

## **Report of the Investigation for Protection for Persons in Care File #7361**

This report seeks to set out the findings pursuant to section 14 of the *Protection for Persons in Care Act, SA 2009, cP-29.1* (the Act) regarding abuse, under the definition of an act or omission that causes serious bodily harm at Supported Lifestyles, Calgary reported on October 24, 2011, and investigated 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.

### **KEY INFORMATION GATHERED**

- [2] The client was a 35-year-old man diagnosed with Lennox-Gastaut syndrome, a severe form of epilepsy characterized by several types of seizures, developmental delay, and behavioural disturbances. He exhibited autistic tendencies, which included self stimulation and isolation. He was non-verbal, and used movements and physical contact with staff to communicate his needs. He would clap or hum to indicate joy; when he was unhappy he became inactive.
- [3] There are no limitations to this investigation.
- [4] The client's primary legal guardian stated that:
- a) The current agency has been contracted to operate the home for the past eight or nine years. During the last three years the client's functioning has deteriorated, his balance has declined and his exercise routine became more difficult for him to maintain. Most of his life he was healthy; this was his first hospital admission.
  - b) There was constant staff turnover at the group home of both front line staff and home supervisors.
- [5] The client's alternate legal guardian stated that:
- a) The home is owned by a non-profit housing society created by the three original families.
  - b) The client expressed pain primarily by body movements and facial expressions.
  - c) When the incident occurred, he was contacted by the hospital before he received a call from the agency. Once the client was moved to the burn treatment unit, his vital signs deteriorated and he was moved to the intensive care unit (ICU). He continued to move between these two units for the duration of his stay in the hospital. He underwent four plastic surgery operations to aid in the healing of his burns and also underwent bowel surgery, as there were indications that he may have had a significant infection. The results were negative. The client received burns to 15-20% of his body.
  - d) When the client passed away, the doctors involved told him that the cause of death was complications arising from the burns. The Medical Examiner has become involved and will make the final decision regarding the cause of death.
  - e) He has received the agency's internal investigation report. It does not address the majority of the issues, and puts all of the blame on the individual involved.

- [6] The Human Resource manager stated that the individual involved has worked for the agency for about two years; she was doing relief in the client's home and part-time work in another. Residential staff #1 is a relatively new staff; it was her fourth shift, and the first time she met the individual involved. They have a mix of long and short-term staff in this home.
- [7] The Residential Supervisor stated that:
- a) He went to the home on the night of the incident at around 21:00, and took a picture of the hot water heater setting. The individual involved was still there and she was calm. She said she changed the client around noon and didn't notice anything wrong. To his knowledge there has never been any problem with the quality of her work at this residence or at the other one. He has observed her, and she was conscientious and caring with the clients.
  - b) Residential staff #2 stated to him, that when she changed the client at around 9:00, there were no marks on his body.
  - c) If a staff wants to leave a shift early, they may do so if the other staff on shift approves it; no approval is required from a supervisor.
  - d) The client's profile does not include specific bathing procedures. The plan does discuss his seizure disorder and the requirement for someone to be with him at all times.
  - e) All new staff receive a three day orientation to the organization, then a home specific orientation by the Home Supervisor. Home orientations are done with a combination of observation and hands on, with seasoned staff. If staff are new to the organization, they receive up to three on-site shifts of orientation.
  - f) Since the incident, a new agency wide procedure has been initiated, where all bath water must be tested with a thermometer and no bath is to exceed 40 degrees centigrade. Bath temperatures for each client are tracked and submitted monthly.
  - g) There is no on-site supervision of week-end staff; if they need help they can call the on-call supervisor. Typically there is no one supervising them on a regular basis and therefore evaluation can be a challenge.
  - h) The organization brought in a grief counselor for an hour to speak with staff. Three of the staff attended. There has been no team meeting since the client's death. To his knowledge there has been no communication with the individual involved since she resigned.
- [8] The on-call supervisor stated that:
- a) On October 23, 2011 at around 16:30, she received a call from the individual involved, who had noticed a mark on the client's finger before his bath. After his bath the mark was still there, but worse, She directed the individual involved to check whether there were any other marks on his body. Ten minutes later the individual involved called back and said there were more marks on his feet and buttocks and the skin was peeling off. The way the individual involved talked, it sounded like a rash. She suggested that the client should be taken into emergency to be on the safe side. The individual involved asked if it would be okay to feed him and give him his medications first, as they may be at emergency for quite awhile. She approved the wait. The individual involved said that the client did not seem to be in pain. She believes she might have missed one of the calls from the individual involved.
  - b) She did not know the client so she did not know his particular problems, (such as being non-verbal) and did not know the general state of his health, so she had to rely on the individual involved to assess the situation. She generally does not go out on an injury

