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Québec Ombudsman's Brief presented to the Commission de la santé et des services sociaux

The living conditions of adults accommodated in long-term and residential care centres — initiative mandate

Québec City, February 17, 2014

Mission of the Québec Ombudsman

The Québec Ombudsman ensures that the rights of citizens are upheld by intervening with Québec government departments and agencies and the various bodies within the health and social services network to rectify situations that are prejudicial to a person or a group of people. Appointed by the elected members of all political parties and reporting to the National Assembly, the Québec Ombudsman acts independently and impartially, whether an intervention is undertaken in response to a complaint or series of complaints or on the institution's own initiative.

Respect for users and their rights and prevention of harm are at the core of the Québec Ombudsman's mission. Its role in prevention is exercised, in particular, by the systemic analysis of situations that cause harm to a significant number of citizens.

Pursuant to the powers conferred upon it, it can propose amendments to acts and regulations and changes to directives and administrative policies with a view to improving them in the best interest of the people concerned.

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When the masculine form is used, it is intended to be gender-inclusive.

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Introduction

This brief is submitted to the Committee on Health and Social Services (the Committee) to support its reflection concerning the living conditions of adults accommodated in long-term and residential care centres (CHSLD). The Québec Ombudsman is participating in this Committee with great interest, considering its mission[1] of ensuring, in particular, respect for the right of CHSLD residents to receive an appropriate, personalized and safe response to their needs in their substitute living environment.

This brief is consistent with the angle of consultation chosen by the Committee[2], i.e. accommodation in CHSLDs. However, the Québec Ombudsman, from the outset, emphasizes the importance, in its view, of considering accommodation and care for seniors as part of a continuum of services, including home support services, access to hospitals (emergency rooms, acute care, extended care) and temporary accommodation. This overview recognizes that seniors whose profile would allow them to have access to a CHSLD are not all accommodated in this type of institution, due to a shortage of places. Therefore, the profile of needs in temporary resources, hospitals and home support is growing heavier. The impact of this reality on the demand for, organization of and quality of services, and on respect for seniors' rights must not be hidden.

This brief by the Québec Ombudsman discusses the nine challenges adopted by the Committee, in the order it chose. It includes suggestions to the Committee, in view of its status and its role. In this context, contrary to its usual practice, the Québec Ombudsman is not making recommendations - which it would address to a government body or the Government itself - but rather suggestions, which it formulates in respect for the prerogatives of a parliamentary committee.

Despite the significant efforts deployed by the different stakeholders to favour a quality supply of care and services, the Québec Ombudsman has found, while processing complaints submitted to its attention, that problem situations remain. The reflection on this issue must therefore have the constant concern of offering an appropriate response to the users' needs, at all times and in all places. Even though dissatisfaction is generally the triggering factor of its intervention, the Québec Ombudsman wishes to emphasize to the Committee's members that it often recognizes the good will, expertise and dedication of CHSLD staff. It hopes to reiterate the importance of their work with and for the accommodated individuals. Several of the issues raised in this brief go beyond their capacity and good will.

Slightly over 13% of all grounds of complaint and reporting addressed annually by the Québec Ombudsman in the health and social services network involve care and services provided in CHSLDs, and the safety and quality of life of the people who live there. Thus, since April 2008, a total of 831 grounds of complaint and reporting concerning the CHSLDs have been routed to the Québec Ombudsman. After investigation, we concluded that more than half (51%) of them were substantiated, compared to 43% for the health and social services sector as a whole.

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[1] Public Protector Act (Chapter P-32) and Act respecting the health and social services ombudsman (Chapter P-31.1).

[2] Commission de la santé et des services sociaux, 2013, *Les conditions de vie des adultes hébergés en centre d'hébergement et de soins de longue durée*, Document de consultation, Mandat d'initiative, 28 p.

The findings and analyses presented in this brief are based primarily on the problems identified during our investigations, because the Québec Ombudsman does not draw conclusions solely on the basis of allegations and hearsay, but following a methodical investigation that allowed the facts to be verified. **Over the past five years, the Québec Ombudsman intervened in 128 CHSLDs, representing 63% of the CHSLDs in Québec.** The substantiated complaints and reports concerned **the quality of care and services** (36%), **the physical environment and the living environment** (23%) and **non-respect for rights** (16%). These three problems account for 75% of the total complaints and reports. For the year 2012-2013 alone, 56 of the 202 CHSLDs (28%) listed by the Committee [3] were the object of substantiated complaints or reports.

It is appropriate to mention that, considering the nature of the Committee's initiative mandate and within the context of this short exercise, we cannot claim to present an exhaustive compilation of all the factors that affect the living conditions of CHSLD residents. In fact, the Québec Ombudsman has chosen to present the observations it considers the most promising with regard to the objectives adopted by the Committee. Out of concern for clarity, these observations are integrated into the analytical framework submitted by the Committee, and are inspired by the challenges listed and the avenues of discussion proposed.

1 Accessibility

Regarding the challenge of accessibility, the avenues of discussion proposed by the Committee concern the admission criteria, the conditions of access, the measures to be adopted to reduce the wait times, both in the regions and in urbanized areas, and the transitional measures. These transitional measures, in particular, are the focus of the Québec Ombudsman's major concerns. The conclusions we reach reveal the management imperatives which, too often, are prioritized to the detriment of the response to the users' overall needs.[4]

Upstream from the users' living conditions once they are admitted to a CHSLD, the entire question of the accessibility of this type of accommodation must be discussed. Although the Act respecting health services and social services (AHSSS)[5] states that users have the right to choose the institution from which they wish to receive health services or social services, this right, which is conditional rather than absolute, is more theoretical than systematically applicable.

Respect for this right is often relegated to the back burner, to the benefit of network management imperatives. The pressure to relieve hospital overcrowding, the long waiting lists for certain CHSLDs and the disparity in the supply of accommodation places depending on the territory are all pitfalls in respecting the users' freedom to choose their last living environment. In the regions, the frequent absence of critical masses of users leads to additional problems of mixed clienteles and results in even more difficulties recruiting qualified staff.

[3] *Op. cit.*, note 2, p. 6.

[4] These needs include consideration of psychosocial factors, such as remoteness from a close relation or a spouse who is often aged as well.

[5] Act respecting health services and social services, Chapter S-4.2, hereinafter AHSSS

1.1 Inordinately long delays

The wait time of a place in a CHSLD varies greatly depending on the region and the facility. Users may wait for the place of their choice for over a year, and sometimes two; in the meantime, they will be admitted to another CHSLD for temporary accommodation. Frequently users do not even have time to benefit from the accommodation place they had chosen as their last living environment: they will die before they gain access.

The CHSLD eligibility criteria and the rigidity of their application mean that many users and their relatives are surprised not to be directed, at the time of their request, to the institution of their choice. In the meantime, the users and their families are very strongly encouraged to accept a temporary living place. Some tell us they felt rushed by the people responsible for the access procedure and had not clearly understood the complex conditions of their accommodation. Moreover, they do not always benefit from correct information on the wait times, which leads them to make a decision that may be prejudicial to them. This is another source of dissatisfaction and concern for users. Some delays are unreasonable. While showing empathy, the case workers often tell the families they feel powerless in the face of the established rules and the imperative of decongesting the hospitals, which appears to be unavoidable priorities.

