorating and requiring emergency transfer to hospital for assessment and treatment.

### INVESTIGATION

- [2] Burness & Associates Consulting Inc. was contracted to carry out this investigation. The final investigation report was provided to me on July 11, 2014, as per section 14(2) of the Act and is attached as appendix A to this decision.

### DECISION

- [3] In making my decision pursuant to section 15 of the Act, I considered the investigator's report and findings of fact about the allegation including feedback to the preliminary results of the investigation.
- [4] I concur with the investigator's finding that the allegation of abuse, under the definition per section 1(2)(f), is founded.
- [5] Section 1(2)(f) of the Act defines "abuse" as "an act or omission with respect to a client receiving care or support services from a service provider that results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without a valid consent, resulting in serious bodily harm." After a thorough investigation, which involved interviewing a significant number of people and reviewing documentation, the investigator found evidence that the client sustained serious bodily harm. The evidence indicates that within the week, the client became progressively ill and that by January 27, 2014, the client was so weak she could hardly walk. The client was short of breath; had audible wheezing; was gasping for air; and had a flushed and swollen face and neck. On January 27, 2014, the client was taken to see a physician who advised that the client was in congestive heart failure and she was transferred to hospital by ambulance.
- [6] There is no issue as to whether the client had experienced serious bodily harm. This leaves whether the "act or omission" of the individuals involved could fall within the



definition of "results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without a valid consent, resulting in serious bodily harm." The individuals involved were: Manager #1; Manager #2; Licensed Practical Nurse (LPN) #4; and the Home Care Case Manager.

[7] The information indicates that:

- a) The client lived independently in the facility with minimal support from home care. The home care services were provided by facility staff but directed by the home care case manager. The client's most recent care plan, dated June 17, 2013, specified the care the client required was medication assistance four times daily and two showers weekly. The information with respect to medication assistance was outdated as the client was only visited three times daily for medication assistance. Manager #1 clarified that the medication assistance was reduced from four times daily to three times daily because of changes made by the client's physician or pharmacist. Manager #2 acknowledged that he failed to inform the home care case manager that the client's medication schedule had changed to three times per day instead of four as indicated on the care plan.
- b) Manager #1 advised that the facility was only funded to provide about 20 minutes of care by a health care aide (HCA) per day to this client and that they were not funded to provide any LPN care. Notwithstanding the above, management advised that normally, HCAs report any concerns about independent clients to the LPN who then reports any issues to the oncoming shift and then Manager #2 or a nurse manager investigate any concerns.
- c) Various facility staff had been aware that the client was ill during the time period of January 21 to 27, 2014; however, communication about the client's illness was inadequate, monitoring of the client was minimal, no comprehensive assessment of the client was completed, and the cursory assessments that were done by LPNs were either inadequate or incomplete, and not documented.
  - i. A health care aide (HCA #1) that worked the morning shift on January 20, 21, 22 and 23, 2014, advised that the client was "a little bit sick" on those shifts. The client was still getting up but was weaker than usual and she had a blister on her face. The HCA reported the blister to an LPN.
  - ii. HCA #2 worked the morning shift on January 25, 2014, and stated that the only unusual thing on that day was that the client had a blister which an LPN assessed.
  - iii. HCA #2 advised that on January 26, 2014, the client got up and walked to the dining room but returned to her room and said she was too sick to eat. The client went to bed and slept the remainder of the day. An LPN was notified.
  - iv. Manager #2 advised that between January 20 and 24 there was no indication in report that there were any concerns with the client; and nothing is noted in the report book, communication book or 24-hour report.
  - v. LPN #1 stated that she only assessed the client once on January 20, 2014, when she looked at the client's swollen eye. She called the client's family to inform them that the client should be taken to a physician to have her eye assessed. LPN #1 reported to managers that although she checked the client's vital signs, she did not document that she had done so.



