Institutions

This section presents the Québec Ombudsman's activities as well as examples of complaints and recommendations according to the different missions of institutions and facilities. The institutions are presented in the following order: residential and long-term care centres, hospital centres, child and youth protection centres, local community service centres and lastly, rehabilitation centres.

Residential and long-term care centres

The mission of residential and long-term care centres (CHSLDs) is to offer, on a temporary or permanent basis, a substitute living environment and accommodation, assistance, support and supervision services, as well as rehabilitation, psychosocial, nursing, pharmaceutical and medical services to adults who have lost their functional or psychosocial autonomy and can no longer remain in their natural living environment, even with help from close relatives.

Type of complaints

Complaints reviewed by the Québec Ombudsman

CHSLD						
Under investigation at April 1, 2007	Received	Investigated*				Under investigation at March 31, 2007
		Referred	Interrupted	Unsub-stantiated	Substantiated	
54	71	-	16	34	22	49

* Excluding complaints whose processing was interrupted or which were referred

Results of the review of complaints

Category	Inquirers*	Complaints*	Unsubstantiated	Substantiated	Number of corrective measures
Clinical aspects	18	25	11	14	25
Financial aspects	6	6	6	-	-
Environment and living environment	14	16	11	5	7
Programs and services	8	9	6	3	9

* Excluding complaints whose processing was interrupted or which were referred

The majority of the substantiated complaints received address clinical elements, particularly the existence and application of healthcare and intervention plans, as well as custodial care for daily and domestic activities. Complaints also address clinical assessments, professional judgment, continuity of services, the organization of treatment and services, and physical treatment and surveillance.

These are followed by complaints regarding the living and general environment, specifically with regard to the safety of property, the facilities and persons, the client mix, and the availability of equipment and materials.

Trailing behind are complaints concerning programs and services, the attitude and behaviour of human resources, and the failure to adhere to the rules and procedures governing the investigation of complaints.

Overview of the situation

Accommodation in an institutional living environment is increasingly reserved for people having complex pathologies and requiring a higher level of care during their stay. Generally speaking, residents spend less time in these environments than was once the case. We must reiterate, however, that such accommodations are nonetheless residences, i.e. living environments.

Department orientations were published in 2003, in a document concerning a quality living environment for CHSLD residents entitled *Un milieu de vie de qualité pour les personnes hébergées en CHSLD*. They define actions that, without constituting absolutely essential conditions for success, facilitate the implementation and use of an approach adapted to persons living in such an environment. The Ministère de la Santé et des Services sociaux (MSSS) specifies the following:

"The range of care and services offered to residents must be aimed not only at answering their physical and psychosocial health problems, but also at helping to support the creation of a true living environment for citizens." [27]

The creation of these living environments requires that numerous CHSLDs significantly change their organizational culture and the ways in which they do things. Nevertheless the implementation of these orientations, as well as their maintenance thereafter, must remain an ongoing concern for managers.

The department visits residential and long-term care centres to assess the quality of the services provided to the citizens living in these institutions. Through these visits, it ensures that all those living in such substitute environments benefit from adequate services and a quality physical setting. These visits also make it possible 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.

The Québec Ombudsman examined the report[28] on visits to 47 residential and long-term care centres. Various items caught our attention:

- There are marked differences between institutions;
- Institutions' strategic plans and management agreements pay little attention to expectations and objectives aimed at providing residents with a high-quality living environment;
- 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 in all of the CHSLDs visited.

Quality assessment visits also revealed that the obsolescence and architectural barriers in many facilities have a negative impact on residents' autonomy, privacy, socialization, safety, identity and dignity. Promiscuity and the generally cramped environments are breeding grounds for hospital-acquired infections and the spread of epiphytotic diseases such as gastroenteritis, the flu and the common cold. The situation is also mirrored in an analysis of complaints submitted to the Québec Ombudsman.

27 Ministère de la Santé et des Services sociaux, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD : orientations ministérielles*, Québec, October 2003.

28 Ministère de la Santé et des Services sociaux, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD : orientations ministérielles – Visites d'appréciation*, Québec, June 2004.