1.2 Temporary accommodation precipitated by management imperatives

The pressure to decongest the hospitals may lead to hasty decisions that will be prejudicial to the users. The Québec Ombudsman has denounced this problem, particularly in its 2011-2012 annual report.[6] It had to intervene that year due to a rushed transfer of some users to a temporary accommodation unit[7] hastily developed in a CHSLD. This approach, dictated by the intention to free up too many acute care hospital beds too quickly, caused harm to the residents. A transfer of their place of accommodation for individuals with this degree of vulnerability is a major source of stress for them, which can cause a deterioration of their state of health.

Hospital emergency room decongestion that compromises users' health and safety

Sixty or so seniors with loss of autonomy were transferred from a hospital, where they were waiting for permanent accommodation, to a temporary living unit developed hastily to receive them.

This unit was created in a rush, in a context of decongestion of the hospital emergency room; the hospital wanted to improve its capacity by freeing up beds. The special context of the unit's opening means that, within 30 days, the CSSS had to adapt the premises, install the required equipment, recruit and train staff, organize the medical personnel, identify and evaluate the clients to be transferred, notify the families and prepare the transfers.

The temporary unit was opened on December 13th. Between December 13th and 23rd, within 10 working days, 60 users were transferred to the unit, which had a major negative impact for some of them in medical and psychological terms.

[6] Protecteur du citoyen, 2012, *Rapport annuel d'activités 2011-2012*, p. 127-128.

[7] A temporary living unit can be developed in a public CHSLD or a private CHSLD under agreement. Temporary accommodation places can also be purchased through agreements with private or intermediate resources. Systematic reliance on temporary accommodation as a first step to permanent accommodation is discussed later in this brief.

To prevent such situations from recurring, the Québec Ombudsman's recommendations addressed the three decision-making levels of the network: first, the CSSS, to proceed with the implementation of an access plan in this matter; then the health and social services agency, to take the appropriate measures to ensure monitoring of the corrective actions taken by the institutions in response to the requests for emergency room decongestion; and finally, the MSSS, to adopt the appropriate measures in order to ensure that the institutions and the agencies do not put other users at risk through rushed implementation of solutions to decongest emergency rooms.

As this report was being written, the Québec Ombudsman was contacted by a family who opposed the transfer of a close relative to temporary accommodation: this transfer would move this senior far from her environment, on top of depriving her of the assiduous presence of her spouse, the only person she still recognizes. The family and the case worker fear that the user's transfer under these conditions will lead to a deterioration of her state of health.

This transfer is also required to respond to management imperatives. First of all, the user has occupied a hospital bed for several months, waiting for a place that meets her needs to become available in one of the targeted CHSLDs, by agreement with the family. Secondly, a place has become available in another CHSLD farther away and the user is the only person on the waiting list who meets the profile required to occupy this bed. Another temporary move could be made later, when a place becomes free in one of the CHSLDs originally targeted. Finally, when a place becomes available in the targeted CHSLD for permanent accommodation, the user will be transferred again.

The Québec Ombudsman is concerned about different solutions proposed to favour hospital decongestion, because they hinder the users' freedom to choose their living environment. The same principle applies to the imposition of a penalty in case of default by the CSSS in taking charge of a user occupying a hospital bed, within 8 days of the end of the user's active care, either by offering home support services or by moving the user to a resource with which the CSSS will have made an agreement. Due to a shortage of available places in public CHSLDs or private CHSLDs under agreement, agreements then are made to purchase temporary accommodation places from private resources. The Québec Ombudsman is apprehensive about the proliferation of such inadequately supervised agreements.

Some of these agreements are made with private seniors' residents for the purchase of "intermediate resource" places. Such agreements raise concerns regarding control of the quality of the services and care provided to the users, which we will discuss later. Under the Act,[8] however, these users are entitled to receive the same quality of care and services, regardless of the place where the network directs them for their temporary or permanent accommodation.

The five avenues of reflection proposed by the Committee attest to its sensitivity to the main problems confronting seniors with loss of autonomy looking for public residential care. Access to the public system is limited by Inordinately long wait times, rigidity in the application of admission criteria, and systematic reliance on temporary accommodation as the first step. These situations generate a sense of powerlessness among seniors and their families regarding rigid and little-known rules.

[8] AHSSS, s. 5.

Our analysis of the situation of seniors waiting for accommodation reveals that the biopsychosocial factors that have a determining impact on the users' general health are not sufficiently taken into account in the management decisions for temporary accommodation. The imperative of decongesting the hospitals appears to take precedence. Given that population aging is increasing, that there is already a long wait to gain access to a CHSLD, and that the number of places is stagnant and even decreasing,[9] the Québec Ombudsman can only question the actual accessibility of CHSLD places for the next generation. This is the context in which it suggests that the Committee further explore the following factors with the aim of improving the living conditions of adults accommodated in CHSLDs.

CONSIDERING :

That the inordinately long wait times, rigidity in the application of admission criteria and systematic reliance on temporary accommodation as the first step limit access to the public system:

That the biopsychosocial factors that have a determining impact on the users' general health are not sufficiently taken into account in the management decisions for temporary accommodation;

The recognized decrease in the number of places in public CHSLDs and private CHSLDs under agreement and the increase in the demand for public residential care.

The Québec Ombudsman suggests that the Committee:

S-1 Request the Minister of Health and Social Services analyze the conditions of access to accommodation, including the realistic wait and the consequences of systematic reliance on temporary accommodation to assure users and their close relatives of the same quality of services.

S-2 Pay special attention, within the context of these analyses of the conditions of access to accommodation, to the quality of communications with seniors and their families, so that they are provided with accurate, complete, transparent and timely information.

S-3 Ask the Minister of Health and Social Services for a quantitative and qualitative analysis of the foreseeable increase in the demand for public residential care for the next few years, accounting for the imperatives of emergency room and active care bed decongestion in the hospitals, and an action plan addressing these issues.

2 Funding

The Committee submits two important avenues of discussion regarding the challenge of funding of the public CHSLDs and private CHSLDs under agreement. In these avenues of discussion, the Québec Ombudsman intends to introduce certain special concerns regarding the impact of funding of accommodation for spouses and families.

[9] According to the Committee's consultation document (supra, note 2, p. 12), between 2006 and 2010, there was a decrease of nearly 4% in the number of places in public CHSLDs and private CHSLDs under agreement.

2.1 The current funding of public CHSLDs and private CHSLDs under agreement

According to Les Comptes de la santé,[10] a document produced by the Ministère de la Santé et des Services sociaux, the costs related to institutional accommodation of adults are high, amounting to $2.89 billion in 2012-2013. Funding of public CHSLDs and private CHSLDs under agreement thus is generated at 78.3% from the Québec Consolidated Revenue Fund, which is fed mainly by taxes and financial transfers collected by the Government. The remaining 21.7% comes from the users' financial contribution. We will return to this in the next section.

