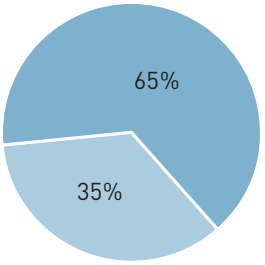
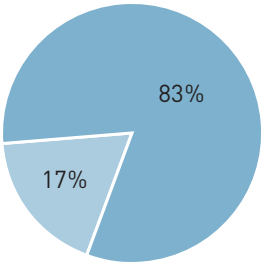
# HEALTH AND SOCIAL SERVICES




**Health and social services network missions**

- Unsubstantiated complaints and reports: 483
- Substantiated complaints and reports: 258




**Government departments and agencies**

- Unsubstantiated complaints: 154
- Substantiated complaints: 32

| | | Investigations not completed | | Investigations completed | | |
|---|---|---|---|---|---|---|
| **Health and social services network missions / Government departments and agencies** | **Complaints and reports received** | **Complaints and reports referred** | **Complaints and reports interrupted** | **Unsubstantiated complaints and reports** | **Substantiated complaints and reports** | **Total** |
| Hospitals | 480 | 29 | 164 | 163 | 147 | 503 |
| Residential and long-term care centres | 136 | 8 | 36 | 51 | 26 | 121 |
| Local community service centres (CLSCs) | 162 | 15 | 57 | 70 | 41 | 183 |
| Rehabilitation centres | 75 | 2 | 15 | 23 | 14 | 54 |
| Child and youth protection centres | 174 | 7 | 69 | 105 | 9 | 190 |
| Health and social services agencies | 92 | 14 | 20 | 37 | 12 | 83 |
| Community organizations | 5 | - | - | 4 | 2 | 6 |
| Private nursing homes | 4 | - | 2 | 12 | 5 | 19 |
| Prehospital emergency services | 25 | - | 2 | 18 | 2 | 22 |
| Not identified | 21 | - | - | - | - | - |
| **Sub-total** | **1,174** | **75** | **365** | **483** | **258** | **1,181** |
| Régie de l'assurance maladie du Québec | 318 | - | 34 | 145 | 29 | 208 |
| Ministère de la Santé et des Services sociaux | 20 | 3 | 10 | 9 | 3 | 25 |
| **Sub-total** | **338** | **3** | **44** | **154** | **32** | **233** |
| **Total** | **1,512** | **78** | **409** | **637** | **290** | **1,414** |

The number of complaints relating to the health and social services network increased considerably to 1,174 this year, compared with 689 in 2007-2008. Despite this increase in dissatisfaction levels, however, the percentage of substantiated complaints fell from 38% in 2007-2008 to 35% this year.

Dissatisfaction with clinical aspects accounted for 44% of substantiated complaints concerning child and youth protection centres, 35% of complaints concerning residential and long-term care centres, 30% of complaints concerning hospitals and 27% of complaints concerning local community service centres.

Nineteen percent of the Québec Ombudsman's interventions with residential and long-term care centres were concerned with the living environment, while 9% of the substantiated complaints relating to hospitals were concerned with the attitude, behaviour and competency of staff members.

Lastly, 27% of the substantiated complaints relating to local community service centres were concerned with access to health care, health services and social services, and 62% of the substantiated complaints relating to the Régie de l'assurance maladie du Québec were concerned with telephone waiting times.

## Ministère de la Santé et des Services sociaux

Since 2006, the Québec Ombudsman has regularly approached the MSSS concerning the handling of numerous complaints addressed to the Ministry as the authority in charge of the proper functioning of Québec's health and social services system. These discussions have focused mainly on service quality control, the complaint examination system, the certification of private resources for vulnerable persons, and the rights of people with intellectual disabilities or mental health disorders.

Following efforts made in 2007-2008, the Québec Ombudsman has noted some progress, but the haphazard, temporary nature of the changes has been disappointing. It notes, for example, that the MSSS, which confers full responsibility for the implementation of policies, programs and guidelines to the regional health and social services agencies, has no systematic way of evaluating the results obtained.

The Québec Ombudsman is aware that the MSSS relies on the cooperation of a great many stakeholders who work in the health and social services network, but feels that persistent inequities among different regions and different institutions must be addressed and that consistency must be reinforced. The current management method is not adequate to define and implement permanent solutions for the underlying problems.

In 2008-2009, in addition to its interventions on the ongoing issues mentioned above, the Québec Ombudsman examined other issues related to the MSSS and to individual health and social service establishments.

These actions and the related results are described in this report under the headings of the various types of institution. The major areas of concern this year were the pilot agreement for professional services between a hospital and a private medical clinic, the reimbursement of mandatory dental costs incurred in relation to cancer treatments, medical care in detention centres, accessibility and continuity of home support services, risk management in residential and long-term care centres, and the management of local and international adoption services.

## RESPONSE TO RECOMMENDATIONS: NOTEWORTHY EFFORTS, RESULTS PENDING

In 2008-2009, the Québec Ombudsman followed up on the recommendations issued to the MSSS in the 2007-2008 Annual Report. Although most of the follow-up information is included under the specific headings presented below, the recommendations that affect most or all institutions are covered here.

### INTRODUCTION OF QUALITY INDICATORS

In light of the MSSS's role and obligations in the matter of care and service, the Québec Ombudsman recommended that quality indicators be introduced in every institution. The MSSS accepted this recommendation. To help ensure that the appropriate indicators are selected to attest to the quality of the health and social services offered, the MSSS has launched three activities in cooperation with the agencies: an inventory of quality indicators used by health and social services institutions, a review of the quality indicators used by recognized bodies, and an implementation and operations report on the various management mechanisms used to assess and improve service quality in these institutions. The MSSS has been asked to report back to the Québec Ombudsman on this process no later than December 31, 2009.

The Québec Ombudsman also recommended that the MSSS report annually on the progress of the quality indicators developed and retained by these institutions, and the MSSS agreed to this request. It has informed the Québec Ombudsman that it will start by setting up a mechanism to track and report on the progress of the quality indicators by December 31, 2009. This mechanism will be developed in cooperation with the regional health and social services agencies.

### END OF A SERVICE AGREEMENT CONTRACT: REQUIRED INFORMATION AND CONTINUITY

The Québec Ombudsman recommended to the MSSS that health and social services centres properly inform users and their agents or legal representatives of the reasons for ending a service agreement with public or private institutions, as well as the measures taken for providing ongoing services to the users. The MSSS acknowledged that reasons related to service quality or the health and wellbeing of the users should be explained diligently and clearly to the users involved or their representatives. The Québec Ombudsman will pay special attention to the Ministry's practical follow-up with the network on this subject. We may also take action with regard to non-compliant institutions.

### PROTECTION OF ESPECIALLY VULNERABLE USERS: THE OMBUDSMAN'S CONCERNS NOT ASSUAGED

*Seniors*

In April 2006, the MSSS announced that it would ensure certification of all private seniors' residences. Owners were given until February 2009 to obtain their certification. At the time of writing, there are several findings that raise concerns for the Québec Ombudsman. First, the MSSS added four months to the deadline that had been agreed and duly sanctioned by law nearly three years ago. Furthermore, while nearly all (99.7%) the owners of private residences submitted their certification applications within the required time, only 31% received certification (686 of the 2,199 applicants). Yet the Conseil québécois d'agrément informed the Québec Ombudsman on April 8, 2009, that it had visited every targeted residence by April 7, 2009.

## *Other vulnerable citizens*

The Québec Ombudsman's findings from last year, presented in the section on residential and long-term care centres and private residences, are not reassuring.

Moreover, we have been asking for more than three years that other types of private resources also be subject to certification, especially those for people with addictions, mental health problems or intellectual disabilities. The MSSS confirms that it is preparing an omnibus bill for the certification of private residences serving vulnerable client groups.

Before the bill is presented to the National Assembly, the Québec Ombudsman feels an analysis of the situation is in order, to correct the problems encountered in the certification of private seniors' residences:

- Does the MSSS plan to change the procedures that led to delays in certification?
- Will the Québec Ombudsman be given guarantees that the certification process for private residences serving vulnerable client groups will not encounter the same problems that occurred in the certification system for private seniors' residences, in order to ensure service quality?
- Does the MSSS plan to use a more detailed definition of requirements based on the size and volume of the residences while still safeguarding service quality and resident safety?

The Québec Ombudsman urges the Members of the National Assembly to understand the need to move quickly in order to correct current errors and avoid the recurrence of prior problems.

The overall response by the Ministry and the network of health and social services institutions to the Québec Ombudsman's 2007-2008 recommendations is presented in a detailed chart on page 125 of this report. New recommendations arising from actions taken in 2008-2009 are set out in the appropriate sections of this chapter, along with descriptions of the problems to be resolved.

This chapter explores the Québec Ombudsman's major efforts over the last year with the authorities of:

**Health and social services institutions:**

- Child and youth protection centres (including international adoption of children in Québec)
- Rehabilitation centres (including family-type resources)
- Residential and long-term care centres (CHSLDs) (including private residences for vulnerable persons)
- Hospital centres (including the reimbursement of fees related to cancer treatments and public professional service agreements in a private clinic)
- Local community care centres (CLSCs) (including home care and services)
- Pre-hospital emergency services

**and the Régie de l'assurance maladie du Québec (RAMQ).**

Specific issues of importance to the Québec Ombudsman are examined next:

- Progress of the complaint management system for institutions in the health and social services network
- Follow-up on the Plan d'action en santé mentale 2005-2010

# Child and youth protection centres

## THE DECISION TO LEAVE CHILDREN IN THEIR FAMILY ENVIRONMENT

About 80% of the youth protection complaints concluded this year came from parents whose children were taken from the family home. These people believe their role as the children's parents was not respected or that they did not receive proper support with parental responsibilities in order to prepare for bringing their child back home. Most of these complaints relate to the execution of the Youth Court order concerning the removal of a child from the family environment and the institution of supervised contact between the child and parents. A great many of these complaints report a disrespectful attitude toward the parents on the part of resource workers. Finally, nearly 10% of the complaints examined relate to parental dissatisfaction with the services given to children, such as access to health care, gaps in the intervention plan or poor quality services in rehabilitation centres or foster families.

The Québec Ombudsman concluded that 5% of the complaints were substantiated. Interventions led to corrective measures, such as apologies from the institutions, improvement in record keeping at youth centres, appointment of a new resource worker for parents, better information given to parents concerning their child's situation and plans, restoration of health care services for the child, and renewed contact between the child and the parents.

Following up on the recommendation made in the Québec Ombudsman's 2007-2008 report, the Ministère de la Santé et des Services sociaux enforced the youth centres' obligation to adopt a policy concerning the removal of children from the family environment. The MSSS review of health and social services agencies this year confirmed that the 16 youth centres have adopted terms of reference based on the ministerial guidelines. The Québec Ombudsman is satisfied with the results of the review.