call, she just advises whether to call 911, go to emergency, or to treat at home. There was nothing in the content of their conversations to indicate to her that she should have gone over to the home herself.

- c) The individual involved told her that although the client's usual bath time was after supper he had a snack at around 15:00 and was messy, so she decided to bathe him. She questioned the individual involved as to whether he could have been burned in the water, but the individual involved said that she had checked the water and it was not hot.
- d) Close to 18:00 the individual involved called her to say that residential staff #1 had left to take the client to the hospital. Between 19:00 and 20:00 residential staff #1 called to tell her the client was being admitted to the hospital for burns and he may be transferred to another hospital. She called her supervisor, and then the alternate guardian. The hospital had spoken to the alternate guardian just prior to her call. The alternate guardian told her that the client had burns all over his body.

[9] The Home Supervisor stated that:

- a) On October 23, 2011, at around 20:00, the on-call supervisor called and asked him to go to the hospital to be with the client. At about 21:00 he saw the client in Emergency; he was shivering sporadically, his eyes seemed "different", but he was otherwise lying quietly.
- b) The individual involved has been working at this home for over three years, generally on Sunday from 9:00 – 21:00. This was the first full shift for residential staff #1, but she had received a complete orientation from him.
- c) There were no written procedures for bathing the client, although common sense dictates that he could not be left alone because of his seizures. There is a copy of the client's profile at the home so staff can reference it if needed. Staff are trained to prepare the bath, test the water, and then put the client into the tub. The client loved the water and would lay back and relax. In the seven months he has been bathing the client, he has never had a bowel movement(BM) in the tub. The client was bathed daily, generally between 18:00 & 19:00.
- d) There is no regular supervision of weekend staff, as he does not work those shifts; an on-call supervisor is available for support if required.
- e) The showerhead has been leaking since May or June. He has advised the alternate guardian, who is responsible for repairs.
- f) He is really grieving the death of the client. The agency hired a grief counselor to meet with staff; three people took advantage of it. The staff were not kept up to date with what was happening to the client in the hospital, and they were told not to communicate with the family.

[10] Residential staff #1 stated that:

- a) The orientation to this group home involved reviewing the policy manual and observing during her second and third shift. October 23, 2011 was her first Sunday shift and the first time she met the individual involved. She was 15 minutes late for her shift, which was supposed to start at 15:00. The doors were locked so she rang the doorbell. The individual involved answered it and then left immediately for the bathroom where she was bathing the client. She wanted to observe the client's bath, but the individual involved said she would show her next week. She completed a number of chores while the individual involved directed her through the bathroom door. The individual involved did come out of the bathroom to show her where one of the co-roommate's clean

bedding was stored, and also to help her use the other co-roommate's lift to get him out of bed. She did not know whether the client was still in the tub during those times, as the bathroom door was shut.

- b) When she came upstairs from the laundry room, the client was sitting in his wheelchair in the bathroom doorway. When she went to say hello, she pointed out to the individual involved that one of his fingers was raw and his socks were wet. The individual involved took the client into his bedroom. There followed a number of calls to the on-call supervisor all made by the individual involved – some of which were not answered – and an examination of the rest of the client's body to determine whether any other parts of his body were red and/or bubbly. The individual involved carried out the examination, but showed her the skin peeling off the client's feet and buttocks. They were eventually directed by the on-call to transport the client to the hospital. She took him in her car, leaving the group home at about 17:45.
- c) After the doctor diagnosed the marks as burns, she called the on-call and informed her that the client was being admitted to the hospital. She stayed with the client until 21:15 when the Home Supervisor arrived. The client's alternate guardian arrived at the hospital between 19:30 and 20:00.