The Committee questions the current funding of the public CHSLDs and private CHSLDs under agreement. In this regard, it is appropriate to remember that the AHSSS[11] entrusts these institutions with the mission to provide adults with loss of functional autonomy who can no longer live in their natural environment, despite the support of their families and friends. This is what justifies public funding of these institutions, which essentially covers the care and health and social services provided there, while the private portion of the funding covers bed and board. **In the Québec Ombudsman's opinion, there is no reason to change this fundamental allocation at the basis of funding of public residential care.**

This allocation in no way prevents the diversification of funding mechanisms. For example, the creation of the "autonomy insurance fund", provided for in Bill 67,[12] concerns the introduction of an eventual autonomy insurance plan.[13] This bill provides that an autonomy support allowance would be paid to all recognized recipients, including the public CHSLDs and private CHSLDs under agreement.[14] This payment would be provided for the delivery of all the services they offer and that are provided for in their residents' individualized service plan. This would have an impact on the allocation of funding, because these same users would also be called on to contribute financially for an as yet undetermined proportion of these services. In the Québec Ombudsman's opinion, it will be necessary to think about the harmonization of pricing practices in this specific context, in the event of the creation of the "autonomy insurance fund".

Several types of public and private resources accommodate seniors who are losing their autonomy: these mainly include public CHSLDs, private CHSLDs under agreement, private CHSLDs (not under agreement), CHSLDs in public-private partnership, intermediate resources, family-type resources and private seniors' residences. The funding mode of these resources is the result of several acts and regulations. Their application sometimes results in inequities. For example, several private CHSLDs complain of inequities in the daily indemnity per user they are granted, under various service agreements, relative to the one granted to other resources. This poses the fundamental question of the harmonization of funding mechanisms according to the public or private resources concerned. In the Québec Ombudsman's opinion, an additional effort must be made in this sense, which will have to be based on a rigorous certified accounting review of the statements of income and expenses of these resources.

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[10] Ministère de la Santé et des Services sociaux, 2013, *Comptes de la santé 2010-2011, 2011-2012, 2012-2013*, Direction des communications, p. 25.

[11] AHSSS, s. 83, 512 and 513.

[12] Bill 67, *Autonomy Insurance Act, s. 27 to 29 and 31*.

[13] Ministère de la Santé et des Services sociaux 2013, *Autonomy for All — White Paper on the Creation of Autonomy Insurance*, 45 p.

[14] The White Paper on Autonomy Insurance provides that services for assistance with activities of daily living (ADL), currently delivered free of charge by the health and social services centres (CSSS), could be opened up to pricing and delivered by new recognized service providers.

2.2 CHSLD pricing

The users' financial contribution amounted to $618 M in 2012-2013, or 21.7% of the total cost, according to Les Comptes de la santé.[15] During the same period, the maximum contribution applicable to a CHSLD user for a private room was $1,743 per month. The financial effort allocated, both by the accommodated persons and by public funds, is therefore substantial.

According to the AHSSS,[16] room and board are essentially private and are governed by standards and regulations. They are not part of the public coverage. Therefore, the fact of residing in a CHSLD or receiving services at home should be financially and fiscally neutral.[17] Moreover, the website of the Régie de l'assurance maladie du Québec[18] indicates, in its section on the users' contribution in a public facility, that *this contribution responds to a concern for equity between the accommodated persons and those living at home.* The Québec Ombudsman subscribes to this principle of equity, but is concerned about ensuring real equity when the time comes to apply it.

The user's contribution should correspond to the actual cost of the expenses related to room and board. While recognizing that it is high, the requested contribution is not the object of complaints or reports to the Québec Ombudsman regarding the total cost charged to the users.[19] Also, the maximum contribution should be revised only to the extent that a distortion exists between the effort requested for a person living at home and a person living in a CHSLD.

Moreover, as it indicated in its brief[20] on autonomy insurance, the Québec Ombudsman does not oppose a financial contribution by the users, but this must never become an obstacle to obtaining services. The users' financial participation must not widen the income gaps that exist between individuals for access to public residential care. The parameters for pricing room and board must be explicit, detailed and fair, both for the most affluent and the least affluent. The Québec Ombudsman is especially concerned about the rates that will be charged to the lower income population who reach retirement with less income than those who are better off financially.

In other words, the financial burden resting on the shoulders of the least affluent must be less than the burden of the most affluent for the benefit to be equivalent. This is why the existing conditions allowing a reduction of the contribution charged to the least affluent individuals – a program administered by the Régie de l'assurance maladie du Québec – must be maintained. This is how CHSLD pricing shows proof of distributive justice, as advocated by the Québec Ombudsman.

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[15] *Op. cit.*, note 10, p. 25.

[16] AHSSS, s. 512 and 513.

[17] There is financial neutrality when public funding does not alter the market's flows and mechanisms. The principle of fiscal neutrality is present when the allocation of public charges is proportional to each person's income. Then there is distributive justice in the Québec Ombudsman's opinion.

[18] http://www.ramq.gouv.qc.ca/fr/citoyens/programmes-aide/Pages/hebergement-etablissement-public.aspx

[19] In February 2014, the rate for a private room is $1,758.30 per month. The rate is $1,470 for a room with two beds and $1,092.60 for a room with three beds.

[20] Protecteur du citoyen, 2013, *Mémoire du Protecteur du citoyen présenté à la Commission de la santé et des services sociaux dans le cadre des consultations particulières et auditions publiques sur le document intitulé : L'autonomie pour tous — Livre blanc sur la création d'une assurance autonomie*, November 12, 2013, 33 p., p. 1.

2.3 The Québec Ombudsman's special concerns

The Québec Ombudsman wishes to draw the Committee's attention to certain special concerns it has regarding CHSLD pricing. The complaints and reports it receives in this regard pertain almost exclusively to the Regulation respecting application of the Act,[21] which governs the contribution of users living in CHSLDs. This regulation has not been revised in over 15 years and results in a growing number of inequities in its application. It is still governed by certain provisions of the Regulation respecting social aid, dating from July 1, 1983.[22] In our opinion, the approach in place does not account sufficiently for the human aspects of accommodation in CHSLDs and should be improved.

The RAMQ is responsible for establishing the contribution a facility collects from the accommodated person. The MSSS determines the maximum cost payable according to the room occupied, and the RAMQ determines this person's ability or inability to pay the maximum rate, accounting for the accommodated person's income, property, savings and financial position, in particular. The calculation of this contribution provides for a base exemption of $2,500 for liquid assets. It also accounts for certain deductions for the personal expenses of the accommodated person, the spouse, dependent children, or the obligation to cancel a lease. Once this rate is determined, the person may ask the RAMQ for an exemption or a reassessment if his or her financial position changes.

