Residential and long-term care centres

A HIGH-QUALITY LIVING ENVIRONMENT FOR RESIDENTS

Residential and long-term care centres (CHSLD) provide specialized accommodation and a substitute living environment. They dispense assistance, support and surveillance services. They must also provide their residents with psychosocial, nursing, pharmaceutical, medical and rehabilitation services.

The increased availability of home-care services designed to maintain people in their natural living environment as far as possible has changed the characteristics and the needs of the clientele admitted to residential and long-term care centres. In general, residents spend less time there than previously, and a greater number of them die there. Accommodation in an institutional living environment is increasingly reserved for people having complex pathologies and requiring a higher level of care during their stay. Above all, however, this type of facility remains a residence, a living environment.

MINISTERIAL ORIENTATIONS

Ministerial orientations set out in the document *Un milieu de vie de qualité pour les personnes hébergées en CHSLD* [a quality living environment for CHSLD residents] were published in 2003. This publication sets out actions which, without constituting conditions absolutely essential for success, facilitate the implementation and use of an approach suitable for persons living in a residential and long-term care environment. This document specifies that

> The range of care and services offered to residents must be aimed not only at answering their physical and psycho-social health problems, but also at helping to support the creation of a true living environment for residents. Consequently, all persons employed by an institution offering residential services must, through their dealings with residents and those close to them and through the role they play with regard to familiar places and objects, contribute to nourishing and enriching the substitute living environment. As a result of the institution's openness to the community, family and volunteers will also gravitate towards the elderly resident. Consequently, members of staff responsible for nutrition, laundry and maintenance of the facilities must, in harmony with the actions of nurses, middle managers, rehabilitation therapists, attendants, dieticians, and all other actors who deal with residents, act in such a way as to ensure residents' welfare and foster optimal use of their capacities.

With regard to clinical services, residential facilities must be able to guarantee residents' daily welfare. As for services that are required intermittently or that call on disciplines that are rare or subject to shortages, other methods must be developed in order to provide access to the services to residents when the need arises.[1]

[Translation]

INTEGRATING CHSLDS INTO HEALTH AND SOCIAL SERVICES CENTRES (CSSSs)

An Act respecting local health and social services network development agencies came into force on January 30, 2004, following the adoption of Bill 25. The new act integrated public CHSLDs into health and social services centres (CSSSs) set up by local health and social services network development agencies. This integration required each CSSS to adopt organization plans that took the new reality into account. CSSS management personnel, in addition to providing daily management of services, had to take part in defining clinical projects and in developing their local health and social services networks. In some cases, this has had the effect of reducing their availability and making them less accessible to teams and to staff in general. This lack of availability has also had an impact on the time required to implement the living environment project.

QUALITY ASSESSMENT VISITS

In fall 2003, the MSSS called for visits to CHSLDs to assess the living environment and services provided to persons living in these institutions. The Minister intended this initiative to identify solutions that contribute to the provision of a quality living environment and to provide a clearer understanding of problems shared by a number of CHSLDs.[2] An initial report, published in June 2004, outlined the situation observed in 47 public CHSLDs. A number of items in this report caught the attention of the Québec Ombudsman, including the following:

1/ Ministère de la Santé et des Services sociaux, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD, visites d'appréciation de la qualité*, Québec City, June 2004, p. 14-15.

2/ *Ibid*, page vii.

- There are marked differences between institutions. In similar conditions and with more or less equivalent constraints, some succeed better than others in integrating the "living environment" concept into the daily routine and manage to provide a more human environment for residents.
- Institutions' strategic plans and management agreements reached with local service networks pay little attention to expectations and objectives aimed at providing residents with a high-quality living environment.

Quality assessment visits also revealed that the obsolescence of—and architectural barriers in—many facilities have a negative impact on residents' autonomy, privacy, socialization, safety, identity and dignity. The situation is also mirrored in an analysis of complaints submitted to the Québec Ombudsman.

Involvement of family members and close relatives in the life of residents does not take the same form and is not interpreted in the same manner by all. Thus, from one CHSLD to another, the nature and degree of their involvement varies. The variation is more the result of the practices of each institution than of an orientation that recognizes and encourages this collaboration. In most cases, residents and their families say they were not involved in developing and periodically revising the individual intervention plan, despite the fact that the Act calls for this.

COMPLAINTS REVIEWED BY THE QUÉBEC OMBUDSMAN

In 2006-2007, citizens submitted 31 complaints relating to residential and long-term care centres to the Québec Ombudsman.

The following table divides the reasons for complaints into categories and indicates the number of corrective measures formulated in each category.