[11] Residential staff stated the following:

- a) Residential staff #2 confirmed that she worked about ten Sundays from 9:00 – 15:00 with the individual involved. She was fine to work with and she connected well with the clients. The individual involved often gave the client a bath early because after his 15:00 medications he was usually messy. The day of the incident the individual involved approved her to leave at about 14:15.
- b) Residential staff #2, #3 and #5 stated that the client did not have bathing protocols in his profile. They said that the temperature gauge on the tub worked okay, but the water still had to be checked with your hand. Staff #3 indicated that the water temperature would change if anyone flushed a toilet or put on the laundry.
- c) Residential staff #2, #4, #5 and #6 stated that the home supervisor trained staff in bathing techniques. The water was to be prepared and tested with your hand before getting the client and bringing him into the bathroom. The client had to be assisted to get into the tub.
- d) Residential staff # 3, and #5 stated that the shower has leaked for months and although it had been reported to the home supervisor, it has not been repaired. Both staff work awake over night shifts. Sometimes in the morning they have an aid, and sometimes they get the three clients ready for their day programs on their own. This includes giving one client a shower.
- e) Residential staff #2 and #4 stated that the client never had a BM in the tub when they were bathing him. They also said that he was non-verbal, and when he was happy he clapped his hands. Staff #5 stated that it was difficult to tell when he was in pain.
- f) Residential staff #3 stated that she is still in shock over the client's death. When the client passed away, agency management contacted her and residential staff #2 on their cell phones. Residential staff #2, #3, #4 #5, and #6 indicated that staff at the group home were closed off from what was happening to the client; they only knew that he was in the hospital. The agency did not keep them up to date on how he was doing. There has been no group/team meeting to debrief staff on the client's death.

- [12] Residential staff #3 stated that:
- a) Because she worked nights, she seldom bathed the client but she knew that he was not to be left alone because of his seizures. The client was burned once before three or four years ago and bathing protocols were to be developed then, but they never were.
- [13] Residential staff #4 stated that he has worked with the client for about ten years; up to last March he was the client's full time career worker. He has seen 16 supervisors since he started at this home. The one before the current supervisor lasted two weeks. He is currently on leave from this home because of his grief over the client's death.
- [14] The client's plastic surgeon stated that:
- a) The client's skin was less healthy than the average person's skin because he was less healthy. The ICU team could never discover why the client did not respond favorably to the treatment. Considering the level of the client's burns they would not be life threatening to a healthy person. Because of this he would have to say that the client's death was not solely attributable to his burns.
  - b) It is not possible to tell whether the delay in treatment could have had an effect on the end result. The client was not really sick until he was in the hospital for a day or so; originally he presented as someone who was just burned, not sick.
  - c) The client's burns were partial thickness burns, and blisters can take a few hours up to a day to appear. Three components determine the degree of a burn through scalding: the temperature of the water, the length of exposure and the resistance to burn injury. The last component varies by the area of the body and by the individual. There have been studies to show that if exposure is long enough, water of 42 degrees is hot enough to cause burns. Generally areas that are mildly burned turn red; the more serious areas blister.
- [15] The individual involved stated that:
- a) She worked at this home every Sunday from 9:00 – 21:00, always with 1:1 staffing. The home supervisor oriented her. On October 23, 2011, the client and his non-ambulatory roommate were both there; the latter was having a nap. The staff working from 9:00 to 15:00 left early, and residential staff #1 was late for her shift. The client normally has a bath after supper but he was messy after his 15:00 snack.
  - b) The client was in the kitchen in his wheelchair. She got everything ready for his bath, and then wheeled him into the bathroom. She ran the tub while he was sitting there and swished his soap around in the tub to make bubbles; then she put on gloves. While the tub was still running she helped him stand in the tub. When she heard the doorbell ring, she turned the water off, helped him sit down, took off her gloves, and went to answer the door. She returned immediately to the bathroom and saw that the client had a BM in the water. She stood him up, put her hand in the water to drain the tub, and cleaned him and the tub using the leaking hand held shower. The water from the shower was hot when it sprayed her, but not enough to scald. She adjusted it before using it on the client.
  - c) She dried him while he was standing, then helped him sit in his wheelchair, onto his clean diaper, put on his socks, shirt, and partially pulled on his pants. She did not notice whether his feet were red when she put on his socks. Residential staff #1 helped hold him while she fixed his diaper and then pointed out the blister on his left pinky finger; he was trying to scratch it. Before the bath, she had noticed it was white. They also saw that one of his socks was wet. She wheeled the client into his room and helped him