Under the regulation in force, married persons must contribute for their spouse, who is considered a dependent. De facto spouses are not bound by this obligation. Some case workers have advised long-time married couples to get a "divorce of convenience" so they can benefit from rate exemptions. This is inadmissible in human terms. The Québec Ombudsman reported these problems to the MSSS in February 2013: it has been too long since this regulation was last reviewed and it does not provide for any mechanism allowing the authorities to suspend or adjust payment of the required contribution in circumstances considered exceptional. One year later, we are still waiting for the plan and timeline of the work concerning the review of this regulation.

In the Québec Ombudsman's opinion, special measures must be provided for and implemented when these exceptional situations arise.

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[21] Regulation respecting the application of the Act respecting health services and social services and the Act respecting health services and social services for Cree Native persons(chapter S-5, r. 1), applicable despite its title to all clienteles.

[22] This regulation has since been replaced by the Individual and Family Assistance Regulation (chapter A-13.1.1, r. 1), but the RAMQ still considers the amounts of $40,000 and $2,500 in the calculation of the exemptions for the residence and liquid assets, even though they are $90,000 and $5,000 in the new regulation.

CONSIDERING

That the CHSLD pricing is supposed to cover the portion relating to accommodation expenses (room and board), since healthcare and social services are assumed by public funding;

The potential impact of the creation of an autonomous insurance fund on the CHSLD funding mode;

The necessity of updating and reviewing the normative framework concerning CHSLD pricing.

The Québec Ombudsman suggests that the Committee:

S-4 Examine the conditions of harmonization of rate practices, maintain the existing conditions allowing reduction of the contribution asked of the least affluent people, and oversee the means that will be implemented with the aim of informing the users clearly in this regard.

S-5 Ask the Minister of Health and Social Services for a status report on the plan and the timeline of the work concerning the review of the Regulation respecting application.

3 Organization of services

The avenues of discussion submitted by the Committee for the challenge of organization of services mainly concern the application of the living environment concept in the CHSLDs, the improvements that could be made to the CHSLDs in this regard and the examples of success in this matter. The investigations the Québec Ombudsman conducts put it in a privileged position to document the problems encountered in the application of the living environment concept and to suggest certain improvements. However, the examples of success would necessitate an in-depth study we have not conducted in view of the limited resources at our disposal and the angle from which we are asked to intervene. Public funding bodies, including the Institut national d'excellence en santé et en services sociaux (INESSS) and the Health and Welfare Commission have such a mandate.

3.1 Complaints on the quality of care and services in living environments

The main complaints by the public are allegations that the quality of the clinical care and services (36%) they receive in public and private residential care resources is unsatisfactory.

The complaints and reports more specifically concern the development and content of the care plans, assistance care, physical care and medication. However, the CHSLDs are the end-of-life residence of the majority of the people they accommodate and who need sustained special attention, in addition to specific care and services. Making CHSLDs quality living environments requires a vision, resources and constant vigilance, due to the incapacity of many residents with severe loss of cognitive abilities. Some private seniors' residences have difficulty ensuring a pleasant, warm living environment that generates a sense of security and belonging. In its annual reports over the past five years, the Québec Ombudsman has pointed out several failings it has noted in living environments for seniors.

Thus, the findings in the 2008-2009 annual report[23] revealed breaches related to inadequate care and services, and a deficient physical environment, particularly in matters of hygiene and cleanliness. They also targeted the difficult relations between staff members and residents or their close relations, in addition to non-respect of the rights of accommodated persons in some circumstances. The 2009-2010 annual report[24] concluded that certain CHSLDs and intermediate resources have not succeeded in appropriating the living environment concept. In particular, they are unable to recreate a pleasant and stimulating environment for the residents.

In 2010-2011,[25] the annual report indicated a substantial increase in complaints and reports concerning the different residential care resources. More specifically, in private seniors' residences, communications and residents' participation in their living environment were often neglected to the benefit of management more focused on administrative imperatives than on the seniors and their particular needs.

The 2011-2012 annual report[26] found problems of deficient organization of care and services, non-compliance with the clinical procedure and protocols and insufficient monitoring, supervision and quality of support or assistance services for activities of daily living. The 2012-2013 annual report[27] put the focus back on the clinical aspects cited above and highlighted staff attitude and behaviour problems as grounds of several founded complaints. Moreover, a special concern was expressed regarding the quality of care and services provided to seniors accommodated in private residential care resources under agreements for the purchase of places by the public network. **To summarize, the situation in the CHSLDs is constantly evolving and the problems encountered are numerous and varied.**

3.2 Investigations in seniors' living environments

The substitute living environment offered by the CHSLDs must be as close as possible to the person's natural living environment, despite the increased level of necessary care. This idea of a substitute living environment, "equivalent" to the natural living environment despite the intensity of required care, is at the core of the living environment concept. The field investigations conducted by the Québec Ombudsman reveal several failures in this regard.

During our visits to the facilities of the public network, we found various situations that confirm the unsuitability of the environment and the absence of organized activities: residents who, for any distraction, are placed in a row in front of the entrance doors or the elevators; the little or no exchange or communication between the staff and the residents during care; an atmosphere that is more similar to an institutional environment than a living environment.

The living areas and the users' rooms should offer a welcoming, personalized, lively and inviting ambiance. Complementary community animation is desirable, by means of a program of adapted activities, developed on the basis of knowledge and understanding of the users' needs, tastes, lifestyle, aptitudes and fields of interest, while respecting their culture and language. In accordance with the living environment concept, intervention

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[23] Protecteur du citoyen, 2009, *Rapport annuel d'activités 2008-2009*, p. 63.

[24] Protecteur du citoyen, 2010, *Rapport annuel d'activités 2009-2010*, p. 96.

[25] Protecteur du citoyen, 2011, *Rapport annuel d'activités 2010-2011*, p. 87.

[26] *Op. cit*., note 6, p. 127.

[27] Protecteur du citoyen, 2013, *Rapport annuel d'activités 2012-2013*, p. 77.

in CHSLDs should translate into a comprehensive, adapted, positive, personalized, participatory and interdisciplinary approach. [28] The findings of our investigations indicate this is not the case in some CHSLDs.

3.3 A shortage of places adapted to a specific clientele

The Québec Ombudsman notes a shortage of places adapted to users exhibiting serious behavioural disorders with a potential for aggression and violence. The critical mass of users is not always sufficient in the regions for institutions to establish a specific unit where the environment and the program of services would offer an adapted response to their needs. The problem of accessibility of well-organized specialized units results in cohabitation in the same unit of people exhibiting very different, and even incompatible, characteristics and profiles: lucid users with reduced mobility cohabit in the same unit with users who wander invasively or who suffer from frontotemporal dementia with aggressive behaviour. The safety risk is increased accordingly.