On a related topic, the very particular situation of babies born into situations of neglect is one of the biggest challenges in the implementation of the Programme-services Jeunes en difficulté, launched by the MSSS in early 2008. This challenge stems largely from the extreme vulnerability of these children and the lack of criteria for rapidly detecting children whose family homes cannot provide the protection, safety and care they need and are entitled to receive. The urgency of upholding these rights makes the protection of these children a high-priority collective responsibility.

As part of its regular monitoring efforts, the Québec Ombudsman has unfortunately observed that some babies slip through the cracks of the safety net set up for their protection. This year, the media reported the suspicious deaths of two babies just a few months old, while a third suffered multiple fractures from abuse inflicted in the family environment. These events occurred in three different health regions. Furthermore, in all three cases, both the staff of the health and social services centre and the Director of Youth Protection had provided or were still providing health or social services to family members.

Concerned about events such as these, which occurred within months of each other in three different regions, the Québec Ombudsman decided to launch a systematic investigation that would shed light on the organization of services and the operation of the facilities and resources responsible for intervening in negligent families.

The Québec Ombudsman is currently comparing individual situations to find similarities and differences, draw lessons and find solutions to prevent repeat occurrences wherever possible.

Through its investigation, the Québec Ombudsman hopes to answer the following questions:

- Can the events in any of these regions be attributed to a lack of resources in the institutions involved and to coordination problems between them?
- Was the risk for these children assessed in accordance with current rules and recognized neglect prevention practices?
- How can service agreements among institutions help provide a stronger safety net and more adequate protection for children who remain in their family environment?
- How is the complementarity of roles and responsibilities put into practice among partners in the evaluation and supervision of negligent families and the provision of assistance and support?
- How are staff members guided and supervised in decisions that are particularly demanding and weighty due to their potential consequences?

## INTERNATIONAL ADOPTION IN QUÉBEC

In 2007-2008, the Québec Ombudsman investigated a situation in which applicants for international adoption apparently did not receive adequate support during the adoption process. This situation reflects concerns about the effective coordination of the authorities involved in the international adoption process, the sharing of responsibility and the obligation to report problems when they occur.

Our investigation found that applicants for foreign adoption do not have access to the same services as people who adopt a child from Québec. Disparities between regions were also observed.

More specifically, the Québec Ombudsman determined that:

- Since the information given to citizens by the Secrétariat à l'adoption internationale includes highly complex legal aspects, it must be simplified and adapted to the audience. The Secrétariat should also ensure that applicants fully understand this often-crucial information. As these essential criteria are not met, applicants do not necessarily grasp all the implications of their status. For example, in certain cases the applicants are not recognized as parents until they receive a placement order or judgment. Whether the child is from Québec or abroad, there must first be a placement order before the adoption judgment is rendered. The placement order confers parental authority on the adoptive parents, but not filiation.
- The support mechanisms offered by youth centres and the health and social services available to local adoption applicants are not available to those involved in the international adoption process. And yet these people may have a need for psychosocial support during the child's integration period, and even throughout the child's development. If they were to receive the same services as those available to parents who adopt children from Québec, the parents of children adopted abroad would have a better chance of success in the adoption and family integration process.

- There are also gaps in coordination and cooperation among the various bodies in Québec and service providers for international adoption applicants. The specialized resources are not widely known and referrals are not systematic.

In following up on the improvements announced by the MSSS and the youth centre, the Québec Ombudsman was informed of the following actions:

- In 2008, the Secrétariat à l'adoption internationale began the process of preparing a guide for resource workers in order to harmonize the services offered to local and international adoption applicants. The Secrétariat expects to complete the guide by June 2009. A training program for resource workers in health and social services centres is also being developed, to ensure greater consistency across all regions of Québec. The outline has been approved and training is expected to begin in 2010. Lastly, an advisory committee is working to improve the quality of the information given to international adoption applicants, which will be presented in a document that should be available by June 2009.
- The youth centre in question has ensured that its personnel are receiving the supervision and training they need and are making good use of the available tools to track local and international adoptions.

In light of the response to our earlier interventions with regard to these issues, the Québec Ombudsman recommends the following to the MSSS:

## RECOMMENDATIONS

Whereas the Ministère de la Santé et des Services sociaux announced its new guidelines for local and international adoption and post-adoption services in 2008;

Whereas this new service offer demands complementarity of services between youth centres and health and social services centres for the evaluation and preparation of applicants, situational follow-up and support of the adoptive parents;

Whereas the MSSS wants all resource workers involved to receive pre- and post-adoption training based on the needs of the children, the adoptive parents and the conditions of international adoption;

Whereas these guidelines must be implemented in all regions of Québec by 2012;

**The Québec Ombudsman recommends:**

**That services for parents of children adopted from Québec or from abroad be harmonized, to achieve equity;**

**That the MSSS submit a progress report and share the results for each region of Québec in order to harmonize the services availalbe to local and international adoption applicants;**

**That the MSSS report to the Québec Ombudsman no later than January 2010.**

### COMMENTS FROM THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

These are the comments from the Ministère de la Santé et des Services sociaux, as expressed by the Deputy Minister:

"In 2004, the Secrétariat à l'adoption internationale set up a coordination committee made up of representatives of youth centres, certified organizations and professional orders. For the sake of consistency, fairness and accessibility, the committee defined a number of priorities for international adoption, including training for professionals, information and preparation sessions for international adoption applicants, and the harmonization of practices. The training program was finalized in September 2008. A deployment program for the network is under development."

The Ministry did not respond to the second and third recommendations.

## Rehabilitation centres

Rehabilitation centres work with people who have physical or intellectual disabilities or pervasive developmental disorders. Rehabilitation centres have agreements with family-type resources and intermediary resources to accommodate their users when necessary.

In its 2007-2008 annual report, the Québec Ombudsman asked the Ministère de la Santé et des Services sociaux (MSSS) to take the steps required to implement special access mechanisms so that speech therapy services would be available within a reasonable timeframe.

According to the MSSS, the *Plan d'accès aux services pour les personnes ayant une déficience* published in June 2008 fulfills the Québec Ombudsman's request, in that it defines standards for service access and continuity. The plan introduces a measure for institutions that cannot meet the demand for service, which promotes resource sharing, agreements with other institutions or, if necessary, recourse to private sector services under certain conditions.

This access plan stipulates that general services and services for people with specific temporary or acute and reversible problems be offered by local institutions or physicians' offices (primary care). Specialized services are to be offered by rehabilitation centres (secondary care). However, the access plan does not specify which activities come under the purview of which of these two levels of intervention. As far as mental impairment is concerned, the vast majority of services have been traditionally offered by mental rehabilitation centres. Due to the transformation of the network, it has become crucial to guarantee service continuity before making a transfer to a primary care resource.

Several complainants had their files closed after being transferred from their original institution, which had closed down, and were put on a waiting list at the new institution to which they were transferred. The Québec Ombudsman feels that wait times in this situation are currently unacceptable and that they contravene the principle of continuity that must be upheld in the provision of user services. Ongoing service must be guaranteed until the new institution takes over.

## REHABILITATION WAIT LIST

*When patience is tested!*

Again this year, the Québec Ombudsman received many complaints about wait times for initial service in a physical or mental rehabilitation centre. These long wait times, up to four years in some cases, are extremely detrimental, especially to children, for whom delays have impacts on learning, school integration and the ability to develop autonomy. Furthermore, the failure to maintain contact with the parents during these prolonged waiting periods is perceived as a lack of interest on the part of the institution.

The Québec Ombudsman intervened again this year to remind rehabilitation centres of the importance, even in situations of resource scarcity, of regular follow-up with users on the waiting list, who often feel forgotten and abandoned. We endorse the initiatives launched by institutions offering services to users on the waiting list, especially social skills activities for children and group meetings to help parents support their children.

### Contact must be maintained with parents on waiting lists

*Pierre is 16 and has been waiting for a spot at a mental rehabilitation centre since he was 12. His parents, who always have to initiate contact to find out how their application is progressing, feel abandoned, and they are losing confidence in the institution's reliability and its interest in their son's situation. The Québec Ombudsman has asked the institution to communicate with the family more regularly in order to maintain contact and inform them of the latest developments.*

## SUPPORT FOR NATURAL CAREGIVERS OF DISABLED PEOPLE

The natural caregivers of disabled people have access, through their CLSCs, to financial assistance for respite and caretaking services. To receive this assistance, they must prove that the person meets the legal definition of *disabled person*. But for some children with non-specific general developmental delays, the diagnosis of disability cannot be confirmed until they are older. To ensure that these parents are not left without support, some institutions provide assistance on a temporary basis that may last for up to several years. Admission is conditional on confirmation of a diagnosis of disability, which often occurs around the age of six. Although this practice is fair to the families in question, it may also be detrimental if information on the temporary and conditional nature of the admission is not communicated clearly. This is illustrated by the following example from a complaint filed this year with the Québec Ombudsman, which resulted in a recommendation to improve the management practice for this kind of admission, especially in terms of the information given to users.

## The right information at the right time: no surprises for the parents

*The mother of a six-year-old boy with a general developmental delay enjoyed five years of natural caregiver support, but her most recent request for renewal was refused because her son, having reached the age of six and having been re-evaluated, does not meet the legal definition of disabled person. The mother, who had not been told that his admission was conditional, had always believed she met the requirements for the assistance measure, which had been granted every year for the five preceding years. The Québec Ombudsman recommended that the management guide for this measure should stipulate the need to officially inform temporary admission recipients that the assistance is exceptional, temporary and conditional on obtaining a diagnosis of disability. It was also recommended that a notice of cessation of assistance be issued, to give the families a reasonable time to organize their situation and avoid sudden and unpleasant surprises.*

Sometimes, during the analysis of a complaint, the Québec Ombudsman concludes that no law, guideline or policy has been broken, but that the specific circumstances justify accommodation. This is the case in the following example.

## Helping can be so simple

*A four-year-old child with pervasive developmental delay is being served by a mental rehabilitation centre under an intensive behavioural intervention program. Initially, the child was receiving program services at a local daycare centre. When the daycare facilities became inadequate, however, it was decided that the services would be dispensed in the local mental rehabilitation centre. The child had to be transported back to the daycare centre after the intensive behavioural intervention sessions. Since the resource workers from the mental rehabilitation centre had to go to the daycare centre after the work session with the child in order to continue the intervention, it seemed natural to the mother that they take the child with them in the car. Her request was refused by the mental rehabilitation centre because the facility's mission is not to provide transportation to users; this is the parents' responsibility. The facility was afraid that granting this privilege to this particular user would set a dangerous precedent.*

*The Québec Ombudsman first ascertained that the provision of transportation for a user would not create any specific insurance issues for the facility or staff. Once this was established, it was determined that in this case it was not a question of creating a new transportation service, which is clearly not part of the mission of a mental rehabilitation centre. It was simply a matter of allowing a user to take advantage of transportation that was already in place, since the resource workers had to make the journey in any case. As far as parental responsibility is concerned, the Québec Ombudsman is of the opinion that it may reasonably be shared with a public facility when circumstances permit. The Québec Ombudsman feels that this case lends itself well to this shared responsibility. Given the overall situation, it was felt that the parent's request was reasonable since the cost and repercussions for the organization of services were inexistent and the facility had the capacity to grant this request at no additional cost. We therefore recommended that the facility authorize, exceptionally, the transportation of this user by the resource workers. The mental rehabilitation centre accepted the Québec Ombudsman's recommendation.*

## ACCESS TO RESIDENCES: RESPECTING RIGHTS

Many disabled people live in non-institutionalized residences. These family-type resources first appeared after deinstitutionalization was introduced in the 1980s. Rehabilitation centres enter into contact with individuals who agree to offer safe and appropriate accommodation for the people they house, in exchange for compensation. The vast majority of families want to maintain close ties with their disabled relatives placed in these residences, but sometimes the host family feels that the natural family is too intrusive. Given the scarcity of this kind of resource and the difficulty of recruiting new resources, rehabilitation centres must uphold the rights of users while ensuring that the working conditions of the residential resources are acceptable.