onto the bed to shave him. Then she called the on-call supervisor about his finger. She was unable to reach her until the third call, when she had already removed his socks and noticed his feet were wet and the skin was peeling off. The on-call supervisor told her to put on polysporin and to check the rest of his body; she would call back when she got home. She found that the client's buttocks were also wet and slimy and there was skin on his diaper; the red mark was getting bigger. She did not recognize the marks as a burn; she had never seen anything like it. She was waiting for the on-call supervisor to call back and give her direction. Between 17:00 & 18:00 she called the on-call supervisor again and left another message. When the on-call supervisor returned her call, she asked whether the client required medical attention. The individual involved felt he did, so the on-call supervisor suggested that one of them drive him to the hospital. Residential staff #1 had the proper insurance, and said she would drive him. The individual involved fed him his 17:00 medications; residential staff #1 read his profile, and then left with the client at about 17:45, taking his binder and medications. The on-call supervisor did not call her back; instead, she called the on-call supervisor to inform her that the client was on the way to the hospital. At about 21:00 the on-call supervisor phoned and told her that the client was on his way to another hospital to the ICU.

- d) She was told not to call anyone about the incident. She did not know how the client was doing, or where he was, so she could not go and visit him. Since the incident and since she resigned, the agency has not contacted her or told her anything. She found out that the client had passed away when the home supervisor sent her a text; no one from the office has contacted her. She is really upset; she only wanted the best for the clients.
- e) The client did not have bathing protocols and there are no general ones for the home.
- f) The on-call supervisors do not know the clients. It was her understanding that the on-call supervisor usually comes and checks on the client if something happens. It is up to the on-call supervisor to make the decision about whether the situation is serious enough to merit medical attention and whether 911 should be called.
- g) She had actually quit the Sunday before the incident, but came back because they could not find anyone else to work. She also quit at the other home for about a month, and they asked her to come back because her replacement quit.

[16] The client's profile states that:

- a) Over the last year his seizure patterns changed and he was experiencing more and of longer duration. Also over the last year his mobility decreased and he was requiring more direct support from staff; he was often weak, and he tired easily. There were days that he required complete assistance to walk and/or stand.
- b) He required one to one support and should never be left unattended.
- c) Because of his instability, when his diaper was being changed, he should be lying down on his bed.
- d) He was non-verbal and used his movements, body language and physical contact with staff to communicate needs and wants.
- e) He expressed unhappiness through inactivity.

[17] The Incident Reports state that:

- a) The report prepared by the individual involved was brief and noted the on-call supervisor's direction to drive the client to the hospital after she reported that the client's skin from his feet peeled off onto his socks, and the skin from his buttocks was on his

diaper and pants. She noted that the client had a blister on the little finger of his left hand prior to the bath.

- b) The report prepared by residential staff #1 stated that the client was in the bathroom from when she arrived at 15:15 pm until about 17:00 pm. The bathroom door was closed for the entire time. When she first saw the client, he was sitting in his wheelchair and she noticed his socks were wet, then she saw him in his bedroom where the individual involved was preparing to shave him. This was when the on-call supervisor was called and told them to check the client all over and put polysporin on the red areas. She left the house at 17:45 pm with the client to take him to the hospital as per the instructions of the on-call supervisor. The hospital confirmed that the client was burned on his feet, buttocks and left hand.
- c) The report prepared by the home supervisor stated that during his conversation with the individual involved at 20:38 pm, she confirmed that the client had a blister on the little finger of his left hand before his bath. He noted that both the nurse and the doctor at the hospital told him that the burns were fresh and had happened within the last few hours.