3.4 Safety

The reported situations of assaults amongst residents reveal a problem of mixed clientele, combined with a deficient organization of care and services. This is another finding revealed in the Québec Ombudsman's annual reports since 2008-2009. The problem persists and is accentuated due to the raising of the eligibility criteria and the growing number of residents suffering from dementia associated with aggression and violence. Some of these situations have serious consequences for the users, as we have observed: accelerated deterioration of the health condition of the assaulted individual, and even death; a major increase in medication for the person who perpetrated the assault, with the associated side effects; high management costs for assignment of staff to constant monitoring of the person who perpetrated the assault.

In the prosthetic unit of a CHSLD, a female resident was the victim of multiple assaults that could have been prevented

A female resident lived in a prosthetic unit intended for seniors with severe cognitive deficits. She was the victim of several physical assaults by two male residents. She died shortly after the assaults.

One of the two residents at the origin of the assaults had previously perpetrated around forty violent acts, including eleven physical assaults perpetrated within one month, and this was known to the staff and the administration of the institution. Also, a behavioural evaluation had confirmed that this resident provoked fear in the people around him and had inflicted many injuries on other residents and employees.

The "prosthetic" unit includes all the problem residents from the other units of the residential care centre. Moreover, 20 residents live in this unit, which is practically double the number of residents recommended for a unit of this type. The unit's physical environment is very conducive to assaults, with small and poorly marked rooms, narrow corridors and an inadequate layout. Moreover, the care team is very unstable: 40% of the staff come from private agencies. There is no team dedicated to the unit. The unit head's supervision and leadership are insufficient and interdisciplinary meetings have been interrupted.

[28] Ministère de la Santé et des Services sociaux, 2003, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD – Orientations ministérielles*, 24 p., p. 10

It is recognized that certain needs profiles are incompatible and that cohabitation of these users is undesirable. Although grouping the clientele according to their needs and the creation of "micro-environments" are recognized as ways to favour a more personalized and safe response to the users' needs, they are not always used or easy to achieve for some CHSLDs, which have difficulty adapting the premises accordingly. The short lead times for admitting new residents and the architectural constraints are major hindrances to the creation of these groupings.

Obsolete and unadapted physical premises and too many residents with different profiles sharing the same environment increase the risk level for their safety, from several angles. This is the conclusion of the Québec Ombudsman's reflection regarding residents' safety. Moreover, for the substitute living environment offered by the CHSLD to be as close as possible to the person's natural living environment, measures to adapt the interventions must be taken in several CHSLDs, within the context of the living environment approach.

In winter 2010, the MSSS tabled a national report[29] to evaluate the level of integration of the living environment approach in the CHSLDs, between 2004 and 2007. Its highlights revealed that the activities of daily living did not necessarily conform to reasonable practices and that maintenance of the users' abilities was not always favoured. The Québec Ombudsman had favourably received the findings and recommendations regarding this evaluation of the living environment approach. But today, in 2014, has the situation improved? Are the orientations regarding the living environment approach implemented any better?

CONSIDERING

That the substitute living environment offered by the CHSLDs must be as close as possible to the person's natural living environment, despite the increased level of care necessary.

The necessity of ensuring the physical integrity and psychological integrity of all residents;

The diversity of the needs profiles of people accommodated in the same CHSLD unit;

That the last national evaluation report on the living environment approach dates back to 2010.

The Québec Ombudsman suggests that the Committee:

S-6 Request the Minister of Health and Social Services to update the evaluation of the living environment approach within the context of the preparation of a new national report on visits assessing the quality of services and ensure effective follow-up.

[29] Ministère de la Santé et des Services sociaux, 2010, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD – Visites d'appréciation de la qualité – Rapport national 2004-2007*, MSSS, 67 p.

4 Special care clienteles

Regarding the challenge of special care clienteles, the first avenue for discussion submitted by the Committee concerns cohabitation in CHSLDs of under-65 and over-65 clienteles. Given that the Québec Ombudsman receives few complaints and reports on this ground, it can only shed limited light on this avenue of discussion. Moreover, surveying the positive experiences of the under-65 CHSLD clientele, determining the special difficulties experienced by Aboriginals, allophones and Anglophones, and discussing the measures implemented to alleviate these problems would require the development of several field interventions.

According to the data provided by the Committee in its consultation document,[30] 11% of users under 65 lived in a public CHSLD or a private CHSLD under agreement as of March 31, 2012. This represented 4,117 younger people, sometimes several decades younger, who reside in a living environment, the vast majority of which is designed for seniors with severely diminished autonomy. According to the Committee, this under-65 clientele is "heterogeneous and little known". For the Québec Ombudsman, this statement raises questions: what are the profiles of this specific clientele accommodated in CHSLDs? Who can adequately inventory their needs? The Québec Ombudsman considers that the Ministère de la Santé et des Services sociaux has the necessary leverage to do so.

Based on the complaints and reports it receives, the Québec Ombudsman considers that people under 65 living in CHSLDs are confronted with a problem of accessibility of a living environment better adapted to the characteristics inherent to their age, their fields of interest and their tastes. Sometimes, they are young adults who are severely handicapped or who have a degenerative pathology requiring more than three hours of care per day and for whom no other residential service is available.

In the absence of a living environment adapted to their special situation, the public CHSLDs or private CHSLDs under agreement then become their substitute living environment. When there is an absence of critical mass to develop the residential blocks model, for example, the CHSLDs must display creativity and innovation to adapt their services to this clientele's special needs. For example, this may involve adapting the meal or wakeup schedules so that they correspond better to a younger clientele's lifestyle.

Also, the partners of these local networks (CSSS, rehabilitation centres serving people with physical or intellectual disabilities and invasive development disorders) must mobilize to offer these people under 65 the necessary services to maintain their social participation. The social integration activities included in the individualized action plan should continue through service agreements with the institutions concerned.

[30] *Op. cit.*, note 2, p. 9.

CONSIDERING

The Committee's finding whereby the profiles and the needs of the under-65 clientele accommodated in CHSLDs must be defined further and better known;

The legitimate expectation of this under-65 clientele accommodated in CHSLDs to benefit from a living environment that better meets their needs and aspirations.

The Québec Ombudsman suggests that the Committee:

S-7 Request the Minister of Health and Social Services identify an institutional player or a recognized research group that can establish the profiles of the under-65 clientele accommodated in public CHSLDs or private CHSLDs under agreement.

S-8 Ask the Minister of Health and Social Services to take the required steps quickly to adapt the living environment approach to the profiles of the under-65 clientele accommodated in public CHSLDs or private CHSLDs under agreement, and the offering of services available, by means of tools such as the individualized service plan.

5 Natural caregivers

Like the Committee, the Québec Ombudsman recognizes the essential role played by natural caregivers regarding the quality of services delivered in CHSLDs. The avenues of discussion put forward by the Committee pertain to the development of partnerships among the CHSLDs, the natural caregivers and the residents, and to the conclusive experiences in this regard.

The decision to accommodate a senior often results from burnout of a natural caregiver who can no longer cope, despite all his or her good will, in responding to the user's needs. It is then expected that once the user is accommodated in a CHSLD, the staff will take over and meet the user's needs as personally as the natural caregiver, while ensuring the user's safety at all times. Some natural caregivers are disappointed to find that the staff's availability does not allow them to respond promptly to the needs expressed by many users.