### The presence of family: grounds for agreement

*The mother of an intellectually disabled youth called on the Québec Ombudsman because the mental rehabilitation centre forbade her access to her daughter's residence. When she went to pick her daughter up, she was obliged to remain on the doorstep. The institution justified its decision because relations between the mother and the host family were very tense. It was feared that the situation would degenerate to the point that the head of the host family would refuse to keep the disabled girl.*

*The Québec Ombudsman's investigation established that these restrictions contravene the agreement between the mental rehabilitation centre and the residential resource, which stipulates that the host family must admit people who are important to the user at reasonable times and facilitate their relationship. In exchange, the resource's obligation to offer services authorizes it to regulate the conduct of the visitors. We recommended that the mental rehabilitation centre hold a meeting between the girl's mother and the head of the host family, in order to come to an agreement that would give the mother access to her daughter under conditions that are respectful of the living and working situation of the host family.*

In 2009-2010, the Québec Ombudsman plans to exercise particular vigilance with regard to waiting times and service disruptions, drawing on the *Plan d'accès aux services pour les personnes ayant une déficience* to formulate its recommendations. In handling complaints, we will ensure that the clients targeted by this plan are treated fairly, no matter what type of disability they have or where they live.

# Residential and long-term care centres

Residential and long-term care centres (CHSLDs) are the final homes of most of the people who live there, many of whom require careful and sustained attention, in addition to specific care and services. The task of ensuring that CHSLDs provide a quality living environment requires constant vigilance and effort because of the serious cognitive losses of many of the residents.

In its last two annual reports, the Québec Ombudsman noted several shortcomings in CHSLDs. Some of these shortcomings were related to inadequate care and services or inadequacies in the physical environment, including cleanliness and healthiness. We also mentioned interpersonal problems between staff and members of the residents' families and between some staff members and the residents themselves, as well as failures to respect residents' rights in certain circumstances.

Because CHSLD residents are so vulnerable, vigilance is particularly critical to their safety and well-being. The MSSS has been carrying out service quality assessment visits in CHSLDs since 2003-2004. These visits take place every year from September to June. The objective for 2008-2009 was the same as in previous years, namely to visit 12% of CHSLDs. The data we received from the MSSS in March 2009 indicate that it is meeting its progressive objective for assessment visits this year.

## MINISTERIAL GUIDELINES CONCERNING THE QUALITY OF THE LIVING ENVIRONMENT

In 2007-2008, after learning of certain shortcomings, the Québec Ombudsman approached the MSSS once again on the topic of implementing the ministerial guidelines concerning the quality of living environment in CHSLDs. Various issues were raised with the MSSS, including privacy and respect for people at the end of life, controlling violent and aggressive behaviour in the centres, and the staff's ability to whistle-blow confidentially and with no fear of reprisals.

The MSSS response demonstrates why the implementation of these guidelines has been insufficient for the last five years – in other words, ever since the guidelines were instituted.

After publishing the guidelines in 2003, the MSSS began quality assessment visits in 2004, increasing the number of visits from 10% to 12% per year. In June 2004, a review of visits to 47 CHSLDs led to the formulation of 29 recommendations and an action plan was prepared for local, regional and provincial facilities. At the end of 2009, the MSSS plans to issue a province-wide report on the quality assessment visits carried out in 2004-2005, 2005-2006 and 2006-2007. A review of the recommendations addressed to the institutions will also be produced, outlining priorities for action.

At this pace, the MSSS will have visited just over 60% of the resources five years after starting the assessment process. The first report, expected at the end of 2009, will cover only 30% of all CHSLDs. Given the low percentage of resources visited and the scope of the review, the Québec Ombudsman is not surprised that there are problems with the implementation of the ministerial guidelines.

To raise awareness of the MSSS guidelines, training programs will continue to be offered to board members, executives and the 35,000 user care attendants. Every regional health and social services agency has the responsibility to work with the institutions in its territory on a deployment plan for the training.

Although this process is both relevant and logical, the Québec Ombudsman has once again found gaps in the system for implementing the ministerial guidelines. Implementation is conditional on the commitment and capacity of all the stakeholders involved. The Québec Ombudsman is still concerned about this matter and will continue to monitor the implementation of the guidelines.

## PRIVACY AND RESPECT FOR RESIDENTS AT THE END OF THEIR LIVES

The Québec Ombudsman noted that residents and families do not always receive the privacy to which they are entitled at the end of the resident's life. In some facilities, space restrictions mean that families are obliged to attend the death of a relative in the presence of another resident.

In response to this deplorable situation, the MSSS 2005-2010 action plan for services to seniors with loss of autonomy includes renovations valued at $500 million. The Québec Ombudsman acknowledges the extent of the investments required, but feels that respecting the need for privacy in these circumstances is not primarily a question of money; it is up to the institutions themselves to provide their residents with privacy. The Québec Ombudsman is aware, however, that the remedial measures required to provide privacy depend on the decisions and priorities of the individual institutions, and that as such, appalling situations such as these may recur.

The MSSS has informed the Québec Ombudsman that the quality assessment visits look specifically at this aspect. We will remain on the alert and take steps immediately if such events recur.

## MANAGING VIOLENCE AND AGGRESSIVE INDIVIDUALS

Last year, the Québec Ombudsman learned that some mandataries and legal representatives behave uncivilly and disrespectfully toward CHSLD staff, make threats or demonstrate physical or verbal violence. It was therefore suggested that the CHSLDs inform mandataries and legal representatives of their code of conduct.

The MSSS reports that during quality assessment visits, all groups are questioned about the information they receive concerning the code of ethics. The Québec Ombudsman believes that by meeting with users, their families and the user committee, the quality assessment visits will help make mandataries and legal representatives aware of the need to comply with the code of conduct. Since this recommendation is addressed to the CHSLDs, the Québec Ombudsman will carry out additional checks during its next investigation of these centres.

We also pointed out to the CHSLDs that mandataries and legal representatives must know who to contact for information, especially regarding the complaint procedure. This would prevent certain conflicts from arising. To follow up on this point, the MSSS asked the local complaints and service quality commissioners and user committees to help develop the appropriate measures for the institutions. Over the next year, the Québec Ombudsman will ensure that the MSSS fulfills this commitment during its ongoing investigation of the CHSLDs.

## FINDINGS FOR 2008-2009

The Québec Ombudsman found that the CHSLDs which were the subject of complaints this year carried out our recommendations within the agreed timelines.

Among the complaints processed in 2008-2009, the Québec Ombudsman discovered some unacceptable situations, including resident transfer conditions, the capacity of some residences to house and care for their residents, hygiene and healthiness, the quality of care, and mixed facilities.

There is extensive pressure to free up beds in hospitals. Close management of hospital beds means that discharged patients must leave as soon as a place can be found that provides the services their condition requires. This practice has advantages and disadvantages. The health and social services network can be compared to a huge corporation with a great many branches, each with its own performance objectives.

The CHSLDs are not isolated from the rest of the network. They have a very specific role to play, namely accommodating and satisfying the needs of people with serious loss of autonomy.

To meet the legitimate expectations for sound management of specialized services, the public sector is calling increasingly on the private sector, as permitted by the Act respecting health services and social services. As such, regional agencies and certain categories of institutions have budgets to purchase places in self-financed private CHSLDs, seniors' residences, intermediary resources or family-type resources. Demand is so great that new resources are being created to meet it, and this, in turn, has increased the number and diversity of partners involved in the supply of residential and long-term care.

One emerging phenomenon is a matter of concern to the Québec Ombudsman, however: the speed at which these new resources are opening. This is worrisome in terms of the quality of the transition, transfer conditions and continuity of care required, especially after hospitalization. Protecting citizens' legal rights is also a matter of concern. The complaints received generally relate to situations where the urgency of placement means that new residents are not informed of their rights ahead of time. It is up to the agencies and institutions entering into agreements with these private residences to ensure that all the patient's legal rights are respected, regardless of the resource to which they are sent.

## RESIDENT TRANSFER CONDITIONS

Section 14 of the Act respecting Health Services and Social Services stipulates that an institution may cease to provide accommodation to a resident who has been discharged only if, based on their condition, the person can return home or be transferred to other accommodations. This section stipulates that no transfer can be made unless a place is guaranteed to the user in another institution, an intermediary resource or a family-type resource where the appropriate care and service is available. The Québec Ombudsman discovered this year, however, that despite this legal obligation, some facilities are not able to adequately care for their residents for reasons that include lack of equipment, defective equipment, lack of qualified personnel or staff shortages.

### Distressing situation due to defective equipment

*An elderly tracheotomy patient transferred from a short-term care facility to a long-term care unit ended up in a distressing situation because of equipment failure. The personnel were not able to suction off the patient's tracheal secretions, leading to respiratory distress.*

*The Québec Ombudsman recommended that the facility adopt a resident transfer procedure and a preventive maintenance procedure to ensure the availability of the equipment required by users after transfer to their care. Both procedures are now in place.*

## CAPACITY

Every institution is obliged to have the staff, equipment and supplies required to meet the needs of the dependent people in their care. It is also critical to ensure that the equipment is functional at all times. It is up to the originating institution to communicate the user's special or ordinary personnel and equipment needs. It is incumbent on the accepting institution, if it does not have the required staff or equipment, to refuse admittance to the user under section 14 of the Act respecting Health Services and Social Services. This is in the best interests of the user.

## CHSLD FOLLOW-UP

CHSLDs house highly dependent users who sometimes return to the centre after a hospitalization. These people often require post-hospital care, and sometimes come back with wounds or nosocomial infections. Can we be assured that every unit of every CHSLD has enough skilled personnel to provide wound care, take steps to prevent infections and manage patient isolation for a nosocomial infection? With regard to wound care and follow-up care for nosocomial infections, the personnel need professional development, must maintain their skills and be available to take action as needs arise. The Québec Ombudsman has found that despite the application of prevention measures in hospitals, nosocomial infections cannot be completely avoided. Even for isolated cases, the consequences can be significant in human terms.