Supported by its network, the department conducted a technical and operational evaluation of residential and long-term care centres. It subsequently launched a $725 million action plan, running from 2005 to 2010, with the goal of improving the infrastructure underlying service delivery.

The action plan's key priorities are the elimination of rooms housing more than two people and accommodation beds in specialized and ultra-specialized hospital centres. It also targets the dilapidation of various facilities, seeking to improve the institutions offering a living environment to elderly persons with limited autonomy.

Over the last year, the department has invested $135 million, $35 million of this amount recurrent, to build new residential and long-term care centres, improve the existing facilities, add beds in various residences, and renovate certain buildings. These amounts were invested throughout Québec and should allow for providing a greater number of citizens with access to the accommodations they need, while also facilitating the implementation of department orientations for creating quality living environments in these long-term residences. The investments' impacts will nonetheless be felt gradually, likely over the next few years.

With the exception of the sizeable investment (with no immediate impact), the Québec Ombudsman observes that the situation vis-à-vis residential and long-term care centres has not changed significantly from last year.

Ombudsman follow-up and actions

The Québec Ombudsman stated, in its 2006-2007 annual report, that:

- Quality assessment visits to CHSLDs should be intensified and strengthened;
- Institutions that had not yet done so should, as rapidly as possible, implement the department 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 could these visits replace the department's power of investigation in situations where its use was warranted.

The department advised the Québec Ombudsman that the pace of the visits begun in 2004 had been sped up. The department had in fact planned to conduct 56 visits in 2007-2008, but in reality executed 36. The Ministère de la Santé et des Services sociaux also developed other measures for intensifying assessment CHSLD visits, including improved quality assessment forms.

In addressing the complaints it received, the Québec Ombudsman noted that institutions had not always implemented the department orientations with regard to a quality living environment for the elderly.

The following examples attest to the variety of complaints grounds concerning the living environment.

Quality sorely lacking in four CHSLD from a same region

On May 1, 2007, the Québec Ombudsman submitted its intervention report and recommendations subsequent to an investigation begun in October 2006 regarding the four residential and long-term care centres of a same health and social services centre.

Given certain troubling facts and information reported by Québec Ombudsman representatives subsequent to a meeting with a CHSLD residents' committee and the local service quality and complaints commissioner for a health and social services centre, the Ombudsperson opted to intervene directly, by virtue of the powers conferred to her. She promptly asked a three-person team, which included a representative, to prepare a report on the quality of the services delivered in four of a CSSS' sixteen facilities. The team proceeded to conduct clinical observations and hold formal and informal meetings with residents, family members, employees and managers. Its observations notably involved all work shifts (day, evening and night).

As a result of its intervention, the Québec Ombudsman was able to ascertain that most of the guiding principles established in support of an improved quality of life by the Ministère de la Santé et des Services sociaux were barely if at all adhered to. The institution did not favour maintaining support of user abilities, nor did it appeal to their ability to express their freedom of choice.

The highly institutionalized routine in force, moreover, did not allow for adequately personalizing the services offered, failed to respect users' individuality, and hindered their rights along with the possibility of giving some meaning to their lives.

The Québec Ombudsman made 30 recommendations in the following areas:

- the living environment (3);
- organization of services (11);
- the physical environment and material resources (3);
- clinical management vis-à-vis residents (5);
- administrative management with regard to employees (5);
- administrative management with regard to the general manager (3).

Subsequent to the report's submission, the health and social services centre submitted to the Québec Ombudsman an action plan for ensuring the quality of the services delivered and a number of senior managers were replaced. The Québec Ombudsman will be formally monitoring the plan's implementation.

Preliminary results are concrete, what with senior management of the health and social services centre introducing measures to fully restructure the accommodations sector and ensure strong leadership to spearhead changes in mentality and practices. Instilling respect for users and the acknowledgement of the importance of their living environment required a significant effort from this institution, which it gave.

The Québec Ombudsman believes that the application of the recommendations ensuing from this initiative will decidedly improve the quality of the treatment and services delivered to the clientele.

Better meeting the needs of persons at the end of their lives

Numerous citizens will live their final days - not to mention die - in a residential and long-term care centre. The following example aptly illustrates how these centres are ill-prepared and ill-equipped to deal with such situations.