5.1 Complaints regarding natural caregivers

In the processing of complaints and reports, the Québec Ombudsman finds that natural caregivers do not always benefit from accurate information on the limits and ability of the CHSLD to meet the needs of the accommodated clientele. Also, they have little information on the various types of profiles of persons likely to be admitted to a CHSLD. They regularly ask the Québec Ombudsman to ensure that a resident with behavioural disorders who is disturbing the user is redirected to another type of facility because, according to them, he "clearly isn't in the right place". Better management of the expectations of family members or close relatives, at the time of admission, would favour a better understanding on their part for the entire period of the user's stay.

Moreover, natural caregivers say they feel excluded once the user is accommodated in a CHSLD. They are often confronted with faits accomplis. Decisions are made daily for the users' welfare, especially if they have seriously diminished autonomy, without necessarily addressing, involving and consulting them: on the wakeup and bedtime schedule and the bath schedule, for example. The Québec Ombudsman regularly observes the distress of natural caregivers who deplore that they are not informed about what is happening regarding their relative.

The drafting of the intervention plan, as required by the Act, is a privileged opportunity to favour the natural caregivers' participation in the decisions concerning the user. However, even when they are invited to participate in a meeting to draft the plan, are frequently only informed after the fact, without the facility really seeking their concrete engagement. However, the drafting of the intervention plan precisely makes it possible to ensure a shared knowledge and understanding of the user's needs and the services that will be deployed by the CHSLD to respond to them.

In short, one must not underestimate the importance of communications and exchanges of privileged information with the natural caregivers, which is the very basis of a solid partnership with them. The more these communications will be favoured, the more the natural caregivers will feel listened to and involved, because the bond of trust will be established and lasting. Thus, they will express less dissatisfaction with the care and services received. In conclusion, the Québec Ombudsman recognizes that the families' complaints result in part from a poor understanding and a lack of information regarding the conditions of delivery of services to the user.

5.2 The impact of Bill 67 on natural caregivers

If it is adopted, Bill 67, the *Autonomy Insurance Act*, will have a positive impact on natural caregivers. Indeed, they would henceforth be eligible,[31] under the future autonomy insurance plan, for support, respite, assistance or training services. In the Québec Ombudsman's opinion, this is an essential factor. Natural caregivers thus would be considered more as co-users and, in this capacity, could benefit better from essential services enabling them to perform this role over a longer period.

CONSIDERING

The essential role played by the natural caregiver with the person accommodated in a CHSLD;

The necessity of strengthening open and frank communication between the facilities and the natural caregivers;

The potential impact of Bill 67, the *Autonomy Insurance Act*, concerning the support the natural caregiver can receive.

The Québec Ombudsman suggests that the Committee:

S-9 Make the connection between the current work resulting from its initiative mandate and the work regarding the study of Bill 67, the *Autonomy Insurance Act*, in order to maximize the expected benefits regarding natural caregivers.

6 Services and care

The Committee proposes seven major avenues of discussion regarding the challenge of the organization of services and care. We will explore the following in greater depth in this section: the various services and care provided to CHSLD residents, their continuity and certain conclusive experiences. The avenues of discussion concerning alternative experiences, namely optimum use of the residents' abilities and innovative ways to stimulate their functional autonomy, would require the drafting of complex clinical research specifications. We prefer to leave the discussion to the experts in these matters.

[31] *Op. cit.*, note 12, s. 7, para.1(5).

6.1 The situation of people with severely diminished autonomy

Having to depend on the availability of others for one's basic needs is already difficult to accept. However, not being able to count on the necessary assistance in a timely manner for one's elimination, hygiene and eating needs becomes a daily source of major frustration for the user. Also, the lack of stability of staff and reliance on private agency personnel - when they are poorly integrated with the regular staff - are major irritants for users, both in the continuity of care and in the bond of trust they maintain with the caregiving staff. Combined, these factors are intrinsically related to the quality of life of the residential care environment.

6.2 Assistance for daily living activities

A CHSLD's mission is to assure users who can no longer stay at home of a substitute living environment offering them quality care and services. Therefore, they are expected to receive assistance, support and monitoring services that provide greater safety than if they had stayed in their natural living environment. Paradoxically, assistance for activities of daily living is the greatest source of dissatisfaction for CHSLD residents.

Considering the major loss of autonomy of CHSLD residents, the performance of activities of daily living takes up most of the care time devoted to them. Residents legitimately want to receive this care from competent caregiving staff - people who know and understand the residents and thereby know how to meet their needs. These conditions are necessary for a good relationship of trust to be established with the residents - conditions that assure them of a response to their needs that is appropriate, personalized, safe and continuous.

While maintenance and reinforcement of the residents' abilities are one of the guiding principles of the ministerial orientations[32] for a quality CHSLD living environment, the Québec Ombudsman's investigation reveal that the patient attendants' daily work plan leaves little leeway to really meet these conditions, which are nonetheless necessary for an adequate response to the needs. These patient attendants say they are aware and often disappointed that they cannot give more time to each resident and thus maximize the relationship of trust. The pressure imposed on the staff in the performance of their duties does not favour respect for the slower rhythm of residents with severely diminished autonomy.

In several CHSLDs that were investigated, we observed that the staff was unable to take time to sit down and assist the residents in eating or encourage them to eat, by interacting and communicating personally with them in a timely manner. We have the same finding for hygiene care and the only full weekly bath. Residents also deplore the long wait for a response to the call bells to accompany them to the toilet. It is also noticed that protective incontinence briefs are worn as a preventive and palliative measure due to the staff's limited availability.

Work organization arrangements are not always made to favour a maximum presence of staff during peak periods. We have noticed that in some CHSLDs, staff breaks and mealtimes occur at crucial moments, such as the residents' meal period, for which many residents require assistance in eating, or at least stimulation. We have observed staff members on their feet, feeding several residents at a time, with little or no communication or exchange. It is also not unusual for residents to wait a long time at

[32] *Op. cit.*, note 28, p. 3.

their table before anyone assists them in eating, while the food served several minutes earlier gets cold.

Accommodation in a CHSLD obliges users to adapt to their new living environment, while the opposite should be recommended. The organization of care and services too often is focused on the task and not on the user's needs. Offering a real living environment to CHSLD residents requires that major efforts be invested in the coordination and revision of the organization of care and services, according to the users' needs. Greater organizational leadership must emerge to support the importance of a living environment adapted to the special needs of CHSLD residents. Despite the budgetary and institutional constraints everyone faces, CHSLD executives must give preference to these values, organize the work and favour increased engagement of the staff so that they adapt their methods accordingly.