### CHSLD personnel overwhelmed by the situation

*An elderly man is discharged from the hospital, where he contracted two nosocomial infections. He also has bedsores. Although his condition seems difficult for the staff to handle, he is nevertheless admitted to a CHSLD. An occupational therapist prepares for his arrival and sets up a mattress as well as special cushions in the bed and on the wheelchair.*

*After a while, the CHSLD personnel are completely overwhelmed by the situation: the man's bedsores get worse despite medical follow-up, changes in treatment and the use of all the centre's resources.*

*The Québec Ombudsman's investigation revealed that the regular procedure was not followed in the assessment of the user's condition and that the deterioration of his condition was not reported. In addition, his urinary incontinence and the effects of Clostridium difficile made it necessary to change the dressings more often. This, along with the fact that the man was having trouble eating, exacerbated the condition of his bedsores.*

*In concluding that there was a shortfall in the follow-up care offered to this resident, the Québec Ombudsman noted that he needed care and attention that the CHSLD was not able to provide. It was also recommended that the CHSLD acquire the expertise to prevent and treat bedsores and provide appropriate care and follow-up for this type of infection.*

### A resident falls three times in one year

*The Québec Ombudsman conducted an investigation after a resident fell three times on the same floor of a CHSLD. The report was substantiated, but the facility had implemented four mechanisms with the principal purpose of preventing various incidents and accidents, including falls.*

*Although each of the falls was properly reported, no thorough analysis of the circumstances was ever carried out. Such an analysis may have prevented subsequent falls. After the resident fell for the third time, disciplinary measures were taken against the employee at fault.*

*Following the Québec Ombudsman's intervention, the director of the facility made a commitment to place more emphasis on the fall prevention program and provide the staff with training on control measures.*

### Insufficient risk management: 21% increase in falls among residents at a CHSLD

*An investigation by the Québec Ombudsman in a CHSLD revealed that the institution had adequate physical and material facilities. A summary examination of the fall report for the last two years, however, showed that there had been a 21% increase in 2007-2008 compared to the previous year, that many falls (46%) occurred between 11 AM and 6 PM, and that numerous incidents (39%) occurred during meal times.*

*These observations led to an examination of the work organization, oversight, training and supervision of the staff. To correct the situation, the Québec Ombudsman recommended that within three months, an individualized intervention plan be created, taking into account the safety needs of every resident and the actions required to meet them. We also recommended that within three months the CHSLD establish a fall prevention program and that the staff be trained on its application. Finally, we asked that the institution file monthly reports concerning accidents, their consequences and the prevention measures applied.*

## MIXED CLIENTELES

User needs in the health and social services network differ based on the user's physical and mental health, lifestyle habits, degree of autonomy, and psychosocial and economic situation. Institutions that house users try to group them together by characteristics to make it easier to provide care and services. But some adults who require permanent placement and have serious behavioural problems have trouble finding care suited to their needs in regular CHSLD units. "Specific" units have been developed to provide them with the support, supervision and services they need.

The vocation, programming, organization and functioning of these specific units differ in different CHSLDs and different regions. The issues stemming from serious aggressivity or agitation problems are quite varied. This means that adults of all ages who may have serious cognitive disabilities caused by intellectual disabilities, mental health problems, cranial trauma, strokes or vascular dementia may end up living together. These people often have different needs, and some say they do not feel comfortable in their living environment. Analysis of one particular situation brought to our attention led to the formulation of recommendations for group and individual applications to provide adequate and optimal orientation for every resident, on a continuous basis. To follow up on this intervention, user needs were reassessed and the mechanism used to determine access to accommodations was reviewed in partnership with network stakeholders.

### An inappropriate place of residence

*A 50-year-old stroke victim with behavioural problems was living in a unit located more than 250 km from his home. He reacted violently to the placement. He contested the choice of the resource he was assigned to, rejected his intervention plan and claimed that his rights were not being respected because he was grouped with people less lucid than himself. He asked to be placed in the CHSLD of his choice, but was refused because of his behavioural problems. The Québec Ombudsman recommended a re-assessment by a team of experts to provide him with services and accommodation that were better suited to his condition.*

## PRIVATE SENIORS' RESIDENCES

Of the 2,199 private seniors' residences targeted, only 686 had obtained certification by April 7, 2009. And yet 99.7% of the owners applied within the deadline. The certification process serves to prove to the residents that these residences comply with the regulations or have made a commitment to achieve compliance within a certain timeframe. Certification also guarantees that the residence operator has and maintains liability insurance.

### False representation: a private residence claims to be equal to a CHSLD

*The Québec Ombudsman investigated a private residence that had begun its certification process with a regional health and social services agency. It was noted that the vocabulary and explanations used by the owner in presenting the residence's services suggested that it could accept highly dependent residents and care for them until the end of life.*

*One of the facility's residents fell repeatedly, also injuring an employee, and as a result specific safety measures were implemented. For example, some furniture had to be removed from the room to facilitate the use of a patient lift, and restricted use of the walker was recommended because of the architectural constraints and the limited number of personnel.*

*The institution was neither suited nor authorized to offer all the services needed by the resident in question, a 98-year-old woman. The Québec Ombudsman therefore recommended that the regional agency ask the directors of this private residence to stop claiming that they could fulfill the role of a CHSLD and immediately correct the content of their advertisements.*

## QUALITY ASSURANCE REQUIRED

### RECOMMENDATIONS

Whereas residents are extremely vulnerable and there is the potential for isolation and the risk of abuse;

**The Québec Ombudsman recommends:**

**That the Ministère de la Santé et des Services sociaux step up the pace of its quality assessment visits in order to offer CHSLD residents a quality living environment;**

**That private seniors' residences be included in the resources that must undergo priority ministerial assessment visits;**

**That quality indicators be included in management agreements between agencies and institutions, and that the contracts made with private resources explicitly set out the level of quality expected and the means of quality control;**

**That the capacity of the resources to meet the specific needs of their residence be ascertained.**

### COMMENTS FROM THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

These are the comments from the Ministère de la Santé et des Services sociaux, as expressed by the Deputy Minister:

"It can be confirmed that the target of 12% of facilities to be visited will be achieved by the end of this current year (June 2009).

In 2009-2010, the MSSS will draw up, for each region, a portrait of the current situation concerning accommodations resources that have a purchase agreement for places or services, and analyse the conditions of the agreements concluded between the health and social services agency, the health and social services centre and the private promoter."

## LEGISLATIVE OVERSIGHT

In February 2009, the Québec Ombudsman intervened with the Office des professions with regard to the proposed Regulation to amend the Regulation respecting the activities engaged in and described in sections 39.7 and 39.8 of the Professional Code. This draft regulation, published in the Gazette officielle du Québec on January 14, 2009, concerns activities carried out under certain conditions by the operator or staff of a private seniors' residence which would otherwise be reserved for professionals. The activities in question are the invasive care involved in assistance with activities of daily living that is required on a sustained basis for the maintenance of health and the administration of prescribed, ready-to-administer medications. The Québec Ombudsman raised concerns about the training of people authorized to carry out these activities, the maintenance of their knowledge, quality control, and the liability insurance of residences in the event of staff errors. To this end, it was recommended that the regulation specify the minimum level of training required to carry out these activities and include a provision that the CHSLD in the residence's territory must establish ongoing professional development and quality control mechanisms for the activities in question. We also asked that a provision be included requiring that the residence hold a valid compliance certificate so that the users will have liability insurance coverage.

The Québec Ombudsman also took the opportunity to state its concerns about the application of the regulation on free access and continuity of services for seniors in residences, which it had also brought to the attention of the Minister of Justice responsible for professional laws, the Minister of Health and Social Services, and the Minister responsible for Seniors. The Québec Ombudsman's aim in doing this was to ensure that health and social services centres are still prepared to offer these services free of charge to all seniors who need them, whether or not the residential facility offers them, so that vulnerable people will not have to assume the cost of these services themselves or go without because the cost surpasses their financial capacity.

## PRIVATE RESIDENCES FOR OTHER VULNERABLE PEOPLE

### WHAT ABOUT MANDATORY CERTIFICATION?

In 2008-2009, the Québec Ombudsman once again received complaints concerning private residences not certified by the MSSS and providing services mainly for people with addictions. The complaints involved addiction resources and the care and services offered to users, as well as the environment in which those services are provided.

Since this type of private non-certified residence is not subject to the complaint examination system and does not fall under the jurisdiction of the Québec Ombudsman, we had to call on a number of ministries and bodies such as the Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec (MAPAQ), the Ministère de l'Emploi et de la Solidarité sociale (MESS), and the municipal health and social services agencies to ensure that these residences meet certain standards. These government bodies are able to verify whether or not the resources comply with their laws and regulations, but do not have the expertise to assess the quality of care or the risks to the users. They were unable to provide answers or suggest corrective measures for the complaints filed by users of private residences.

In the spring of 2001, the MSSS launched a certification program for private and community organizations providing addiction services and offering accommodation. The program is voluntary, not mandatory. As of February 24, 2009, 46 of the 95 known residences had received compliance certificates for the standards deemed necessary and sufficient to provide users with quality services and physical and psychological security.

### NEED TO ACT

The Québec Ombudsman reiterates the recommendation made in our 2007-2008 annual report, to the effect that private residences accepting addicts with mental problems or intellectual disabilities should be certified and subject to the application of the complaint examination system under the Act respecting Health Services and Social Services. Without mandatory certification, there is no guarantee of adequate intervention and treatment in a safe and healthy environment. Furthermore, the users – or third parties acting on their behalf – have no recourse to the complaint examination system in case of dissatisfaction.

In its December 2008 action plan, in response to the Québec Ombudsman's recommendations, the MSSS states that it is preparing an omnibus bill to provide for the certification of private residences serving various vulnerable client groups. This bill would also provide oversight for private or community resources offering accommodation to these clients. The Québec Ombudsman notes that no date has been proposed by the MSSS for the adoption of this omnibus bill.

Given the importance of guaranteeing the quality of the care and services offered to vulnerable people, the Québec Ombudsman would like to emphasize the urgent need for this new legislation.

# Hospital centres

Given the scope of its actions and the resources at its disposal, it is not surprising that the hospital sector is the source of the most health and social services related complaints received by the Québec Ombudsman. The continuity of care and services, wait times, backlogs in emergency rooms and the risk of infection continue to be matters of concern or dissatisfaction for users.

## CONTINUITY OF CARE AND SERVICES

A user's journey through the complex health network to obtain care, either personally or for a relative, is sometimes torturous and full of obstacles. The complaints received by the Québec Ombudsman indicate the existence of problems when users move from one service to another within the same CLSC, from one facility to another within the same health and social services centre, or from one institution to another via an existing service corridor. The Québec Ombudsman notes that the lack of continuity is evident in emergency wards, during hospitalization and on the patient's return home.