Respect for persons before and after they die

A citizen contacted the Québec Ombudsman to report a situation he had witnessed in a CHSLD. A patient in her final days was not placed in a private room, but shared her room with several other users. To these other people were added members of her family, who spent her last days and nights at her bedside.

Following death, the body is not immediately moved out. If a death occurs during the evening, the dead body is in fact left in the room all night.

Such a situation is uncomfortable for many people, including the family members of the dying patient and the room's other occupants. The lack of privacy, moreover, creates an environment that is at best unpleasant for the family members to express their emotions and grief. In addition, the fact of leaving a dead body in a room overnight can provoke strong reactions in other residents, possibly leaving them distressed for a significant period of time.

The procedure surrounding the death of residents was revised subsequent to the Québec Ombudsman's intervention. In the final moments, particularly when family members are present and the dying user is sharing a room, the patient is transferred to the salon or solarium to provide the family with a modicum of privacy and the room's other occupants with peace and quiet. At the time of death, the body is respectfully laid out in the patient's bed, in the salon or solarium, and is not moved for at least two hours. It is thereafter transported to a room for this purpose, where it will stay until the arrival of the undertaker.

COLLECTIVE benefit

This complaint is indicative of the need to better meet the requirements of persons at the end of their lives, particularly given the growing number of users relying on CHSLD services. It is also critical to show respect when taking care of the body and ensure an

environment where family and relatives can cope with the death of someone dear to them in private. The actions taken as a result of the Québec Ombudsman's intervention generated a collective benefit, in the sense that all residents and their families can now enjoy improved conditions in such circumstances.

While this service does not constitute a lack of palliative care, the Québec Ombudsman acknowledges that it is nonetheless a component of the services to be delivered by residential and long-term care centres.

An appropriate approach, in addition to providing terminal patients with adequate services, would have the added advantage of avoiding an unnecessary reliance on emergency and hospital resources.

Attitudes of a close relative and respect for others

The Québec Ombudsman in 2007-2008 received complaints from citizens with regard to behaviour considered problematic. One such situation is described hereafter.

Some boundaries shouldn't be exceeded...

The son of a woman who was staying in a CHSLD, who was with his brother the joint legal representative of his mother's tutorship and who had lived with her until she was placed, was becoming increasingly interfering with in the institution's regular activities. He was at the centre every day, from 8:00 a.m. to 10:00 p.m., and would object to his mother being assisted by orderlies, would claim that she was antisocial and ask that she be allowed to eat in her room, and would ask for permission to lock her door. He would also frequently request that his mother be allowed to spend time at home. His mother, in the meantime, would helplessly watch her son's mood swings.

The local service quality and complaints commissioner first decreed the lack of grounds to support the son's requests for a change of orderly and stated that because of safety considerations, the mother's door could be closed but not locked from the inside. After he had made a mistake in preparing a puréed meal the son threatened the cook, and he generally became more aggressive with the entire staff. He even went so far as to ask that the head nurse for the floor and two orderlies be replaced. At this point, the institution decided to restrict his visits. The son refused to accept delivery of the letter notifying him of this decision, such that it had to be read to him by a security agent, at the facility and in front of both his mother and the accommodations manager. He proceeded to contact the Québec Ombudsman, claiming that the institution was acting in a retaliatory manner.

Once its investigation was completed, the Québec Ombudsman noted that employees had been making considerable efforts to meet the son's demands. It also observed that his behaviour was perceived as threatening by employees and constituted a danger for his mother and other residents. The Québec Ombudsman supported the institution's measures aimed at limiting the son's visits, ensuring the nearby presence of a security agent and if need be, denying the son access to the institution.

The following complaint illustrates the importance of being transparent in exchanging with close relatives should the organization of resources be modified.

Transparency is reassuring

A citizen, acting in his capacity as the legal representative of his mother, communicated to the Québec Ombudsman his dissatisfaction with the reasons for which the health and social services centre had terminated a contractual agreement with an intermediary residence.

The local service quality and complaints commissioner cited confidentiality as the grounds for not releasing this information. The citizen mentioned, in his exchange with the Québec Ombudsman, his right to information on the reasons why the intermediary resource where his mother was being kept no longer respected the quality criteria necessary to have its contract with the health and social services centre renewed. He felt entitled to know of any serious grounds that could, according to the conclusions of the local service quality and complaints commissioner, "compromise the safety of residents". In reality, however, the decision to not renew the agreement between the two parties had been a mutual one.