Results of the Review of Grounds for Complaint

Complaint Grounds	Number of Grounds*	Unsubstantiated Grounds	Substantiated Grounds	Number of Corrective Measures
Accessibility of care and services	6	2	4	4
Clinical and professional aspects of care and services	16	6	10	19
Specific rights	6	4	2	9
Financial aspects	5	5	–	–
Interpersonal relations	11	7	4	6
Environment and material resources	15	10	5	14
Total	**59**	**34**	**25**	**52**

* Excluding complaints whose processing was interrupted

The greatest number of complaints about CHSLDs involve technical and professional aspects of care and services, accounting for 40% of the well-founded complaints. Dissatisfaction was with the quality of nursing care and assistance, medication and the approach of staff to persons having cognitive difficulties. Next come complaints relating to the organization of the environment, material resources and interpersonal relations. Complaints in the category of specific rights mainly involve the right to complain, and free and informed consent to care.

A number of grounds for dissatisfaction for a citizen

A citizen complained about the services provided to her mother, a CHSLD resident. The grounds for complaint focused on accompaniment, lack of staff, physical organization of the premises, quality of care, involvement of the family and availability of physicians.

After analyzing the file, the Québec Ombudsman found that the situations brought to its attention to which it was able to attest could have been avoided had the institution implemented the ministerial orientations. The majority of its recommendations tallied with these orientations.

The absence of intervention plans for residents of the centre

During an investigation, the Québec Ombudsman noted that a residential centre had not drawn up intervention plans for its residents. It considered that this was a significant shortcoming and mentioned this to the management of the centre. The centre's managers attributed the delay in introducing this practice to the numerous administrative upheavals that they had experienced. Although sensitive to this argument, the Québec Ombudsman insisted that the situation be remedied in the interest of residents.

The Act obliges institutions to formulate an intervention plan for each of their residents, in order to identify the resident's needs, objectives, methods, and the expected duration of the period during which services will have to be provided. This plan must also provide for coordination of the various actors involved in the provision of these services.

Clearly, regardless of the cause, delays in implementing the ministerial orientations compromise the creation of an appropriate living environment for CHSLD residents.

REPORTS

Results of the Review of Grounds for Complaint

Report Grounds	Number of Grounds*	Unsubstantiated Grounds	Substantiated Grounds	Number of Corrective Measures
Accessibility of care and services	2	1	1	1
Clinical and professional aspects of care and services	6	5	1	2
Specific rights	3	1	2	2
Financial aspects	–	–	–	–
Interpersonal relations	3	3	–	–
Environment and material resources	8	6	2	5
Total	22	16	6	10

* Excluding the grounds for reports referred to regional agencies and those whose processing was interrupted

CHSLDs were at issue in 7 notifications for a total of 22 reasons. The Québec Ombudsman came to the conclusion that, to remedy the situation, corrective measures were required for 6 of the reasons. Out of the 10 corrective measures identified, it formulated 9 recommendations, while the 10th measure is an undertaking by the institution. All the corrective actions have been implemented and carried out by the authorities concerned to the satisfaction of the Québec Ombudsman.

MAIN PROBLEMS

Of all the reasons for notification that put CHSLDs at issue, 63.6% (14 out of 22) fall into two categories. The greatest number of reasons involving the mission of a CHSLD fall into the category of environment and material resources (8 out of 22), or 36.3%. Among other things, problems had to do with the security of the premises and of persons, hygiene and salubrity, and the quality and variety of food. Clinical and professional aspects and specific rights each accounted for 27.3% (6 out of 22) of reasons.

URGENT ACTION REQUIRED

Quality assessment visits, complaints and notifications concerning CHSLDs revealed that a number of them are experiencing difficulties. The nature and importance of problems vary from one institution to another. In some cases, a number of difficulties were found. The result is situations in which users do not receive the quality services to which they are entitled and situations in which the services are provided in an environment that does not meet all the standards needed to guarantee the safety and comfort of residents.

In light of these findings, the Québec Ombudsman considers that:

- quality assessment visits to CHSLDs should be intensified and strengthened;
- institutions that have not yet done so must, as rapidly as possible, implement the ministerial orientations designed to create a quality living environment for residents;
- the Department should systematically assess the condition of residential facilities and, where required, make plans for their renovation;
- the Department should ensure that objectives concerning the improvement of service quality are included in management agreements between health and social services agencies and CSSSs with reference to CHSLDs;
- assessment visits should be made on an ongoing basis, be carried out in depth, and focus primarily on the creation of a quality living environment. In no event can these visits replace the Department's power of investigation in situations where its use is warranted.