### A social resource worker would have been of valuable assistance

*A user who regularly suffered intense headaches due to a deformity often went to the emergency room. He would spend a few days there, be discharged and return home when he felt better. And then the cycle would repeat. As the years went by, he was increasingly fearful of returning home alone because he was afraid of falling and wanted a convalescence period before being sent home. This user would have benefited from the support of a patient navigator, but no one thought of asking the emergency ward social worker to evaluate his temporary care needs and match him with the most appropriate resource.*

### Information that would have made all the difference

*During a stay in the hospital, an elderly woman fell on her way to the bathroom, fracturing her hip and undergoing orthopaedic surgery as a result. The nurse's aid who went with her to the bathroom had not been informed by the nurse in charge that the woman suffered from a significant weakness on her right-hand side which limited her ability to walk independently. The nurse's aid was also not told how to keep the woman safe during displacements. Continuity of service relies on specific factors, and this lack of information could have led to dire consequences.*

### After waiting fifteen months, he only had the wheelchair for five days

*An elderly man with seriously impaired autonomy due to chronic obstructive pulmonary disease needed an electric wheelchair. The multidisciplinary team at the hospital that assessed his functional needs and the required changes to his home passed this information along to the CLSC. The man had to apply for the wheelchair through the occupational therapist at the CLSC, but it was the rehabilitation centre that would actually provide the equipment. After a series of misunderstandings and delays in obtaining the wheelchair, the family finally approached the rehabilitation centre directly. Fifteen months passed before the user was finally given the wheelchair he needed. If a patient navigator from the CLSC had been working with the user and his family, he would have received the wheelchair much more quickly. Unfortunately, he died just five days after receiving the wheelchair. In this case, gaps in service continuity occurred after he was discharged from the hospital.*

## ACCESS MECHANISM FOR SPECIALIZED MEDICAL SERVICES: AN ATTEMPT TO REDUCE WAIT TIMES

The complaints received by the Québec Ombudsman reveal lengthy wait times for initial appointments with specialists to undergo prescribed tests, surgery or treatment. At every step, the user's name is added to a waiting list for appointments. Surgeries are also deferred at the last minute, sometimes repeatedly for the same patient. A number of the complaints handled by the Québec Ombudsman revealed that appointments are often given to people on the waiting list based on the date on which they registered, with no consideration for the urgency of the situation. The health problems of some users may become worse as the wait time increases.

To reduce wait times, the MSSS has established an access mechanism for specialized medical services, especially non-emergency surgery. The Government made a commitment that, as of June 1, 2007, surgery for complete knee or hip replacement and for cataracts would be completed within six months for patients registered in the access to specialized services information system. If the institution has valid reasons for not meeting this timeline, it must, jointly with the attending surgeon, make a second offer to the patient. This offer consists of one of the following options:

- Have the operation performed by another physician in the same hospital
- Have the operation performed by a physician in another hospital in the same region
- Have the operation performed by a physician from outside the region
- Have the operation performed in a specialized medical centre

The patient has the right to refuse the second offer. A patient who refuses will remain on the hospital's wait list but the wait time may be longer than six months. If the patient accepts, the transfer will be arranged and the wait time for treatment will be no more than six months in total, including that related to the second offer.

This year, the Québec Ombudsman heard complaints which suggested that this access mechanism requires further refinement.

### Back to the beginning after a refusal

*The access mechanism was triggered following a complaint from a woman awaiting hip surgery since September 2006 (twenty months at the time the complaint was filed). Since the expected wait time for the surgery was over six months, the institution made a second offer which the patient refused, for valid reasons. However, she was told her name would be placed at the end of the waiting list as a result. The Québec Ombudsman considers this practice, which is clearly punitive to the user, to be unacceptable.*

### Waiting for more than two years for surgery

*A user awaiting surgery complained to the Québec Ombudsman about the long wait time and the lack of access to information. In April 2006, the orthopedist determined that the man needed an operation to reconstruct a ligament. In December of the same year, the man was called to a pre-operatory appointment for certain tests, and was told he would be contacted in January 2007 to set a date for the surgery. In October 2007, with still no word from the hospital, the man decided to inform the local complaints and service quality commissioner. In December 2007, he was called to a second pre-operatory appointment, because the test data originally gathered had become obsolete.*

*In January 2008, nearly two years after having been told he needed orthopedic surgery, the man still had received no news and was no longer able to participate in any sports. He had missed several work opportunities because he dared not leave his region, in case the hospital called during his absence and he missed the opportunity to have the operation. This considerably reduced his quality of life. He eventually had the operation in March 2008. Our investigation concluded that the wait time and lack of information were unreasonable, and the institution has made a commitment to take steps to improve the situation.*

## EMERGENCY SERVICES: AN ONGOING CHALLENGE

The state of emergency rooms is an indicator of the overall state of the health service network. Overuse of stretchers and corridors in emergency rooms reflects a shortage of beds on the floors, which in turn reflects the shortage of residential placements, convalescence beds and home care. There is also the question of whether the wait time to see a physician in the emergency room is indicative of the lack of access to front-line medical services.

Despite financial investments and efforts to improve the functioning of emergency rooms in recent years, wait times were still the primary reason for complaints about hospital centres in 2008-2009.

### Pregnant, bleeding and in pain, the user waited for 15 hours!

*On the recommendation of her family doctor, a woman who was ten weeks pregnant, with spotting and abdominal pain, went to the emergency room with her husband. The triage nurse evaluated the treatment priority at level 4, which requires re-evaluation every hour.*

*Although the woman and her husband asked to see the nurse again because of increased pain and bleeding, the woman was only re-evaluated 12 hours later and did not see a doctor until 15 hours after first arriving at the emergency room. The Québec Ombudsman found that the nursing staff did not provide the couple with any information and did not reassure the woman or make her more comfortable, even though the couple was facing a difficult emotional situation, given the risk of losing the baby.*

Most of the complaints filed with the Québec Ombudsman with regard to emergency services came from patients whose state of health was evaluated at level 4 or 5 treatment priority, mostly in the Montreal region. The professional practice guide entitled *Le triage à l'urgence* states that the permitted time for level 4 patients, considered "less urgent," is 60 minutes, while for level 5 "non-urgent" patients, it is 120 minutes. However, the complaints received suggest that these wait times are commonly exceeded without the users being re-evaluated or informed of the situation. On the other hand, there were few complaints from patients whose state of health was evaluated at level 1, 2 or 3. When these patients did complain, it was also because of the wait time. Sometimes patients whose state of health was evaluated at priority level 4 were actually more critical.

## With no family doctor, the user went to emergency

*A woman and her husband went to the emergency room of a regional hospital. She had felt exhausted for some time, and wanted to see a doctor for a specific diagnosis of her condition. According to the file notes, the woman arrived at emergency at 10:05 AM. She was seen in triage immediately and her condition was assessed as being level 4. The file notes specify that the woman was tired, was no longer able to sleep, had been feeling sad for two weeks and was having problems with her daughter, who was using drugs. She was not in pain and wanted to see a social worker. Around 1 PM her husband asked the reception staff why there was such a long delay. He was informed that a patient had arrived in cardiac arrest. It was not until 4:50 PM, after nearly seven hours, that the woman was finally able to see a physician.*

*The day the woman came to the emergency room, a single physician was on duty. According to the standard established by an MSSS / Fédération des médecins omnipraticiens du Québec parity committee, only a single physician is required at this emergency ward. These standards take traffic and activity volume into account. However, with only a single physician on duty, patients evaluated at priority level 4 or 5 will automatically be made to wait if people needing immediate care are admitted.*

In this example, the woman should obviously have gone to a family doctor or the local CLSC to meet a social worker. Why did she go to the emergency room? What were her options? According to the institution, people evaluated at priority level 4 or 5 are often forced to go to the emergency room because they have no family physician.

After its investigation, the Québec Ombudsman determined that the health and social services centre in question has been working actively to try to reduce the public's use emergency services. For example, it has set up a walk-in consultation service, and has established group prescription protocols to allow the emergency ward nurse, in certain circumstances (emergency contraception, thrush in infants, broken wrists or hips, etc.) to prescribe medication or x-rays without waiting for the patient to see the physician. It has also eased access to the technical support centre in order to accelerate diagnostic tests (radiography, laboratory tests, etc.) for users sent in by physicians in the community, and set up a follow-up clinic (outpatient services) for users seen by the emergency room nurse the day before.

In addition to illustrating inappropriate use of an emergency room, this example shows that solutions exist and that institutions have the capacity to take initiatives that will help them assume their responsibility towards the public. The Québec Ombudsman strongly encourages them to do this.

Last year, the Québec Ombudsman hailed certain new actions by the Ministère de la Santé et des Services sociaux to improve the performance of emergency rooms. Examples include easier access to front-line services and hospital medical equipment. The Québec Ombudsman also acknowledges the $15 million spent in 2007 on measures to facilitate the transition of hospitalized individuals to CHSLDs or convalescence centres, and the publication, in 2006, of the second edition of the Guide de gestion de l'urgence.

On March 4, 2009, the Québec Minister of Health and Social Services set up a round table on access to family medicine and front-line services. The round table, which will meet three times a year, has three main goals: to increase the number of family medicine groups from 180 to 300 within four years, to increase to 50% the proportion of medical students who choose family medicine over specialties, and to provide more people with access to the services of a general practitioner. The Québec Ombudsman feels that any initiative to this end is a step in the right direction, as long as it results in concrete solutions that can be applied in the short term and that will help reduce wait times in emergency rooms.

In light of the fact that wait times persist despite the measures proposed by the MSSS in recent years, the Québec Ombudsman is asking for a statement concerning the extent of implementation of the measures outlined in the last few years. We have also asked the MSSS to provide a report on the difficulties encountered and the actions planned to relieve congestion in emergency rooms and monitor the quality of the services for users whose state of health is evaluated at priority level 4 or 5 upon arrival in emergency. Finally, the Québec Ombudsman wants to be informed of the measures that the MSSS intends to adopt to ensure adequate application of the *Guide de gestion de l'urgence*.

## RECOMMENDATION

Whereas the situation in the emergency wards that the Québec Ombudsman investigated continues to be problematical;

Whereas emergency services are used extensively by people whose state of health is evaluated at a priority level of 4 or 5;

Whereas a round able has been set up to examine access to family medicine and front-line medical services, and expects to take four years to produce results;

**The Québec Ombudsman recommends that the Ministère de la Santé et des Services sociaux plan temporary solutions for the interim period, so that users whose state of health is evaluated at priority level 4 or 5 can gain access to front-line services.**

## COMMENTS FROM THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

These are the comments from the Ministère de la Santé et des Services sociaux, as expressed by the Deputy Minister:

"The key to the solution is access to primary care. In the meantime, certain steps can be taken to partly improve the situation:

- Conclude agreements between emergency rooms and the existing primary care network for patients with level 4 or 5 priority, in order to redirect them during triage. This cooperative approach should be supported by collective protocols and prescriptions and bolstered by quality control measures.
- Support innovative work organization projects that seek to improve the efficiency and effectiveness of the teams in place.
- Apply collective prescriptions during triage that accelerate processes and initiate therapeutic or diagnostic actions.
- Develop mechanisms such as clinical windows to allow family doctors to direct their patients to the right place."