[18] Agency documents concerning the incident noted the following:

- a) The On-call Supervisor's report stated that:
  - i) The individual involved told her that when she put a small amount of water in the tub, it was too hot and she left it to cool. When she put the client in, it was just warm.
  - ii) At 16:24, the individual involved told her that the left hand, both feet and the client's buttocks were watery and slimy, but she could not tell if he was in pain. Residential staff #1 suggested that it might be bed sores. When she directed the individual involved to take the client to the hospital, they discussed waiting until after the client had been fed and had his medications. They agreed that this would be all right. At 17:51 the individual involved called to say that residential staff #1 had left for the hospital with the client.
- b) The agency summary of activities of October 23, 2011 stated that:
  - i) The morning of October 23, 2011, the client was very weak and congested.
  - ii) There were no unusual marks on the client's body when he was changed at 9:00 by residential staff #2, or at 11:00 when changed by the individual involved.
  - iii) The individual involved stated that the client was put in the tub at about 15:05 with the water still running. She turned off the water and left him alone to answer the door. When she returned he had a BM in the tub. She had him stand while she cleaned him with the hand held shower.
  - iv) At 16:15, when he came out of the bathroom, residential staff #1 noticed the blisters on the fingers of his left hand. Subsequently, residential staff #1 and the individual involved noted that both of his feet and his buttocks were watery and slimy, much like his hand.
  - v) At about 17:45, residential staff #1 took the client to the hospital.
- c) The residential supervisor's contact notes state that:
  - i) At 21:00 hours on October 23, 2011, he arrived at the client's group home and spoke with the individual involved, who said that she noticed the burns on the client's feet and buttocks when she was giving him a sponge bath following his BM in the tub.
  - ii) When he examined the hot water heater that same evening, it was set at "B", the middle setting. He did not have a thermometer to check the actual temperature.
  - iii) When he checked the water temperature the next morning at 7:30, it was 47.5 C at the hottest setting.

- d) In an October 25, 2011 interview by two members of the agency management, the individual involved stated that:
- i) She put about 3 inches of water into the tub while she undressed the client. She checked the water temperature with her hand, put on gloves and left the water running while she helped the client into the tub.
  - ii) When she heard the doorbell, she turned the water off, took off the gloves, and answered the door.
  - iii) When she returned to the bathroom, the client had a BM in the tub. She put her gloves back on, and while he was standing in the tub, she used the hand held shower to clean the client and the tub. When she started the hand held shower it sprayed her and she noticed the water was too hot, so she adjusted the temperature.
  - iv) She dried and dressed the client putting on a diaper, pajamas, and socks. Prior to the bath, she noticed that the client had a small red blister on his left pinky finger, and his feet were pale and whitish. Following the bath he feet still looked the same and three fingers on his left hand looked pale, swollen and white.
  - v) Residential staff #1 noticed that the client's socks looked wet, and his pinky finger was red, whereupon the individual involved called the on-call supervisor, who directed her to undress him and see if there were any other marks on his body. At about 16:45 she reported that skin on his buttocks and both feet were wet and slimy and peeling off. They were directed to take the client immediately to the hospital. Residential staff #1 and the client left the home at 17:45.
- e) Other documents showing interview questions/answers from agency management representatives with the individual involved, the home supervisor, the residential supervisor, the on-call supervisor, and residential staff #1 basically confirm the previous information. In addition:
- i) The individual involved noted that during his bath the client was sleepy and did not make any noise until he stood up and then he hummed.
  - ii) The home supervisor stated that he had never worked with the individual involved because she only worked on Sundays. Other staff have told to him that they got along with her, and if he dropped into the home, it was always clean, and she appeared to work well with the clients. When he spoke with her after the incident she seemed to talk normally.
  - iii) The on-call supervisor said that when she called back to tell the individual involved that the client had been burned, the individual involved seemed alarmed and shocked.
  - iv) Residential staff #1 said that the second call the individual involved made to the on-call supervisor between 16:30 – 17:00, there was no answer. At 17:30 the individual involved called the on-call supervisor again, and that was when they discussed insurance and going to the hospital. When she called the on-call supervisor from the hospital to update her at 18:30, she had to leave a voice message, as there was no answer.
- f) Management's summary of the situation reiterated the preceding information and confirmed the following:
- i) That the client was left alone in the tub, which is counter to the directions in his profile.
  - ii) That the client's bath was started when there were two dependent clients and only one staff in the home, leaving the co-client unattended.

- iii) That the individual involved continued to run the water after placing the client in the tub, which is counter to the established procedure.
- iv) That the individual involved has training as a VON Personal Care Attendant and is also certified in Emergency First Aid.
- v) That according to the individual involved she noticed the smallest finger on the client's left hand was red and blistered prior to his bath, but did not report this to the on-call supervisor or complete an incident report, as per agency protocols.

