

DECISION RESPECTING PROTECTION FOR PERSONS IN CARE FILE #7361

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 involving a client receiving care or support services from Supported Lifestyles, Calgary, reported on October 24, 2011, and investigated by a contracted investigator under the Act.

ALLEGATION

- [1] It was alleged that on October 23, 2011, unknown staff bathed the client in hot water, resulting in the client sustaining severe burns to his back, buttocks and hands. The client required hospitalization for assessment and treatment of the burns.

INVESTIGATION

- [2] Ms. Mary Kay Russell of WMC Holdings Inc. was contracted to carry out this investigation. On January 19, 2012, Ms. Russell provided to me her final report. This final investigation report was provided to me, 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 her findings of facts.
- [4] I concur with the investigator's finding that the allegation of abuse is founded.
- [5] Section 2(a) 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 causes serious bodily harm." After a thorough investigation, which involved interviewing a significant number of people, the investigator found evidence that the client sustained serious bodily harm. The client was taken to the hospital on October 23, 2011 with severe burns to his body, involving his left hand, his feet and buttock, where his skin was peeling. At the emergency department the client was diagnosed with partial thickness and deep partial thickness burns to his inner thighs, buttocks, perineum, scrotum, lower legs and feet, left hand and forearm (approximately 20% of his body). Once the client was moved to the burn treatment unit, his vital signs deteriorated and he was moved to the intensive care unit (ICU). The client was in and out of ICU and the burn unit until he passed away five weeks later. During that time he underwent four plastic surgery operations to aid the healing of his burns and he also underwent bowel surgery.
- [6] There is no issue as to whether the client received serious bodily harm. This leaves whether an "act or omission" by the individual involved, who was identified during the investigation, caused the serious bodily harm. The individual involved, who was the only witness to the client's bath, was working alone as one staff person had left and the on-coming staff person was late. She indicated that:

- She ran the tub, swished soap around to make bubbles, and then put on her gloves. While the tub was running she helped the client stand in the tub.
- When the doorbell rang, she turned the water off, helped the client sit down, took off her gloves and answered the doorbell. When she immediately returned to the bathroom, she noticed the client had a bowel movement in the tub.
- She stood him up, put her hand in the water to drain the tub, and cleaned the client and the tub using a leaking hand held shower. The water from the shower was hot when it sprayed on her. She adjusted it before using it on the client.
- She dried the client when he was standing and then dressed him. Another staff person noted the client's blister on his left hand and that his feet were wet. His skin peeled when his socks were taken off.
- Several staff noted that the client did not have bathing protocols on his profile but due to his history of seizures he is not to be left alone.
- While the hot water heater was set at "B", the middle setting, the water temperature checked the next morning read 47.5 degrees C at the hottest setting.
- A staff person said the water temperature can fluctuate if a toilet is flushed or laundry is being done.

[7] In my view, because the client received burns from the bath, and because of the circumstances of the case and the fact that the burns caused serious bodily harm, I agree with the investigator's conclusion that the allegation of abuse per the *Protection for Persons in Care Act* is sustained.

[8] The client's file has been referred to a police service, and the medical examiner's office is involved. The individual involved had resigned prior to the incident.

[9] I direct the service provider to take the following steps, as recommended by the investigator, or where actions have already occurred, to provide confirmation that the steps have been taken:

a) That regarding water temperatures:

- All service provider homes be outfitted with anti-scald and/or mixer valves at the tub/shower, to maintain a constant temperature regardless of water usage in other parts of the home, and to prevent temperatures above 42 degrees C in the tub/showers;
- The use of, and training in the use of thermometers be continued according to the service provider's new procedures, implemented as a result of this incident, to ensure water temperatures of 40 degrees C unless otherwise specified in the client's profile; and
- Staff training/orientation include the nature of scalding burns and the recognition of same.

b) That regarding the management of emergency situations:

- The service provider revise the on-call procedures and the agency/guardian contract to indicate that in the case of a medical emergency, staff have the authority to call 911 first, and the on-call supervisor second as this was not clear;
- These emergency procedures be posted by the phone or in a central, visible location;

- A checklist of questions be developed that will provide the on-call supervisors with guidance and adequate information to make an informed decision;
- The on-call supervisors be trained on their roles and responsibilities when contacted in emergency situations, including providing a detailed report on every step of an emergency, such as the number of calls received and/or missed.
- The on-call reports should be reviewed by the service provider on a regular basis and be used as part of the supervisors' annual evaluation.
- c) That regarding bathing clients, the service provider:
 - Ensure that where clients are dependent and require supervision at all times, no client is bathed/showered when there is more than one client in the home, and there is only one staff present in the home – including night staff;
 - Ensure that bathing procedures are noted in the clients' profiles and visible to staff at bathing times.
- d) That the service provider ensures that the home supervisor rotates through all shifts to enable observation and supervision of staff and this include weekend and night shifts.
- e) That the service provider examines and resolves the reason for high turnover in this home and develop practices to prevent future concerns of this type as this was noted as a concern.
- f) That the service provider arrange, as soon as possible, for a debriefing session for the entire group home team, to assist them to deal with their shock and grief, help to rebuild team morale, and to help rebuild their confidence that the service provider is there to support them in difficult situations and the service provider revisit their procedures regarding the provision of information to staff during and following an investigation.


[10] I also direct the service provider to establish a policy guiding on-call supervisors about when it is appropriate to make a site visit.

DIRECTION

[11] Supportive Lifestyles Calgary is to provide by March 31, 2012 supporting documentation such as evidence that: 1) anti-scald and/or mixers have been installed in their homes; b) the date(s), number and designation of staff receiving training on the use of a thermometer in bathing clients, bathing procedures and the nature of scalding burns; c) the date(s) client profiles have been reviewed regarding bathing and that these are visible to staff when bathing; d) a copy of the emergency procedure, including on-call supervisory responsibilities, and the policy regarding when they should attend on-site; e) a review of the high turnover has occurred and the steps taken to address this issue; and f) a debriefing has occurred with the staff, thus complying with this direction and with section 10(1) of the Act.

[original signed]

Edith Baraniecki, Director
Protection for Persons in Care

Dated  25/12 at Edmonton, AB