

Protection for Persons in Care

Nova Scotia Department of Seniors and Long-Term Care

2023-24 (Q1)

December 2023

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Overview

The *Protection for Persons in Care Act (PPCA)* is a safeguard for patients or residents 16 years of age or older receiving care from a hospital under the *Hospital's Act* or a facility licensed under the *Homes for Special Care Act*. PPCA requires facility administrators and service providers, including staff and volunteers, to promptly report all allegations or instances of abuse. Members of the public may also report abuse under the Act by calling 1-800-225-7225.

After a report is received by the Protection for Persons in Care unit, a detailed review of each referral is done to determine if a more extensive investigation is necessary. If so, an investigator is assigned to conduct a formal investigation, which may involve referrals to police or a regulator. The investigator develops a report with conclusions, and there may be directives issued to the health facility that are to be complied with.

Types of Abuse

Under the *Protection for Persons in Care Act*, abuse is defined in section 3(1) of the Regulations as follows:

- 3(1)(a) the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding;
- 3(1)(b) mistreatment causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
- 3(1)(c) the administration, withholding or prescribing of medication for inappropriate purposes;
- 3(1)(d) sexual contact, activity or behaviour between a service provider and a patient or resident;
- 3(1)(e) non-consensual sexual contact, activity or behaviour between patients or residents;
- 3(1)(f) the misappropriation or improper or illegal conversion of money or other valuable possessions;
- 3(1)(g) failure to provide adequate nutrition, care, medical attention or necessities of life without valid consent.

Role of the Protection for Persons in Care Unit:

The role of the Protection for Persons in Care unit includes:

- Receiving reports of alleged abuse.
- Conducting a thorough review of all reports of alleged abuse to determine if the case falls under the scope of PPCA.
- Conducting extensive investigations of alleged abuse where there are reasonable grounds to believe abuse occurred.
- Issuing Ministerial directives to health facilities regarding operational and other measures considered necessary to protect all patients or residents from abuse, regardless of the results of the investigation.
- Monitoring health facilities actions taken to address any directives that are issued.
- Making referrals to professional regulators where appropriate.
- Providing education for the public, health care staff, and organizations about the Act and on the identification, reporting, prevention, and management of abuse and neglect.

Protection for Persons in Care Process

After receiving a report of alleged abuse, each referral is reviewed in detail. During this phase, information is gathered by contacting the complainant, health facility, and any other relevant individuals. The purpose of this is to check the reliability and validity of the intake information, confirm if the allegation falls within the scope of PPCA, and to gather and review detailed information to determine if there are reasonable grounds to believe that abuse has occurred, or is likely to occur.

If the Protection for Persons in Care unit determines there are reasonable grounds to believe a patient or resident has been abused, or is likely to be abused, and it has been determined that the case is most appropriately handled by the Department of Health and Wellness rather than another regulator, an investigator will carry out a more extensive investigation.

A decision to not conduct an investigation could be because: the referral is not within the scope of the PPCA, the facility has provided reasonable care and support to address the incident, the referral is more appropriately addressed by another jurisdiction (such as licensing), or the allegation has been referred to the police or a regulator.

The investigation process includes:

- Notifying the administrator, and relevant people involved in the incident (or the substitute decision maker) of the investigation.
- Gathering evidence by conducting interviews with the complainant, the person who has allegedly been abused (if they are able), the person who is alleged to have committed the abuse, health care staff, and any witnesses.
- Reviewing health records, facility based policies, procedures and processes, and provincial legislation and standards.
- Consulting with experts.
- Sharing a preliminary investigation report with the administrator of the health facility, and relevant people involved in the incident (or the substitute decision maker) to provide an opportunity to respond with additional information or clarification.

- Sharing a final investigation report with the administrator of the health facility and relevant people involved in the incident which outlines the findings of the investigation and any directives that may be issued. Directives include measures necessary to protect all patients or residents from abuse, regardless of whether the investigation has determined that abuse occurred.