This complaint emphasizes the problems inherent in communicating information to users and their close relatives with regard to a decision to terminate or not renew a contract or agreement with an intermediary residence and subsequently relocate residents. On the surface, a contract termination or agreement that is not renewed can allude to the existence of incompetence, inability, embezzlement or other problems. Such perceptions are reinforced when an institution hesitates or refuses to provide information, leading close relatives to fear that someone close to them could have received poor quality services or been mistreated.

The Québec Ombudsman feels that this complaint underscores the need for responsible institutions to develop a communication plan for residents and their close relatives whenever an agreement with an intermediary residence and the related services is terminated. Experience has shown that adopting a transparent approach and explaining the reasons for the non-renewal are effective ways of calming the fears of loved ones and even possibly obtaining their support.

Reports

Reports reviewed by the Québec Ombudsman

CHSLD						
Under investigation at April 1, 2007	Received	Investigated*				Under investigation at March 31, 2007
		Referred	Interrupted	Unsub-stantiated	Substantiated	
13	9	1	2	2	4	8

* Excluding complaints whose processing was interrupted or which were referred.

A total of four reports were submitted to the Québec Ombudsman, respectively concerning attitude and behaviour, the organization of treatment and services, the organization of food services, and the adaptation and layout of facilities.

Results of the review of reports

Category	Inquirers*	Complaints*	Unsubstantiated	Substantiated	Number of corrective measures
Clinical aspects	2	2	1	1	2
Environment and living environment	3	3	1	2	4
Programs and services	1	1	-	1	8

* Excluding complaints whose processing was interrupted or which were referred.

The importance of reports

It is still a matter of urgency to make reports since numerous citizens or relatives fearing reprisals often prefer not to make a report. Moreover, when the Québec Ombudsman visits a given institution, matters are often worse than what it was led to believe from the reports received. In some instances, reports are not justified, but the Québec Ombudsman's visit can nonetheless provoke reflection and help improve certain situations. The following case is a good example of the types of situations reported to us.

From baths... to restructuring services

A residential and long-term care centre employee decried a health and social services decision to decrease the number of weekly baths from two to one to the Québec Ombudsman. Moreover, residents were raced through their meals, with five minutes allocated to each user.

The Québec Ombudsman's investigation revealed that 24 of the 32 residents in question were under a public curatorship, with most of them suffering from psychiatric problems. It is well known that when a large number of users are unable to feed themselves, employees cannot feed everyone within the allotted time, as a result of which mealtimes are akin to a race.

On the other hand, our visit of the residential and long-term care centre we were investigating allowed us to discover that three night orderly positions were vacant. Moreover, employee turnover was such that an efficient meal service was far from a certainty. Orderlies, whether they were giving meals or baths, were generally overworked, in addition to being constantly disrupted by unexpected occurrences. Management introduced corrective measures during the Québec Ombudsman's intervention, notably filling the open orderly positions on the night shift and reorganizing the meal service.

The Québec Ombudsman noted that these 32 residents would have certainly received better services had the department orientations for a quality living environment been implemented in this institution. In fact, the process for introducing these orientations forces managers and employees to review the organization, the manner in which services are delivered, and the status of resources. Any problems would necessarily have been identified, and means would have been taken to solve them.

The Québec Ombudsman would like to note that facility residents had neither the means nor the power to file complaints with us or with the local service quality and complaints commissioner. They are in fact citizens who lack the requisite skills to clearly express themselves and being for the majority under curatorship, they are prevented from complaining directly. Interventions are thus only initiated if a witness to such a situation files a report. In this case, an employee's courage saved these citizens from their fate.

2007-2008 recommendations

Recommendation 1 :

The Ministère de la Santé et des Services sociaux, given its role and obligations vis-à-vis the quality of treatment and services, must take supplementary measures to promote the successful introduction of a " living environment ", an observation that led the Québec Ombudsman to make the following recommendation.