[19] Other agency documents include:

- a) The contract between the agency and the client's legal guardian states that:
  - i) The agency is to provide support services to the client as per the written profile and lifestyle plan, and inform the guardian of any concerns;
- b) The new procedures developed by the agency to determine temperature of water in a hot water tank outlines various ways to set different types of hot water tanks, sets 49 degrees as the lowest temperature a tank should safely be set at to prevent bacterial growth, and explains how to use a thermometer to test the temperature of tub and shower water.
- c) Job descriptions for the home supervisor and the individual involved state that:
  - i) The home supervisor is responsible to train and support staff, monitor and ensure all in-home procedures and agency policies and procedures are followed, ensure that all staff follow the procedures outlined in the client profiles, review staff interactions and relationships with clients, provide supervision to all staff, and debrief challenging situations.
  - ii) The residential relief service worker (individual involved) is required to know and follow procedures outlined in the client's profile.
- d) Staff records for the individual involved demonstrate that she has completed up-to-date training in Emergency First Aid level C, Personal Care Attendant Certification from the VON, and the Home Specific Orientation requiring a complete review of client profiles. Residential staff #1 has also received training in Emergency First Aid.

[20] Health Services documents state that:

- a) 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. The burned areas were blistered and reddened. He had an obvious line consistent with submerge and burn. He was alert, cooperative, and had no fever. The client's vital signs were basically stable. A decision was made to transport the client to another hospital that evening, to a specialized burn treatment unit, and assessment by a plastic surgery team. It was not until after he had been transferred that the client began to exhibit problems with his vital signs.
- b) Although the client was initially transferred to the burn treatment unit, he was in and out of ICU during his stay at this hospital. A burn area chart was completed to illustrate the areas of his body affected by the burns.

[21] Agency policy states that:

- a) On-call Supervisory Personnel and Procedures have been developed to provide an immediate response to all extraordinary situations by experienced and authorized personnel. These procedures state that for homes that have a Home Supervisor, that is the first person to call for assistance. It is the on-call supervisor's responsibility to ensure that the guardian has been notified. The emergency instruction card indicates

that if staff do not get an answer, they should leave a voice mail. If they do not get a return call within three minutes, they should try again. If there is no response after two tries, they should phone a Supervisor, a Coordinator, or Director.

- b) Emergency Situations Policy states that all employees are to be oriented in these procedures and in on-call supervisory procedures. Supervisory personnel are to thoroughly document each emergency contact made and received. Employees accompanying clients to the hospital are provided with a list of things to take with them, and should accompany the client to the ward.

[22] The Calgary Police Service was contacted on December 1, 2011, and advised the investigator to continue with the investigation. The police were contacted again on January 18, 2012, at the conclusion of the investigation, whereupon they requested a copy of the report. The name and number of the investigating officer was provided to the PPC office so appropriate arrangements could be completed regarding sharing of this report.

### **INVESTIGATOR'S PRELIMINARY RESULTS AND RECOMMENDATIONS**

[23] Based on the above findings, the allegation, defined as an act or omission that causes serious bodily harm, is founded, considering:

- a) An act took place causing the client to suffer burns because: following a bath the client was seen to have slimy and peeling skin on his feet and buttocks and was taken to the hospital where it was determined that his injuries were consistent with a submerge and burn situation, and where it was stated that the burns were fresh having been acquired within the last few hours.
- b) Serious bodily harm occurred as the client was admitted to the hospital for treatment and subsequently transferred to a specialized burn treatment unit.

[24] The following recommendations are made:

- a) That all agency homes be outfitted with anti-scald fittings at the tub/shower, to maintain a constant temperature regardless of water usage in other parts of the home, and to prevent temperatures above 40 degrees C in the tub/showers.
  - i) Residential staff #3 indicated that in spite of the gauge on the tub, the water temperature could fluctuate based on whether water is being used in another part of the home. Residential staff #2, 3 & 5 indicated that the gauge worked all right, but testing with the hand still needed to be done to ensure a proper temperature.
  - ii) The home supervisor, and residential staff #2, 4, 5, & 6 all indicated that the home orientation/training was specific in requiring that the tub be filled and "hand" tested for temperature by the staff prior to helping the client into the tub. The new procedures, which stipulate the use of a thermometer, still rely on staff following established practices.
  - iii) The new procedures established by the agency indicated that the hot water tank must still be set at 49 degrees C to inhibit the growth of bacteria; this temperature is high enough to cause scalding injuries. The client's plastic surgeon stated that temperatures of 42 degrees C could still cause burns on some individuals.
- b) That the agency revise the on-call procedures to clarify whether the home supervisor or the on-call supervisor is the first point of contact in an emergency; that the on-call binder contain detailed information on all clients and their presenting problems and a series of