## NOSOCOMIAL INFECTIONS

The Québec Ombudsman observed progress in the application of measures to prevent and control the transmission of infections, and notes that teams have been set up to address this task. The nature of the complaints received this year suggests that the actions taken by the MSSS have begun to produce results, although further progress is still required. These actions relate to screening times, the application of precautionary measures, and the accuracy of the criteria for placing patients in isolation and subsequently releasing them.

The complaints clearly show that measures to counter these problems are in place, but that they are not yet fully applied. The Québec Ombudsman has insisted institutions in respect of which complaints were received should communicate their measures to the staff and establish means of encouraging the acquisition of the required knowledge and skills.

In May 2008, given the wide variety of practices in both daily sanitary maintenance and disinfection, the MSSS issued an update to the guidelines concerning hygiene and cleanliness measures for *Clostridium difficile*. The Québec Ombudsman believes the rigorous and systematic application of all the proposed hygiene and cleanliness measures will ensure help to prevent and control infections.

Given the difficulties encountered by the health and social services network, the Québec Ombudsman has asked the MSSS to inform it of the steps that will be taken to ensure that institutions do in fact apply the May 2008 hygiene and cleanliness guidelines.

# PILOT AGREEMENT FOR PUBLIC PROFESSIONAL SERVICES IN A PRIVATE CLINIC

In October 2006, the Québec Ombudsman appeared before the Commission des affaires sociales to submit comments for the consultations on Bill 33, amending the Act respecting health services and social services. The bill will improve access to specialized and superspecialized medical services.

The Québec Ombudsman said at that time that it is important to uphold users' rights by ensuring that people who are sent to different resources to receive treatment enjoy the same quality of care and have the same access to recourse. It reiterated the importance of preserving the values of equality, freedom, dignity and solidarity for all citizens, as laid out in the Government proposal. In its opinion, this bill is an opportunity for the public and private sectors to uphold and respect these fundamental values.

At the same time, the Québec Ombudsman insisted on the need to control the quality of specialized medical services offered outside hospitals, while acknowledging that the bill (now a law) provides special measures to allow for this. If the measures are applied, they will reassure the people sent to these resources and fulfill their expectation of receiving the same quality of service as in a public network hospital.

With this in mind, the Québec Ombudsman will remain vigilant with regard to the introduction of new medical entities. The pilot professional services agreement between the Hôpital du Sacré-Cœur and the Centre de chirurgie Rockland MD offered the first opportunity for action.

## HÔPITAL DU SACRÉ-CŒUR DE MONTRÉAL AND CENTRE DE CHIRURGIE DE ROCKLAND MD

The Québec Ombudsman examined this pilot agreement in June 2008, to ensure that users temporarily directed to the Centre de chirurgie Rockland MD for outpatient surgery would enjoy the same rights and the same quality of service as in a public institution. It also wanted to ascertain that, in the event of dissatisfaction, the users in question had access to the recourse stipulated in the Act respecting health services and social services to defend their rights.

When taking on this issue, the Québec Ombudsman was not questioning the appropriateness of sending a patient to a private clinic for health services. These are social decisions that, under our democratic system, are the responsibility of the duly elected MNAs and the Government.

Following its analysis of the pilot agreement, the Québec Ombudsman formulated 11 recommendations for the MSSS and the network. These recommendations included a reminder about various obligations under the Act respecting health services and social services, and also addressed issues such as medical record confidentiality, health service security, and clinical supervision of nurses and respiratory therapists.

COLLECTIVE GAINS

The Québec Ombudsman's recommendations were accepted by the Health and Social Services Minister. The report can be consulted online at www.protecteurducitoyen.qc.ca.

The Québec Ombudsman also formulated two additional recommendations for the MSSS, concerning the implementation of similar agreements in the future. First, it asked the MSSS to establish guidelines for the content of agreements between other types of public institutions and private clinics, and to develop a model agreement. We also asked the MSSS to ensure that no balance billing be issued to users seeking specialized medical services at private clinics under such an agreement.

In November 2008, the MSSS informed the Québec Ombudsperson that it had taken note of the recommendations and would add them to the framework agreement currently under development.

The Québec Ombudsman plans to monitor the content of this framework agreement, which should be available to health and social services agencies in the coming months. It will also examine the draft regulation allowing for the expansion of private clinics and the provision of approximately 50 medical treatments. The coming into force of the regulation has been postponed until September 30, 2009.

### REIMBURSEMENT OF FEES FOR DENTAL CARE RECEIVED AS PART OF CANCER TREATMENT

To improve the treatment of mouth or throat cancer, doctors often prescribe dental care, including tooth extraction, but dental care is not covered by the Health Insurance Act. As a result, patients often have to pay thousands of dollars for this kind of care. In April 2008, the Québec Ombudsman took steps to have these fees reimbursed, and the MSSS agreed to do this by drawing on a discretionary budget. In March 2009, after receiving a list from the Centre hospitalier de l'Université de Montréal of users who had to pay these costs themselves, the Québec Ombudsman made a second request to the MSSS to reimburse preliminary dental care related to cancer treatment. The MSSS has yet to communicate its decision on the matter.

In addition to settling individual complaints, the Québec Ombudsman also asked the MSSS to ensure that dental care directly associated with cancer treatment be automatically covered by the network from now on. A ministerial committee has examined the question and has made the same recommendation to the MSSS.

COLLECTIVE GAIN

The Québec Ombudsman was informed by the MSSS on January 6, 2009, that the authorities had accepted the recommendation. Work began with the CEOs of health and social services agencies and radiation oncology services to provide free access to dental services for patients who require radiotherapy treatment, starting on April 1, 2009.

These services will be offered and paid for by the ten radiation oncology services in the Quebec health and social services network, and will represent an annual investment of some $1.2 million.

The Québec Ombudsman will approach the MSSS once again if the recommendation is not implemented by the proposed date.

## Local community service centres (CLSCs)

### ACCESSIBILITY AND CONTINUITY OF HOME CARE SERVICES AND HOME SUPPORT PROGRAMS

In its 2007-2008 report, the Québec Ombudsman made two recommendations to all institutions in the health and social services network that provide home support services. First, it recommended that the health and social services centres plan a timeframe for making contact with users, to inform them of the approximate wait time for services. Second, it urged that the institutions systematically take into consideration the consequences of reducing or ceasing services, both for the user and for the other resources in the health care system.

In response to these recommendations, the MSSS informed the Québec Ombudsman that following the publication of its access plan for the disabled[1], which includes specific standards for the management of wait lists and service continuity, it would undertake the same process for home support services. With regard to the actual wording of the Québec Ombudsman's recommendation on wait times, the MSSS has not made any commitment concerning the establishment of standards to govern the information provided to the users on access times, either for the time within which the information must be given or the way it must be given.

With regard to service continuity in particular, the MSSS points out that it is pursuing the creation of integrated service networks for seniors, and especially home support for people with age-related loss of autonomy. According to the MSSS, this new network will boost service continuity by ensuring that information is coordinated.

The Québec Ombudsman is not satisfied with the progress made, however, and would like the access plan for home support services to be submitted as soon as possible, so that the agencies and facilities can begin to implement the procedures.

In 2008-2009, the Québec Ombudsman also continued to receive complaints related to the accessibility of home support services. According to these complaints, users are not receiving the appropriate number of hours of service for their needs. In addition, the complaints show that wait times may compromise home support and that priority criteria are not the same in all institutions and sometimes contradict policy guidelines. Although the Québec Ombudsman has taken steps to correct or improve certain individual situations, it is clear that service access is still a problem for many people.

Six years ago, in 2003, the MSSS adopted a home support policy to promote home support. The purpose of this policy is to guarantee access to equivalent service for everyone, without distinction, and to provide a response based on need. The policy specifies that the services must work together to keep dependent people in their own homes for as long as possible, if they so wish, up to the cost of lodging them in a public facility.

One of the methods proposed by the policy to provide a better and more equitable response to the needs of people who require home support is to harmonize the practices of local CLSCs. The use of a standardized tool, the *Outil d'évaluation multiclientèle*, is therefore recommended for needs evaluation. The policy also determines the criteria for establishing a priority order for responding to needs, which relate to the needs expressed by the person requesting support and his or her natural caregivers, the urgency of the situation, and the quality of the user's living environment. The policy adds that these criteria will be further clarified in an implementation plan, requiring collaboration with the regional authorities and the CLSCs. It stipulates, however, that in no case can socio-economic criteria constitute a motive for refusal, since home support services must be accessible to everyone, regardless of their income.

[1] Ministère de la Santé et des Services sociaux, *Plan d'accès aux services pour les personnes ayant une déficience. Afin de faire mieux ensemble*, Québec, June 2008.

## RECOMMENDATIONS

Whereas the six-year-old ministerial home support policy seeks to guarantee access to equal services for everyone without distinction and to provide a response based on needs;

Whereas, in the policy, and in the subsequent clarification document[2], the MSSS announces that the prioritization criteria should be clarified and improved;

Whereas, in its response to the Québec Ombudsman concerning wait times, the MSSS announced its intention to specify standards for access to home support services based on the access plan for the disabled;

Whereas the Québec Ombudsman has found that the application of prioritization criteria for access to service sometimes contradicts the policy guidelines;

**The Québec Ombudsman recommends:**

**That in the home support service access plan it is about to develop, the Ministère de la Santé et des Services sociaux specify the prioritization criteria for access to service and that it instruct institutions to apply them with timelines and specific accountability, in order to ensure consistent handling of requests for home support, no matter which institution is approached by a person in need of such services;**

**That the MSSS inform the Québec Ombudsman, no later than September 30, 2009, of the timeframe in which it plans to submit the access plan and the related implementation schedules to the institutions in question.**

## COMMENTS FROM THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

These are the comments from the Ministère de la Santé et des Services sociaux, as expressed by the Deputy Minister:

"In terms of home care, it should be specified that the MSSS does not plan to establish a home care plan based on the model used for people with disabilities. Rather, it has made to a commitment to develop access, continuity and quality standards for home care services."

[2] Ministère de la Santé et des Services sociaux, *Chez soi : le premier choix. Précisions pour favoriser l'implantation de la politique de soutien à domicile*, Québec, 2004.

## Two regions, two different applications of the same policy

*Two women living in two different regions were both paralysed, one following a stroke, and the other after brain surgery. Based on evaluations of their functional autonomy carried out by their local CLSC, they were allotted 21 and 25 hours of weekly home support service, respectively. Upon being discharged from the hospital, they were given the full allotment of service hours, but over time the number of weekly hours began to decline, and two years later, although their needs remained the same, the first woman was receiving only two hours of service a week, and the second was receiving only one.*

*Because they did not have enough resources to meet the needs of their clients, the institutions were using a prioritization mechanism based on a standardized grid of risk factors and urgency levels. The Québec Ombudsman noted that the two CLSCs did not allot the same weight to the risk factors. In addition, one of the CLSCs took the woman's financial capacity into consideration, which further reduced her access to service. This example illustrates the disparities that exist in different regions with regard to the interpretation of a single policy. The Québec Ombudsman deplores this situation.*

*The Québec Ombudsman approached the centre considered the woman's financial capacity, to ensure that this criterion was removed from the evaluation process. Even though it did not change this woman's immediate situation because of other prioritization criteria, at least she is now treated on the same basis as the other users.*

The Québec Ombudsman is also concerned about the repercussions of wait times for all users who wait, sometimes for years, for access to home care and support services, and about the consequences of different wait list management methods in different CLSCs. It notes that needs are increasing faster than resources, for a number of reasons including the population ageing, the shift to ambulatory care, and the tightening of access criteria for public accommodation. The result is a gap between needs and services, between ministerial intentions and the response in the field.