7 Monitoring the quality of care and services

The Committee identifies several mechanisms deployed to ensure effective monitoring of the quality of care and services in the network, including using the Québec Ombudsman's services, who "shall exercise the functions of the Health and Social Services Ombudsman".[33]

Each of the internal and external mechanisms to which the Committee refers seeks to ensure continuous improvement of the quality of care and services for CHSLD users and respect for their rights. The respective mandates of these various mechanisms are exercised periodically or ad hoc, and the scope of the recommendations issued is a key factor. The Québec Ombudsman has chosen, within the context of this consultation, to focus on the avenues of discussion that more specifically concern its role as Health and Social Services Ombudsman.

7.1 The capacity of the mechanisms to ensure quality care and services

In the Québec Ombudsman's opinion, the current mechanisms for monitoring the quality of care and services are adequate. Instead, it is especially concerned by the lack of rigour in the application of certain existing processes and the deficiencies observed in the follow-up of recommendations.

For example, in 2009,[34] it recommended that the Ministère de la Santé intensify its assessment visits to CHSLDs and intermediate resources in order to ensure that the implementation of its ministerial orientations[35] would be completed by December 2011. Up to December 2013, the Québec Ombudsman was dissatisfied with the number and progress of the CHSLD assessment visits.[36] Moreover, it is still dissatisfied[37] with the absence of quality assessment visits to intermediate resources and family-type resources for vulnerable persons.

However, the Québec Ombudsman regularly meets with the MSSS administrative authorities regarding the follow-up of its recommendations. It appreciates the efforts made and planned over the past few years to review the assessment process for the

[33] *Op. cit.*, note 2, p. 17.

[34] *Op. cit.*, note 24, p. 97-101.

[35] *Op. cit.*, note 28.

[36] *Op. cit.*, note 27, p. 160.

[37] *Idem*, p. 159.

quality of services in the CHSLDs. It notes that in fall 2012, the MSSS undertook an in-depth review of the CHSLD evaluation visit process.

More than 10 years after the release of the ministerial orientations for a quality living environment in the CHSLDs, concrete measures should be deployed, in the short term, to ensure implementation of these orientations in all CHSLDs. Also, the Québec Ombudsman intends to follow the new evaluation process closely in this regard.

7.2 The difficulties encountered within the context of agreements with private partners

The Québec Ombudsman wishes to inform the Committee of the difficulties it observes in quality control when places are purchased in the context of agreements made between the CSSS or the agencies and the private residential care partners. Indeed, the Québec Ombudsman has been asked to intervene in situations where seniors waiting for a place in a public CHSLD or a private CHSLD under agreement had been directed to private CHSLDs not under agreement or even to private seniors' residences. This is a growing phenomenon, due to problems of access to residential care and hospital overcrowding. The Québec Ombudsman emphasized its strong concern on this subject in its 2012-2013 annual report.[38]

In several situations, over the course of its investigations, it found disturbing deficiencies in these private resources regarding workforce training and on-site clinical supervision. These deficiencies do not make it possible to ensure delivery of safe and appropriate care for the residents, especially in situations where the public partner does not ensure vigilance or spot check the situation of residents thus referred to the private partner. Users need and have the right to the same quality of care and services, regardless of the type of accommodation to which the public network refers them while waiting until a place is available in the CHSLD of their choice.

The Québec Ombudsman has no reservations regarding the principle of agreements to purchase places from private partners. However, it emphasizes its concern regarding the insufficient quality control it observes when processing the complaints and reports it receives. In a context where reliance on private partners will increase, it is therefore essential that the CSSS and the agencies assume their responsibilities regarding the quality of the services provided to the users when they direct them to their private partners.

Several CSSS and agencies have not adopted clear procedures to favour a sound and informed choice of a private partner. This is the private partner that will accommodate their clientele in temporary accommodations while waiting for a place to become available in a public CHSLD or a private CHSLD under agreement. In the Québec Ombudsman's opinion, the following factors, related to the organization of work, would merit better consideration: the private partner's staff evaluation and hiring criteria, the staff's skills and competencies based on target client profile, the staff ratios relative to the number of residents at this specific site, and the clinical supervision tools.

[38] *Idem*, p. 166.

7.3 Other means allowing improved monitoring of the quality of services and care in the CHSLDs

The Québec Ombudsman was able to observe that, despite all kinds of constraints - architectural, for example, — good will, initiative and creativity make it possible to offer quality services to the residents in a clean, warm environment where it is a joy to live and work. This is not only possible, but should become the objective to achieve everywhere.

In this regard, the introduction of a quality assurance policy associated with an action plan would be an effective means, in our opinion, contributing to the implementation of the ministerial orientations[39] for quality living environments. This tool for change has become unavoidable, ten years after the establishment of these orientations. Moreover, this is the recommendation made by the Québec Ombudsman to the Ministère de la Santé et des Services sociaux During the hearings on the *White Paper on Autonomy Insurance*[40], in November 2013.

CONSIDERING

The necessity of reinforcing follow-up of the recommendations made by the different mechanisms reporting to the executive authority;

The necessity of reinforcing follow-up of the recommendations issued by two National Assembly institutions exercising an oversight mandate, i.e. the Auditor General of Québec and the Québec Ombudsman;

The necessity of guiding this reflection with a quality assurance policy, associated with an action plan.

The Québec Ombudsman suggests that the Committee:

S-10 Request the Minister of Health and Social Services to institute a quality assurance policy associated with an action plan, in light of the results of this consultation.

S-11 Include in its concerns the examination of procedures favouring the sound and informed choice of a private partner, including ad hoc and regular quality control mechanisms, which the CSSS or the agencies will have to deploy with preferred partners.

8 Organization of work

In its consultation document, the Commission brings up the challenge of the organization of work in forward-looking avenues for discussion: How can this organization be upgraded based on the CHSLD residents' needs? What are the main obstacles related to this vision and what are the examples of success? The Québec Ombudsman believes it can shed relevant light on the main obstacles encountered in organization of services and it will focus its reflections on this particular aspect.

8.1 Staff practising in public CHSLDs or private CHSLDs under agreement

Residents of a private CHSLD or a private CHSLD under agreement want to be provided with services by staff they know and who have the necessary competencies to meet

[39] *Op. cit.*, note 28.

[40] *Op. cit.*, note 20, p. 15.

their needs appropriately. From the user's point of view, a stable staff is fundamental. This not only ensures better continuity of care, but favours the creation and maintenance of an essential bond of trust. This is how the delivery of care and services becomes focused on the needs of the residents, in accordance with the ministerial orientations, and not only centered on the organizational task to be accomplished. This finding emerges when one examines the organization of work of staff providing services both in public CHSLDs and in private CHSLDs under agreement.

This means that resorting to independent labour, often patient attendants from agencies, requires adequate management to ensure the users' satisfaction. Users who constantly have to repeat to a new staff member how to work with them are more likely to be dissatisfied. This poses an additional difficulty concerning the continuity of care and its overall quality. Private agency staff do not regularly work with the users and are not as familiar with their needs and habits. Thus, communicating relevant and up-to-date information regarding the users becomes all the more important. When staff is changed too frequently, there is a risk of breaking the continuity of care and services.

Ensuring the presence at all times of a sufficient number of qualified and motivated staff to provide a personalized response to the residents' needs remains a major challenge for the facilities. When this further occurs in a tight budget context, as is often the case, this challenge sometimes becomes excessive.