questions be developed to provide the on-call supervisor with adequate information to make an informed decision; that the on-call supervisor be expected provide detailed information on the number of calls received and missed, the time they were received, and the information exchanged; and that where a decision for medical care is made, the on-call be required to go out to the home.

- i) The on-call supervisor indicated that she did not know the individual and did not realize that he was non-verbal. She also indicated that she relied solely on the information provided by the individual involved in order to make her decision, who in turn relied upon the questions and the experience of the on-call supervisor to determine how to react to the client's situation, and whether he required medical attention. The on-call supervisor did not go out to the home to assess the situation herself.
  - ii) The on-call procedures are not clear whom the home staff should contact first, the home supervisor or the on-call supervisor. Residential staff are expected to make a decision as to the urgency of the situation prior to calling anyone.
  - iii) The on-call supervisor did not complete the on-call form in detail, and the timelines and information provided by her differed from that provided by the individual involved and residential staff #1. Not all of the calls made by either staff were answered by the on-call supervisor, which was not reflected in the on-call report, and according to the report, there appeared to be an hour unaccounted for between discovery of the injury and the departure for the hospital.
- c) That the agency ensure that where clients are dependent and require supervision at all times, no client is bathed/showered when there is only one staff present in the home, including night staff; and that the agency ensure that bathing procedures are noted in the client's profiles and posted visibly in the bathroom.
- i) The agency's summary report of alleged abuse indicates that one of the mistakes made by the individual involved was to begin a bath with one vulnerable individual, while another one was in the home, without a second staff present; however, residential staff #3 & #5, both indicated that they regularly showered one of the clients in the morning, whether or not a morning aid was present, while the other two clients remained in bed and/or unsupervised.
  - ii) There was nothing in the client's profile concerning bathing procedures specific to his concerns, nor were general bathing procedures for all clients posted in the bathroom, or anywhere else in the home.
- d) That the agency ensure that the home supervisor rotates through all shifts to enable him to observe and supervise all staff. This includes weekend and night shifts.
- i) The individual involved was a weekend staff and was no longer working according to the client's profile or the established procedures for bathing, even though she had been trained in both.
  - ii) The home supervisor, according to his job description and his own admission, has the responsibility to supervise the weekend and night staff to ensure they are applying the procedures and following the client profiles, but he never works with these two groups of staff.
  - iii) The residential supervisor confirmed that supervision of the night and weekend staff is difficult given that the home supervisor never works with them and he seldom sees them as well.
- e) That the agency examine and resolve the reason for high turnover in this home, and develop practices to prevent future concerns of this type.

- i) The family stated that there was constant turnover of front line staff and home supervisors.
- ii) Residential staff #1 was a new relief staff who was working her first full Sunday shift. Orientation to the Sunday routine was assigned to the individual involved, who was a part-time relief staff.
- iii) Staff #4 indicated that during his 10-year tenure, he has worked for 16 different home supervisors. The home supervisor before the current one lasted two weeks.
- f) That the agency arrange for a team debriefing session for group home staff with the presence of an outside party who is trained to assist them to deal with their shock and grief, and to help rebuild team morale; and that the agency revisit their procedures regarding provision of information to staff during and following an investigation, to include acknowledgement of the affection that staff develop with group home clients.
  - i) A number of staff stated they were still shocked, grieving, and morale is low.
  - ii) Two of the staff indicated that they were notified of the client's death on their cell phones.
  - iii) One of the staff is on leave from the home due to his grief over the death of the client.
  - iv) Most of the staff stated that the agency did not keep them informed regarding what was happening with the client, and they did not feel supported by the agency.