For this reason, in 2009, the Québec Ombudsman is asking the MSSS for clarification of its intentions and details of what it plans to do to guarantee that its home support policy is implemented and applied consistently by the health and social services centres, which have been responsible for dispensing these services in their own regions since 2005.

# Pre-hospital emergency services

## ACCESSIBILITY AND QUALITY OF AMBULANCE TRANSPORTATION SERVICES

This year, the Québec Ombudsman received twice as many complaints about pre-hospital emergency services as last year.

The most common reasons for these complaints were:

- The need to pay transportation costs, although users were not informed about or did not choose to use this type of transportation;
- The lack of respect for and discomfort of users during ambulance transportation;
- Wait times for ambulances.

Pre-hospital emergency services for people transported in ambulances are not covered by the public medicare or hospital insurance plans, and prices are established by the Government. In some exceptional cases, however, transportation is free. These include transfers between two facilities in the health and social services network, situations where the service is covered by Government programs (such as traffic or work accidents, for example), and in some circumstances for people aged 65 or over. The complaints received by the Québec Ombudsman suggest that people are generally not aware of their financial obligations, and are therefore extremely upset when they receive an unexpected bill for $100 or more for ambulance transportation that they may or may not have wanted.

In examining other complaints, the Québec Ombudsman took steps to enforce the code of ethics or clinical intervention protocols that must be applied by ambulance technicians. These protocols were developed by the MSSS, in compliance with the Act respecting pre-hospital emergency services, to provide guidelines for the care dispensed during ambulance transportation to avoid further deterioration of the user's condition. As a corrective measure, the Québec Ombudsman asked that information and training sessions be offered to personnel to ensure the quality of clinical services.

The Québec Ombudsman also observed problems in gaining access to pre-hospital emergency services in some regions, resulting in unreasonable delays in the provision of service. To correct these situations, the Québec Ombudsman proposed a number of measures, including changes to the ambulance transportation contract upon renewal, the presence of an ambulance in certain locations to provide adequate coverage of the territory, and the establishment of a three-year service organization plan including a plan to connect the municipalities in question to a health communications centre, approved by the MSSS, for quality control purposes.

# Régie de l'assurance maladie du Québec (RAMQ)

## REIMBURSEMENT OF FEES FOR CARE

### *Our investigation is conclusive: the decision-making process for the reimbursement of medical services received outside of Québec is adequate*

The RAMQ offers a wide array of medical services that are essential to the health of the general public. But in some specific circumstances, services may not be available in Québec, and in such cases it is possible to request prior authorization from the RAMQ for the reimbursement of services that must be received outside Québec.

Newspaper articles reporting the RAMQ's refusal to authorize treatment in a specific case were brought to the attention of the Québec Ombudsman, which launched an investigation to determine the conditions and procedures of the RAMQ's decision-making process in such cases.

### *A few statistics*

Some statistics illustrating the extent of this problem may be helpful. In 2006-2007, for example, the RAMQ received 89 requests for authorization to receive services outside Québec. Of these, 49 were authorized immediately, and 26 were refused (the remaining the files were closed for various reasons). Two further requests were accepted for review. In 2007-2008, 46 out of 102 requests were accepted immediately and two more were accepted after review.

Although the number of requests may seem small, it is important to remember that the cases are complex and affect people who are extremely vulnerable and whose hopes depend, rightly or wrongly, on treatment that is available only outside Québec.

### *Investigation*

The Québec Ombudsman first checked the legislative and regulatory framework governing this issue, mainly comprising the Hospital Insurance Act and the Health Insurance Act and the ensuing regulations. These texts clearly set out the information that is required by the RAMQ to make its decisions. For example, the requested services must not be available in Québec, must not be experimental, and must be recognized and medically required by the user's personal condition.

The Québec Ombudsman then used a sampling method to examine 25% of the requests received in 2006-2007 and 2007-2008, for a total of 56 cases. Its principal findings were as follows:

- All the cases complied with the law and the regulations
- In all the cases, the RAMQ had checked the accuracy of the information provided and obtained additional information where needed
- The background information in the patient file was complete
- All the cases were medically documented
- The responses given to users were in keeping with the Act respecting administrative justice

The Québec Ombudsman's investigation therefore showed that the RAMQ treats requests for permission to obtain services outside Québec properly and in compliance with all its legislative and regulatory obligations.

# Complaint examination system

## SPIRIT AND PURPOSE OF THE COMPLAINT EXAMINATION SYSTEM

The health and social services complaint examination system was created to allow users to file complaints when they are dissatisfied with the service or care they receive, or when they feel their rights have not been respected. The local or regional complaints and service quality commissioner is responsible for processing complaints, promoting service quality and ensuring that users' rights are upheld. If users are dissatisfied with the commissioner's responses or conclusions, they can address their complaints to the Québec Ombudsman. The Québec Ombudsman may also intervene of its own initiative if it has reason to that an individual or a group of individuals has been wronged by the actions or inaction of a Government department or agency, or by a recognized health and social services institution, including a private residence.

## COMPLAINT EXAMINATION SYSTEM

In its 2006-2007 annual report, the Québec Ombudsman reported concerns about the implementation of the complaint examination system, which was substantially modified in 2006 by the Act to amend the Act respecting health services and social services and other legislative provisions (2005, chapter 32).

The Québec Ombudsman was concerned in particular about the non-availability of complaints and service quality commissioners and, by extension, questioned their capacity to fulfill their functions and meet users' service demands. The Québec Ombudsman suggested at the time that the MSSS take certain steps to speed up the implementation of the plan.

In 2007-2008, the Québec Ombudsman took note of the MSSS's efforts in this regard, but in light of its observations in the field and the results of a second survey of the plan's implementation, it recommended that the boards of directors of health and social services institutions and regional agencies ensure that local complaints and service quality commissioners have the resources and are given the conditions they need to perform their duties effectively and efficiently. In response to this recommendation, the MSSS indicated that each individual institution was responsible for allocating resources and creating appropriate working conditions.

The Québec Ombudsman also recommended that the MSSS continue and expand its support for the implementation of the plan, in particular by granting priority to user information, taking particular care to meet the needs of vulnerable people. In response to this recommendation, the MSSS indicated that in 2007-2008, management agreements stipulated that each agency would adopt a combined action in collaboration with the institutions and partners in its territory, with a view to promoting users' rights, including the right to recourse in the event of dissatisfaction with services received. In January 2009, the MSSS informed the Québec Ombudsman that these action plans are now in place at every regional agency. In addition, in March 2009, the MSSS asked the agency CEOs to ensure that priority is given to interventions involving vulnerable clients. The MSSS made a commitment to submit this same request to the complaints and service quality commissioners in the spring of 2009.

## RESULTS OF THE 2009 SURVEY

For the third year in a row, the Québec Ombudsman surveyed the chairs of health and social services network facility boards, in order to update its information on the progress made with the complaint examination system. The chairs were invited to answer an online survey between January 6 and February 9, 2009. Since the questions related to the work of the complaints and service quality commissioners, the task of answering the questionnaire was usually delegated to the commissioner or to someone on the commissioner's team. The response rate this year was 80% (222 respondents out of a total of 276 facilities), up from 73% last year.

### *Highlights*

- The turnover rate for coordinators was lower than in 2007.
- The position of commissioner was rarely vacant.
- The commissioners and their assistants spent about 20 hours a week at this task.

The survey findings show that users were rarely left without service for prolonged periods, despite the commissioner turnover rate. Although 30% of institutions said they had changed commissioners since the initial appointment, 89% had changed only once or twice. And despite the turnover, only 5% of the institutions had vacancies for the position.

Like last year, each board of directors had an average of 5.4 institutions under its responsibility. The median or most common number was two; 51% of the boards were in charge of no more than two institutions.

As for the number of hours worked, the commissioners and their assistants spent an average of 20 hours per week on the various tasks related to their functions. Typically, however, commissioners dedicate 14 hours per week to their functions. Thirteen respondents said the commissioner and his or her assistants work a combined total of at least 70 hours per week. After analysing these results more closely, the Québec Ombudsman found that the number of hours worked is a product of the number and type of institutions covered. The survey showed that CHSLD commissioners were the ones that worked the fewest hours (1 to 10). Those who worked more than 20 hours a week were mostly in institutions such as hospital centres, health and social services centres or youth protection centres, where most network users are concentrated.

The survey findings also showed that commissioners spend an average of 44% of their time handling complaints and reports. This is by far the task that takes up the most time. Next in line is helping with complaints (10%) and promoting the system (9%). The type of help was not specified, however, so it is impossible to say whether it involves support for formulating a complaint – such as to a medical examiner – or, as mentioned recently to the Québec Ombudsman by representatives of the complaint assistance and coaching centres, handling real complaints which the commissioners classify under this heading for reasons as yet unknown.

## THE QUÉBEC OMBUDSMAN'S CONCERNS FOR 2009-2010

In the coming year, the Québec Ombudsman plans to pay particular attention to an emerging practice in some facilities, which consists of registering and handling complaints as if they were requests for assistance. Following up on our 2008-2009 recommendation, we will check systematically, as part of our complaint and report handling process, to see whether regional and local commissioners have the appropriate resources and working conditions to perform their duties effectively and efficiently.

# Mental health

## THE QUÉBEC OMBUDSMAN IS STILL DISSATISFIED WITH THE LEVEL OF RESPECT FOR THE RIGHTS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

In its 2007-2008 annual report, the Québec Ombudsman made reference to gaps in the care and services offered to people with mental health problems. Again this year, it observes that these gaps persist and a number of problems have yet to be resolved, particularly with regard to the Act respecting the protection of persons whose mental state presents a danger to themselves or to others, the institutions' recourse to isolation and restraint measures, and regionalization. In the Québec Ombudsman's opinion, the rights of people with mental health problems are not sufficiently protected in some institutions, and it was for this reason that it began a systematic investigation of the issue during the year.

## 2005-2010 MENTAL HEALTH ACTION PLAN: INSUFFICIENT FOLLOW-UP

### *Relying on the quality of care and services*

In its annual report last year, the Québec Ombudsman voiced concerns about the fact that the evaluation objectives listed in the 2005-2010 Mental Health Action Plan do not include improvement of care and service quality, and recommended that the MSSS add this aspect for all types of service and service locations.