- vi. On January 20, 2014, a fax was sent to the client's physician to inform him of the client's swelling around her eye.
  - vii. On January 21, 2014, the client's private companion indicated that at 1300 hours, the client was in bed and stated that she did not feel well. The companion noted that the client was flushed, had dark circles under her eyes, was warm to touch, and she was slightly short of breath. The companion advised that she called an LPN who listened to the client's lungs, took her temperature and her pulse. The companion stated that the LPN indicated the client's vital signs were normal, that the client was fine and that staying in bed was a "behavior." The LPN advised the companion that the client had missed going to the dining room for her lunch so a lunch tray was brought in for the client.
  - viii. LPN #2 stated that she only assessed the client on one occasion between January 20 and 27, 2014, when the client complained of a headache and her vital signs were normal at that time.
  - ix. LPN #3 said that she only assessed the client once, when she took the client's temperature after the client said that she was not hungry and did not want her lunch. LPN #3 denied that she told the client's companion that the client was exhibiting a behavior.
  - x. Management confirmed that they were advised by an LPN that the client's companion stated that the client was sick. Management indicated that the LPN did not do vital signs and only noted finding a blister on the client's face.
  - xi. LPN #4 confirmed that she was responsible for the client on day shift on January 25, 26, and 27, 2014. She also advised that she did not know the client well enough to know if her condition was deteriorating. This is contrary to what management indicated, stating that the LPNs knew the clients well and if they had observed anything untoward, they would have sent the client to hospital.
    - On January 25, 2014, after an HCA told LPN #4 about the blister under the client's eye, LPN #4 went to assess the client's blister, but the client was agitated and would not permit the LPN to touch her. LPN #4 noted that the client did not appear sick and she told the HCA to monitor the client but nothing further was reported her that day. LPN #4 called the client's son to request he take the client to the physician.
    - On January 26, 2014, LPN #4 said that she did not see or assess the client. She spoke with the client's son on the telephone who advised her that he attended at the facility that day but the client refused to go with him to see a physician. LPN #4 left a note for the evening LPN to monitor the client and to call the client's son if there were any concerns.
    - On January 27, 2014, LPN #4 said that nothing was reported to her about the client's condition so she did not assess her before the client's family took her out of the facility to see a physician.
  - xii. Management was not notified about any additional concerns with the client until January 25, 2014, when an LPN indicated the client's blister was bigger and that she had called the client's son to take the client to the physician.
- d) Neither management nor the LPNs followed up with the client's physician after the physician did not respond to the fax that was sent on January 20, 2014.



- e) The validity of certain documentation is questionable as there was both lack of documentation and inaccuracies with documentation. Further, documentation was not monitored or corrected by any responsible person.
  - i. LPNs did not document that they assessed the client.
  - ii. There are inaccuracies about the client attending meals in the dining room.
  - iii. There is no documentation to indicate the client was assessed when staff took meal trays to her room. (The resident handbook indicates that tray service is provided when clients are ill; clients are to inform the dining room if they will be absent from meals; and all clients will be checked on at mealtime.)
  - iv. Facility multi-disciplinary notes from January 20 to 28, 2014, indicate that there were no physical nursing assessments done during that time, and no entries regarding the client's condition on January 27, 2014, prior to her family taking the client to a physician or about her admission to hospital.
  - v. Inaccurate documentation was also demonstrated by documentation that shows the client received medication assistance when she was already in the hospital.
- f) There is contradictory information as to whether the home care manager was notified about the client's circumstances in January 2014 and there is lack of clarity as to who is responsible for notifying home care.
  - i. The home care manager advised that she was not notified in January 2014 that the client was sick or was sent to hospital. Home care documentation also confirms that there was no communication to the home care manager by any facility staff between January 21 and 27, 2014.
  - ii. The home care manager advised that the client's family member contacted her on January 30, 2014, regarding the client's illness.
  - iii. This is contrary to what Manager #1 stated who indicated that the home care case manager had been notified of the client's condition between January 20 and 27, 2014.
  - iv. Manager #2 could not recall if an LPN notified the home care case manager of changes to the client's condition between January 20 and 27, 2014.
  - v. Manager #2 advised that LPNs can call the home care case manager directly or they can document the problem on a special document that was developed for that purpose, which Manager #2 reviews, and then he sends it to home care; however, in this case, this did not occur.
  - vi. Manager #1 stated that she did not expect LPNs to communicate with the home care manager. In her view, the LPN's responsibility is to report concerns to the facility manager who then communicates directly with home care.
- g) The client experienced significant cognitive decline over time but her support needs were not assessed and care planning was outdated.
  - i. The date of the last resident assessment instrument – home care (RAI-HC), was May 7, 2012. This should have been done annually by the home care case manager, but it was not. Provincial continuing care health standards indicate the RAI-HC should be done by home care case managers at least annually and with any significant change in condition. Care plans are to be reviewed and updated every three months or more often if necessary. In this client's case, the care plan was outdated and had not been reviewed for over 1.5 years.