Additional information about Protection for Persons in Care can be found at:
<https://novascotia.ca/dhw/ppcact/>

Statistical Information

Historical Statistics:

Fiscal Year	Calls Received (Total)	Calls Received (Hospitals)	Calls Received (LTC)	PPCA Investigations (Total)	PPCA Investigations (Hospitals)	PPCA Investigations (LTC)	Unfounded Cases of Abuse	Founded Cases of Abuse	Decision not yet determined
2018-19	513	149	364	74	16	58	40	34	0
2019-20	620	165	455	55	12	43	26	29	0
2020-21	534	143	391	51	11	40	20	31	0
2021-22	440	117	323	48	3	45	21	27	0
2022-23	455	147	308	60	13	47	17	42	1

Fiscal Year 2023-24 (Q1) Quarterly Statistics

	Calls Received (Total)	Calls Received (Hospitals)	Calls Received (LTC)	PPCA Investigations (Total)	PPCA Investigations (Hospitals)	PPCA Investigations (LTC)	Unfounded Cases of Abuse	Founded Cases of Abuse	Decision not yet determined
Apr-Jun	122	39	83	18	2	16	4	3	11
Jul-Sep									
Oct-Dec									
Jan-Mar									
Total	122	39	83	18	2	16	4	3	11

Fiscal Year 2023-24 (Q1) Quarterly Statistics (Investigations by nature of alleged abuse*)

	3(1)(a)	3(1)(b)	3(1)(c)	3(1)(d)	3(1)(e)	3(1)(f)	3(1)(g)
Q1 (Apr-Jun)	11	3	0	0	3	1	4
Q2 (Jul - Sep)							
Q3 (Oct - Dec)							
Q4 (Jan - Mar)							
Total	11	3	0	0	3	1	4

*3(1)(a) the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding;
 3(1)(b) mistreatment causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
 3(1)(c) the administration, withholding or prescribing of medication for inappropriate purposes;
 3(1)(d) sexual contact, activity or behaviour between a service provider and a patient or resident;
 3(1)(e) non-consensual sexual contact, activity or behaviour between patients or residents;
 3(1)(f) the misappropriation or improper or illegal conversion of money or other valuable possessions;
 3(1)(g) failure to provide adequate nutrition, care, medical attention or necessities of life without valid consent.

Protection for Persons in Care Investigation Summary

The following tables present a summary of investigations pursuant to section 8(2) of the *Protection for Persons in Care Act*. The summary includes the facility name, the nature of abuse investigated, whether the investigation was founded, unfounded, or a decision is yet to be determined, and whether directives were issued to the facility.

This summary is for information purposes only and represents findings regarding a specific incident at a particular point in time. The summary should not be used to form conclusions about the current or future quality of care offered by the identified health care facility.

To protect the privacy of residents, the names of facilities with 5 or less patients or residents have been redacted and replaced with "5 or less".

Table 1: 2022-23 Investigations

(Total = 60; Unfounded = 17; Founded = 42; Decision yet to be determined (TBD) = 1)

Facility	Nature	Decision	# of Directives
Aberdeen Hospital	3(1)(a)	Unfounded	4
Annapolis Royal Nursing Home	3(1)(b)	Founded	2
Arborstone Enhanced Care	3(1)(g)	Founded	5
Cape Breton Regional Hospital	3(1)(a)	Unfounded	3
Cape Breton Regional Hospital	3(1)(a)	Founded	1
Cape Breton Regional Hospital	3(1)(d)	Unfounded	5
Dartmouth General Hospital	3(1)(g)	TBD	TBD
Dartmouth General Hospital	3(1)(a)	Unfounded	3
Dykeland Lodge	3(1)(c)	Unfounded	5
East Coast Forensic Hospital	3(1)(e)	Founded	0
East Coast Forensic Hospital	3(1)(a)	Founded	0
Evergreen Home for Special Care	3(1)(g)	Founded	4
Evergreen Home for Special Care	3(1)(a)	Unfounded	2
Glace Bay General Hospital	3(1)(g)	Founded	4
Glen Haven Manor	3(1)(g)	Founded	3
Grand View Manor	3(1)(b)	Unfounded	4
Hants Community Hospital	3(1)(b)	Unfounded	3
Harbor View Haven	3(1)(g)	Unfounded	1
Harborstone Enhanced care	3(1)(a)	Founded	3
Harborstone Enhanced care	3(1)(b)	Founded	6
Harbourview Lodge	3(1)(g)	Founded	3
Heart of the Valley	3(1)(e)	Founded	4
Melville Gardens	3(1)(a)	Founded	2
Melville Lodge	3(1)(a)	Founded	2
Melville Lodge	3(1)(e)	Founded	2
Milford Haven	3(1)(b)	Founded	3