In response to these recommendations, the MSSS provided the Québec Ombudsman with information about its evaluation processes. On March 31, 2009, it made four quality assessment visits to non-institutional resources. Two additional visits are planned between April and June 2009, then the MSSS will then turn its attentions to eight CHSLDs that care for people with mental health disorders. At the same time, the MSSS is continuing to offer training sessions and tools to help improve service quality.

However, the Québec Ombudsman deems these efforts insufficient. It notes that the MSSS has not undertaken to evaluate the quality of life of users in general, and draws the attention of the Commission des affaires sociales to this fact. The Québec Ombudsman deplores the Department's lack of interest in the quality of life of users, an issue that is critically important as it encompasses the entire question of rights. It reiterates its recommendation that the action plan implementation assessment should include an evaluation of the quality of services and quality of life of users, regardless of where the services are offered and what type of services they may be.

### *Increasing public awareness to counter prejudice against people with mental health disorders*

In 2007-2008, the Québec Ombudsman recommended that the MSSS step up its communications activities to increase public awareness of the situation of people with mental health problems. In particular, it asked the MSSS to take action in areas where there is strong stigmatization of the mentally ill. The MSSS accepted this recommendation and launched an advertising campaign in 2008 on the subject of depression and how it afflicts people.

The Québec Ombudsman reiterates the importance of continuing these efforts. It recommends that the public also be made aware of other mental illnesses in respect of which prejudice persists.

## ACT RESPECTING THE PROTECTION OF PERSONS WHOSE MENTAL STATE PRESENTS A DANGER TO THEMSELVES OR TO OTHERS

*Application difficulties*

The Act respecting the protection of persons whose mental state presents a danger to themselves or to others allows for exceptional measures to keep a person in an institution without his or her consent when a doctor or a court is of the opinion that this individual presents a danger to self or to others. Since the fact of being placed in confinement contravenes the person's rights and freedoms, it is imperative that it be done in compliance with the law, the Civil Code of Québec and the Code of Civil Procedure, which govern these exceptional circumstances.

Like other stakeholders in the fields of health, justice and public security, the Québec Ombudsman agrees that it is difficult for institutions to comply fully with the law in this respect. To rectify some of the related problems, the Québec Ombudsman made recommendations to the institutions last year, on the following issues:

- Review the law's application protocol to ensure that people's rights are upheld, including the right to information and the right to give free and informed consent for psychiatric evaluation;
- Train staff on the issue;
- Place a note in the patient file of all information given to the user by staff members;
- Perform systematic checks to ensure that these measures are being observed.

In the fall of 2006, the Direction de la santé mentale (MSSS) asked a consultant to evaluate the application of the law, in collaboration with the Québec Ombudsman. Last January, the MSSS informed the Québec Ombudsman that the report would be submitted in the spring of 2009. Meanwhile, the brochure Rights and Recourses of Persons Placed Under Confinement was updated, and the MSSS reminded the institutions of their obligation to inform people and their relatives of their rights and recourses.

After an intervention with a health care institution in 2007, the Québec Ombudsman received seven new reports, each related to more than one institution. It also notes that the number of complaints and reports concerning application problems and failure to apply the law in health care institutions across Québec has remained constant from year to year.

Given the serious consequences of not upholding the fundamental rights of every individual, the Québec Ombudsman is currently engaged in a systematic analysis of the situations brought to its attention, in order to inform the Ministre de la Santé et des Services sociaux and the National Assembly.

## ISOLATION AND RESTRAINT IN HEALTH CARE INSTITUTIONS

*Exceptional measures of last resort*

Like institutional confinement, isolation and restraint using mechanical or chemical means must only be used with scrupulous respect for the law and the guidelines issued by the Ministère de la Santé et des Services sociaux, including section 118.1 of the Act respecting health services and social services.

*"Force, isolation, mechanical means or chemicals may not be used to place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must be appropriate having regard to the person's physical and mental state. [...]" Excerpted from section 118.1 of the Act.*

In its 2007-2008 annual report, the Québec Ombudsman asked the MSSS to set out guidelines for the use of chemical substances as a means of control. The MSSS informed us that it would consult the appropriate associations and professional orders on this matter by March 31, 2008. The consultation report, prepared in cooperation with the MSSS Direction de la santé mentale and the Direction de la qualité, is expected to be published in the fall of 2009. The Québec Ombudsman deems it unacceptable that the guidelines for chemical control substances still not be available when they were initially expected in June 2003.

The Québec Ombudsman's concerns are heightened by the complaints it receives, since it is clear that, even today, some institutions are still not complying with the law or the MSSS's instructions. The measures introduced by the MSSS (a training course on the subject of changing practices to reduce recourse to confinement and isolation, and the publication of a job aid presenting alternatives to confinement and isolation) have been insufficient in the face of a well-established culture that promotes practices contrary to individual rights and dignities.

The Québec Ombudsman has also noted that some facilities use different terms to get around the definition of isolation set out in the MSSS guidelines, such as plan de chamber (room plan), *chambre d'observation* (observation room), *retrait en chambre* (room confinement) or *plan de soins thérapeutiques* (therapeutic care plan). In reality, these practices correspond to the definition of isolation and, in fact, constitute isolation.

Again this year, the Québec Ombudsman recommended that certain institutions review their application protocol for control measures, obtain user consent when planning to use these measures, ascertain that there is an imminent risk of harm to the person or to others before using measures of last resort, and ensure that staff members thoroughly understand the rules governing the use of these practices, and clearly note down the actions taken and the context in which they are taken in the user's file.

The Québec Ombudsman began a systematic investigation in 2008, to ensure that isolation and restraint measures are applied appropriately and respectfully.

## Protective custody and the application of a room plan

*A user came to the emergency room of a hospital in his region. A few hours after his arrival, he asked a staff member for permission to go outside to smoke. He was told at that time that he was in protective custody and could not smoke because he was not allowed to go outside. The user was astonished because he came to the hospital of his own free will to receive care and was neither suicidal nor aggressive.*

*The next day, after meeting with the physician, the user was admitted, by his own consent, to the hospital's psychiatric unit. As soon as he was admitted, he was subjected to a room plan; that is, he was obliged to stay in his room at all times. On the third day of the room plan, he asked for authorization to circulate freely in the unit. Two thirty-minute periods were granted. The next day, he was authorized to leave his room freely, no longer being subject to the room plan. The user did not understand why he was subject to the room plan since his hospitalization was voluntary.*

The Québec Ombudsman has no jurisdiction to examine a physician's decision to place a person in protective custody or to apply a room plan. However, clinical decisions such as this must comply with the Act and the guidelines issued by the MSSS, and the Québec Ombudsman is able to intervene with regard to this aspect.

An examination of the complaint revealed a flagrant lack of information when the user was placed in protective custody. Accordingly, the Québec Ombudsman recommended that the hospital review its application protocol for the Act, to ensure that when a person is placed in protective custody, or as soon as he or she seems able to comprehend, that information be provided on the conditions of custody, including the place, the reason and the right to communicate immediately with friends or family and a lawyer. In such cases, the institution must also indicate the day on which and time at which the custody will begin and end. Furthermore, the person's file must contain a note to the effect that the physician who instituted the protective custody immediately advised the director of professional services.

Likewise, the institution's protocol must clearly indicate the exceptional nature of the act and reiterate that protective custody can be prescribed only where the person's mental state presents a serious and immediate danger to self or to others and where the person is not cooperating. The Québec Ombudsman also recommended raising awareness in hospital emergency rooms concerning the extraordinary nature of protective custody and reminding staff of the importance of placing detailed notes in the person's file to ensure that all legal requirements have been met.

With regard to the application of a room plan, the Québec Ombudsman concluded in this specific case that, for the first 24 hours, there was an agreement between the user and the staff that he remain in his room to rest and give the staff members the chance to get to know him. Maintaining the plan beyond the first 24 hours was not justified, however. The user wanted to move freely through the unit and nothing in his file indicated that he was at risk of harming himself or others. It should have been responsibility of the nursing staff to assess his needs and determine the appropriateness of continuing the room plan. Free and informed consent was required. A room plan applied without the person's consent becomes an isolation or control measure, which consists in confining a person to a location for a predetermined time, and should therefore only be used to prevent someone from hurting themselves or others.

In this situation, the Québec Ombudsman recommended that the hospital take the necessary steps to ensure that the nursing staff understands and plays its health care role as set out in section 36 of the Nurses Act, especially with regard to monitoring and adjusting the therapeutic nursing plan. It was also recommended that the facility update the control measure application protocol, especially concerning restraint, isolation and the use of chemical substances, while also informing all personnel about changes in practice in order to significantly reduce the use of restraint and isolation measures. Finally, it was recommended that, other than for the situations stipulated by law, the staff should obtain free, informed and specific consent from the person or the person's representative before instituting isolation.

## REGIONALIZATION

### *More complaints*

Because of regionalization, institutions sometimes refuse to provide care to people who do not live in the territory they serve. However, the right to choose an institution or a health care professional is stipulated in the Act respecting health services and social services. The 2005-2010 Mental Health Action Plan expressly reiterates this aspect.

Once again this year, despite the efforts of the Ministère de la Santé et des Services sociaux to inform institutions of the limitations of regionalization, the Québec Ombudsman received seven complaints on this issue, relating in particular to mental health care in institutions in the Montreal region. It has therefore decided to launch a systematic analysis, in order to situate this issue within the context of the restructuring of front-line mental health care and services and end the problems people encounter when seeking care in the institution or from the professional of their choice.

## SEXUALITY IN HEALTH CARE FACILITIES

### Proximity of users

*This year, the Québec Ombudsman examined a complaint about a specific situation relating to the delicate matter of sexuality in health care institutions. The complaint concerned a teenage girl who had sexual relations with another patient when they were both in a psychiatric ward. The complaint, filed by the girl's father, claimed a lack of oversight by the personnel. According to the father, his daughter was in no condition to provide consent to sexual relations and the personnel should have prevented the incident from occurring. The event came to light a month after the fact and was admitted by the other patient.*

As soon as the institution learned about the situation, it introduced constant supervision for the teenage girl. The local complaints and service quality commissioner also took steps to ensure that adults and teens be physically separated in the psychiatric unit. A special area was designated for the observation of teens. The Québec Ombudsman endorsed the steps taken by the local commissioner and the care team, but its investigation also revealed that the institution had no policy on sexuality. Efforts are currently being made to adopt such a policy, which will apply to the entire institution. The Québec Ombudsman feels this policy is necessary to protect vulnerable patients.

Lastly, a visit to the psychiatric emergency room also revealed that men and women shared the same bathrooms and showers, which the Québec Ombudsman deemed to be completely unacceptable. We urgently recommended setting up separate men's and women's bathrooms and showers. These recommendations were accepted and an action plan was adopted. Follow-up is underway.

The Québec Ombudsman intends to take a more systematic approach to the issue of mental health in the coming year. This will help ensure that users' rights are respected and will also help to improve the quality of care and services available to people with mental health disorders and their families.