Given that the department has already initiated a program of quality assessment visits of residential and long-term care centres ;

Given the department's role and obligations with regard to the quality of the treatment and services delivered in its network ;

Given the importance of creating a quality living environment for all those being accommodated ;

Given that the program of quality assessment visits is not sufficient to enable reaching objectives ;

THE QUÉBEC OMBUDSMAN RECOMMENDS :

That the Ministère de la Santé et des Services sociaux advise it with regard to the measures it will adopt to ensure the implementation of the department orientations regarding the living environment in all CHSLDs.

Recommendation 2 :

Given that numerous citizens spend the last months of their lives in residential and long-term care centres ;

Given that numerous citizens are likely to die in a CHSLD ;

Given the frequent sharing of rooms by several residents ;

Given residents' need for privacy when spending time with close relatives while at the end of their lives ;

THE QUÉBEC OMBUDSMAN RECOMMENDS :

That residential and long-term care centres provide an appropriate environment to allow users to spend time with their loved ones in private, and ensure that agencies are treated with respect at all times, up until they are taken away by the undertaker.

Recommendation 3 :

Given that residential and long-term care centres are the living environment of sick and vulnerable residents who have lost their autonomy ;

Given that CHSLDs are public places where residents close relatives spend time ;

Given that CHSLDs constitute the workplace of employees devoted to providing residents with the necessary services ;

Given that numerous CHSLD residents are incapacitated ;

Given that the demands made by some agents or legal representatives to institution employees or management are sometimes exaggerated ;

Given that some agents or legal representatives are at times impolite or irreverent when dealing with employees, threatening them or being physically or verbally abusive ;

Given that behavioural problems have an impact on the implementation of treatment programs ;

THE QUÉBEC OMBUDSMAN RECOMMENDS :

That residential and long-term care centres communicate their code of ethics and rules of behaviour to agents and legal representatives.

That they provide agents and legal representatives the names of those persons they must contact for any information, comments or demands, as well as the contact details and procedure for filing complaints with the local service quality and complaints commissioner.

That they develop and institute a policy and methods for controlling individuals who are violent or aggressive with residents, employees or managers.

Recommendation 4 :

Given that institutions can enter into agreements for the purpose of housing citizens ;

Given that circumstances change and may result in the non-renewal, end or termination of an agreement or contract ;

Given the user's right to information, as well as that of its agents and legal representatives ;

THE QUÉBEC OMBUDSMAN RECOMMENDS :

That health and social service centres adequately inform users and their agents or legal representatives of the reasons why a contract or services agreement was terminated, as well as the measures taken to ensure continuity of services.

Recommendation 5 :

Given that numerous residents in such centres do not or cannot personally file a complaint ;

Given that employees are often front-line witnesses to unacceptable situations involving residents ;

Given the fear of reprisals ;

THE QUÉBEC OMBUDSMAN RECOMMENDS :

That residential and long-term care centres develop mechanisms to enable employees to confidentially blow the whistle on any situations where users' rights are compromised, while also advising staff members that they can contact the Québec Ombudsman, who will confidentially handle their report, should they fear reprisals.

Comments from the department

The following statement from the department was issued by its Deputy Minister :

" This series of recommendations is in line with the orientations of the action plan regarding services for the elderly. The department will give these recommendations due consideration as it continues with the implementation of the plan. "

Hospital centres

The mission of hospital centres is to offer diagnostic services as well as general or specialized physical and mental healthcare services.

Type of complaints

Complaints reviewed by the Québec Ombudsman

Hospital centres						
Under investigation at April 1, 2007	Received	Investigated*				Under investigation at March 31, 2007
		Referred	Interrupted	Unsub-stantiated	Substantiated	
215	300	2	41	136	93	238

* Excluding complaints whose processing was interrupted or which were referred.

The following table depicts the distribution of the complaints evaluated according to complaints grounds, also indicating the number of corrective measures.

Results of the review of complaints

Category	Inquirers*	Complaints*	Unsubstantiated	Substantiated	Number of corrective measures
Clinical aspects	63	100	58	42	87
Financial aspects	45	50	29	21	55
Environment and living environment	13	19	12	7	8
Programs and services	46	60	37	23	37

* Excluding complaints whose processing was interrupted or which were referred.