9 Staff training

The Committee proposes six avenues for discussion regarding the challenge of staff training. Several of the avenues suggested would necessitate the development of a systematic intervention, requiring the use of proven and scientifically validated methodologies. In this context, we have chosen to focus our comments on what we found over the course of our field investigations.

Staff knowledge, knowhow and interpersonal skills are essential to favour the implementation of a quality living environment. This is why our comments will more specifically concern staff providing care and services affecting the user's integrity. For the Québec Ombudsman, an offering of quality care and services that meets the needs of residents of a public CHSLD or private CHSLD under agreement necessarily involves reliance on skilled labour to provide the care.

Apart from the question of staff stability, which was discussed previously, the staff's competencies to respond appropriately to the special needs of the various types of accommodated clienteles must remain at the core of the managers' concerns. The Québec Ombudsman is regularly asked to intervene in situations where residents or their families deplore staff negligence. Our investigations lead us to draw an important conclusion: the lack of quality observed in the service offering often is due to the caregiving staff's lack of knowledge of the approaches to favour with a clientele who increasingly exhibit cognitive deficits associated with behavioural disorders.

More specifically, within the context of service agreements with private partners, the Québec Ombudsman finds that the workforce does not have all the competencies required to respond adequately to residents. Often, this workforce will not have benefited from complete training adapted to the various needs profiles of the users it serves. This dimension merits serious consideration within the context of controlling the quality of services and the competency requirements to be stipulated in the service contracts.

Conclusion

The findings set out in this document confirm that the living conditions of CHSLD residents do not always correspond to what they are entitled to expect from a substitute living environment. These conditions do not always conform to the standards of the Ministère de la Santé et des Services sociaux.

Indeed, it must be recognized that the living environment approach is not implemented in all CHSLDs and, when it is, this is not always done in a manner conducive to ensuring adequate case management of individuals with major needs, who require sustained attention and services. This results in great dissatisfaction for users and their families. The organization of care and services, and the organization of work, too often remain focused on the task to be accomplished rather than on satisfying the user's needs. Users are required to adapt to the living conditions of the facility to which they are directed, whereas the opposite should prevail.

It is therefore imperative that the management requirements of the health network do not take precedence over the welfare of individuals. To achieve this goal, it is essential that all players in the network, especially institutional executives, adhere to and concretely appropriate the living environment concept. Their strong leadership must make the difference: leadership that must never lose sight of the human dimension, by far the most essential of all the dimensions that must be considered by managers and staff at all levels.

List of suggestions

CONSIDERING :

That the inordinately long wait times, rigidity in the application of admission criteria and systematic reliance on temporary accommodation as the first step limit access to the public system:

That the biopsychosocial factors that have a determining impact on the users' general health are not taken into account sufficiently in the management decisions for temporary accommodation;

The recognized decrease in the number of places in public CHSLDs and private CHSLDs under agreement and the increase in the demand for public residential care.

The Québec Ombudsman suggests that the Committee:

S-1 Request the Minister of Health and Social Services analyze the conditions of access to accommodation, including the realistic wait and the consequences of systematic reliance on temporary accommodation to assure users and their close relatives of the same quality of services.

S-2 Pay special attention, within the context of these analyses of the conditions of access to accommodation, to the quality of communications with seniors and their families, so that they are provided with accurate, complete, transparent and timely information.

S-3 Ask the Minister of Health and Social Services for a quantitative and qualitative analysis of the foreseeable increase in the demand for public residential care for the next few years, accounting for the imperatives of decongestion of the emergency rooms and active care beds in the hospitals, and an action plan to deal with this.

CONSIDERING

That the CHSLD pricing is supposed to cover the portion relating to accommodation expenses (room and board), since healthcare and social services are assumed by public funding;

The potential impact of the creation of an autonomous insurance fund on the CHSLD funding mode;

The necessity of updating and reviewing the normative framework concerning CHSLD pricing.

The Québec Ombudsman suggests that the Committee:

S-4 Examine the conditions of harmonization of rate practices, maintain the existing conditions allowing reduction of the contribution asked of the least affluent people, and oversee the means that will be implemented with the aim of informing the users clearly in this regard.

S-5 Ask the Minister of Health and Social Services for a status report on the plan and the timeline of the work concerning the review of the Regulation respecting application.

List of suggestions (cont'd)

CONSIDERING

That the substitute living environment offered by the CHSLDs must be as close as possible to the person's natural living environment, despite the increased level of care necessary.

The necessity of ensuring the physical integrity and psychological integrity of all residents;

The diversity of the needs profiles of people accommodated in the same CHSLD unit;

That the last national evaluation report on the living environment approach dates back to 2010.

The Québec Ombudsman suggests that the Committee:

S-6 Request the Minister of Health and Social Services to update the evaluation of the living environment approach within the context of the preparation of a new national report on visits assessing the quality of services and ensure effective follow-up.

CONSIDERING

The Committee's finding whereby the profiles and the needs of the under-65 clientele accommodated in CHSLDs must be defined further and better known;

The legitimate expectation of this under-65 clientele accommodated in CHSLDs to benefit from a living environment that better meets their needs and aspirations.

The Québec Ombudsman suggests that the Committee:

S-7 Request the Minister of Health and Social Services identify an institutional player or a recognized research group that can establish the profiles of the under-65 clientele accommodated in public CHSLDs or private CHSLDs under agreement.

S-8 Ask the Minister of Health and Social Services to take the required steps quickly to adapt the living environment approach to the profiles of the under-65 clientele accommodated in public CHSLDs or private CHSLDs under agreement, and the offering of services available, by means of tools such as the individualized service plan.

List of suggestions (cont'd)

CONSIDERING

The essential role played by the natural caregiver with the person accommodated in a CHSLD;

The necessity of strengthening open and frank communication between the facilities and the natural caregivers;

The potential impact of Bill 67, the *Autonomy Insurance Act*, concerning the support the natural caregiver can receive.

The Québec Ombudsman suggests that the Committee:

S-9 Make the connection between the current work resulting from its initiative mandate and the work regarding the study of Bill 67, the *Autonomy Insurance Act*, in order to maximize the expected benefits regarding natural caregivers.

CONSIDERING

The necessity of reinforcing follow-up of the recommendations made by the different mechanisms reporting to the executive authority;

The necessity of reinforcing follow-up of the recommendations issued by two National Assembly institutions exercising an oversight mandate, i.e. the Auditor General of Québec and the Québec Ombudsman;

The necessity of guiding this reflection with a quality assurance policy, associated with an action plan.

The Québec Ombudsman suggests that the Committee:

S-10 Request the Minister of Health and Social Services institute a quality assurance policy associated with an action plan, in light of the results of this consultation.

S-11 Include in its concerns the examination of procedures favouring the sound and informed choice of a private partner, including ad hoc and regular quality control mechanisms, which the CSSS or the agencies will have to deploy with preferred partners.

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