- [8] The evidence indicates that the acts and omissions of the individuals involved in failing to assess and monitor the client resulted in a failure to provide the client with adequate medical attention, resulting in serious bodily harm, and in my view, these circumstances do constitute "abuse" as defined in the Act.


#### DIRECTION

- [9] Accordingly, I *direct* the service provider to take the following steps, or where actions have already occurred, to provide confirmation that the steps have been taken:
- a) *Given the requirements set out in the provincial continuing care standards, work in collaboration with home care to identify clients at the facility that need updated RAI-HCs and/or care plans and develop a joint strategy to update them now and at regular intervals to comply with the standards.*
    - i. Provide a copy of the strategy including: (a) details about the type and number of clients who have outdated RAI-HCs and care plans indicating the total duration of time they are overdue, and (b) a description of the timelines and steps that will be taken to ensure these updates are completed in a timely manner.
  - b) *Given the service provider's duty of care, obligation to take reasonable steps to protect clients from abuse, and the duty to maintain a reasonable level of safety for clients, work in collaboration with home care to:*
    - (1) *set out clear processes and standards with respect to the service provider's communication with home care in relation to clients served, indicating what must be communicated, when, how, and by whom, and*
    - (2) *determine oversight responsibility for clients who are living independently to ensure that any gaps related to the monitoring of clients and provision of client care are minimized or eliminated.*
    - i. Provide: (a) a copy of the final, communication processes and standards that are established for implementation by both parties, and (b) written confirmation, along with any supporting documentation, that clearly indicates oversight responsibilities for independent clients.
  - c) *Consider using the existing "Change in Condition" process for independent clients who have symptoms of illness.*
    - i. Provide: (a) confirmation that the Change in Condition process will be used for independent clients, and (b) supporting documentation that demonstrates how this has been communicated to staff.



- d) *Arrange for all LPNs to receive an in-service on the components of a comprehensive (head to toe) assessment; how to perform the assessment; when such assessment should be completed; and how to document it.*
  - i. Provide confirmation that all LPNs are targeted to receive an in-service and specify: the total number of LPNs on staff; the actual number and percentage of LPNs that have completed the in-service (by the date specified below); the date by which the remainder of LPNs will receive an in-service, if applicable; the date(s) the in-services were held; and the total duration of time for each in-service.
- e) *Provide dietary staff with an in-service on completing meal checklists, emphasizing the need for accuracy when completing documentation and the importance of informing other staff if a client is not in attendance at meals.*
  - i. Provide confirmation that all dietary staff responsible for completing meal checklists received an in-service and specify: the total number of dietary staff employed who fulfill this function; the actual number of dietary staff who participated in the in-service (by the date specified below); and a target date by which any remaining dietary staff will participate in an in-service, if applicable.
- f) *Review staffing levels on day shift to determine what changes can be considered to improve the delivery of care to all clients.*
  - i. Provide confirmation that a review was completed and specify: who (by position) was involved in the review; the date(s) of the review; the options considered; the outcome of the review; and include rationale for any decisions made with respect to staffing levels.
- g) *Revise the abuse policy to better reflect the components of the Protection for Persons in Care Act and provide education on the same. Emphasize the mandatory reporting requirement for any individual who has grounds to believe that there is or has been abuse involving a client, and ensure that the policy makes it clear that staff must report abuse to PPC, a police service, or if the abuse involves a regulated health professional, to the appropriate regulatory college.*
  - i. Provide a copy of the updated abuse policy.
  - ii. Provide supporting documentation that staff receives education on the updated policy, including date(s), number and designation of staff that received education. Include a brief summary of materials covered.

10 Rutherford Heights Retirement Residence, Edmonton, is to provide, in writing, by November 30, 2014, the above required supporting documentation, thus complying with this direction and with section 10(1) of the Act.

  
Anita L. Sieben, Acting Director  
Protection for Persons in Care

Dated September 3, 2014 at Edmonton, AB