North Queens Nursing Home	3(1)(c)	Unfounded	5
Northside Community Guest Home	3(1)(g)	Founded	7
Northwood Bedford	3(1)(e)	Founded	2
Northwood Bedford	3(1)(d)	Unfounded	2
Oakwood Terrace	3(1)(g)	Founded	6
Ocean View Continuing Care Centre	3(1)(a)	Unfounded	4
Ocean View Continuing Care Centre	3(1)(e)	Founded	4
Ocean View Continuing Care Centre	3(1)(a)	Unfounded	2
Parkstone Enhanced Care	3(1)(e)	Founded	1
Parkstone Enhanced Care	3(1)(e)	Founded	2
Parkstone Enhanced Care	3(1)(a)	Founded	2
QEII	3(1)(b)	Founded	2
QEII	3(1)(e)	Founded	3
Richmond Villa	3(1)(g)	Founded	6
Saint Vincent's Nursing Home	3(1)(a)	Founded	3
Saint Vincent's Nursing Home	3(1)(e)	Unfounded	3
Saint Vincent's Nursing Home	3(1)(g)	Unfounded	3
Ivey's Terrace	3(1)(g)	Founded	5
Saint Vincent Nursing Home	3(1)(a)	Founded	2
Taigh Na Mara	3(1)(b)	Founded	2
The Admiral	3(1)(a)	Founded	0
The Admiral	3(1)(f)	Founded	2
The Birches	3(1)(g)	Founded	8
The Birches	3(1)(g)	Founded	6
The Birches	3(1)(e)	Founded	12
The Birches	3(1)(e)	Founded	9
The Cove Guest Home	3(1)(a)	Founded	0
The Mira	3(1)(g)	Founded	5
The Mira	3(1)(e)	Founded	7
Tideview Terrace	3(1)(a)	Unfounded	4
Valley Regional Hospital	3(1)(e)	Founded	2
Valley View Villa	3(1)(g)	Unfounded	7
Villa Acadienne	3(1)(g)	Founded	4
Waterford Heights	3(1)(b)	Founded	2

Table 2: 2023-24 (Q1) Investigations

(Total = 18; Unfounded = 4; Founded = 3; Decision yet to be determined (TBD) = 11)

Facility	Nature	Decision	# of Directives
Evergreen Home for Special Care	3(1)(g)	Founded	3
Evergreen Home for Special Care	3(1)(a)	Unfounded	4
Fisherman's Memorial Hospital	3(1)(a)(g)	TBD	TBD
Glen Haven Manor	3(1)(a)	TBD	TBD

Facility	Nature	Decision	# of Directives
Harborstone Enhanced Care	3(1)(g)	Unfounded	2
Melville Lodge	3(1)(a)	TBD	TBD
Northwoodcare	3(1)(a)(b)	Unfounded	5
Ocean View Continuing Care Center	3(1)(a)	TBD	TBD
Ocean View Continuing Care Center	3(1)(e)	TBD	TBD
RK MacDonald Nursing Home	3(1)(g)	TBD	TBD
Seaview Manor	3(1)(a)(b)	TBD	TBD
The Admiral Long Term Care Centre	3(1)(e)	TBD	TBD
The Mira	3(1)(e)	Founded	2
The Mira	3(1)(a)	TBD	TBD
Tideview Terrace	3(1)(a)(b)	Unfounded	3
Victoria Haven	3(1)(f)	TBD	TBD
Whitehills Long Term Care Centre	3(1)(a)	Founded	0
Yarmouth Regional Hospital	3(1)(a)	TBD	TBD