### **FEEDBACK TO THE PRELIMINARY RESULTS**

- [25] These relevant parties were contacted to discuss the preliminary finding and recommendations.
- a) The complainant, the primary and alternate guardians, the agency representatives, the PDD representative, and the individual involved, all agreed with the preliminary finding and all of the recommendations.
  - b) The guardians recommended that:
    - i) Even with the anti-scald device, training in the use of the thermometer should continue, and that staff training/orientation contain information on the nature of scalding burns, recognition of same, and the knowledge that scald burns can be life threatening.
    - ii) The questions for the on-call supervisor be in the form of a checklist developed by a professional; that the supervisors be trained by a professional how to access and assess the information; that the on-call and emergency procedures be posted by the phone or in a visible, central location; that the procedures contain clear protocols on when staff may call 911; and that staff be trained and encouraged to utilize Health Link when they have a question.
    - iii) They also recommended that the staff debriefing should create an atmosphere of sharing and discourage one of covering up what happens at the home.
  - c) The agency representatives and PDD stated that:
    - i) They are having problems sourcing anti-scald fittings that are CSA approved. They are installing mixer valves (PDD has offered to pay for these) and will try to have them set at a range of 41 – 43 degrees C in all homes where individuals are non-verbal and/or non ambulatory. They have a number of individuals who specifically do not want bath water of 40 degrees as they feel it is too cool. They will continue the thermometer testing.

- ii) PDD was concerned that the on-call procedures be monitored to determine whether everyone understands what is expected. The agency will begin to scrutinize the on-call reports on a regular basis and will include quality on-call reports as part of the supervisors' annual evaluation. The on-call supervisor has access to all written client profiles, in binders or on laptop computers. They could also include as part of the agency/guardian contract, that in cases of medical emergencies, staff are authorized to call 911, so that no staff person is expected to make a determination of the seriousness of a medical emergency given that this is not their area of expertise.
- iii) The agency stated that they have 53 individuals who require assistance with bathing. They are looking at a variety of strategies to ensure that there are always two people present in these situations. They have trained staff in the use of the thermometer and also in the requirement that bathing procedures specific to the individual should be in the bathroom with the client, and they are adding bathing procedures to the client profiles as the profiles come up for renewal. They will also begin a process of reassessing individual clients ability to bathe independently.
- iv) The home supervisor's position is a very difficult one to hire into, as they are not adequately paid for the responsibilities.
- v) Turnover is a major problem in general, partly due to salary and partially due to difficult parents. They will need to look at new strategies to help the staff deal with difficult parents.
- vi) The agency would like to have the debriefing done internally with the entire team as they have already had outside counseling services offered to the staff. They tried to pass on whatever information they had about the client's progress, but they didn't know much either.
- d) The individual involved recommended that the on-call staff be familiar with the clients they are making decisions about. She noted that there were no protocols indicating that she should not bathe the client when she was alone and the other client was in bed asleep. She also noted that when the home supervisor first started work, it was several months before she even met him.

## CONCLUSION

[26] The above results and recommendations are changed as follows:

- a) Recommendation a) is reworded to read as follows: "That all agency 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; that the use of, and training in the use of thermometers be continued according to the agency's new procedures, to ensure water temperatures of 40 degrees C unless otherwise specified in the client's profile; and that staff training/orientation include the nature of scalding burns and recognition of same."
- b) Recommendation b) is reworded to read as follows: "That the agency 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; that these emergency procedures be posted by the phone or in a central, visible location; that a checklist of questions be developed that will provide the on-call supervisor with guidance and adequate information to make an informed decision; that the on-call supervisors be trained to provide a detailed report on every step of an emergency including the number of calls received and/or missed; and that these reports

be reviewed by the agency on a regular basis and become part of the supervisors' annual evaluation."

- c) Recommendation c) clarified and reworded to read: "That the agency 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; and that the agency ensure that bathing procedures are noted in the clients' profiles and visible to staff at bathing times."
- d) No change to recommendation d).
- e) No change to recommendation e).
- f) Recommendation f) changed to read as follows: "That the agency 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, to help rebuild their confidence that the agency is there to support them in difficult situations; and that the agency revisit their procedures regarding provision of information to staff during and following an investigation."

Dated Jan 19, 2012 at Calgary, AB

[original signed]

Mary Kay Russell, WMC Holdings Inc.