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Intervention report (excerpts)

Intervention at Centre d'hébergement Harricana

of

Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue

Québec City, August 21, 2015

The intervention

The Québec Ombudsman received reports of major deficiencies in the quality of the care and services provided to the residents of a residential centre in Abitibi, primarily regarding basic care, nursing care, means of control, reprisals and harassment, and a nurse's attitude and behaviour.

Given the disturbing nature of the information brought to its attention, the Québec Ombudsman decided to conduct an investigation in order to ensure the safety of all residents in the living environment concerned and the quality of the care and services provided to them.

Facility concerned

The institution concerned is Centre d'hébergement Harricana (hereinafter the Centre) of Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue (hereinafter the CISSS).

Characteristics

At the time of the investigative visit, the Centre had 100 residential places on the third, fourth and fifth floors of the building.

The third floor consists of three distinct living environments secured with doors equipped with access codes. These environments are designed for a client population at risk for elopement. The psychogeriatric unit located on this floor houses residents who have a certain degree of mobility, but who have cognitive impairments coupled with behavioural difficulties (for example, wandering, agitation, aggressiveness).

The fourth-floor residents also have cognitive impairments combined with severe physical disabilities. Most of the residents on this floor are completely dependent on care and services by the staff for their activities of daily living.

The fifth floor of the Centre houses residents who are more autonomous but who still need to be in a long-term care setting. This floor also has residents who are convalescing or in need of temporary lodging and services as well as those there for assessment or rehabilitation.

Conclusion

The investigation conducted by the Québec Ombudsman brought to light serious flaws in the quality of the care, services and living environment provided to fourth-floor residents. In the Québec Ombudsman's opinion, these failings are very harmful to the residents and require decisive measures by the Centre.

Recommendations

Given the results of the investigation conducted at Centre d'hébergement Harricana (hereinafter the Centre), the Québec Ombudsman recommends that Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue (hereinafter the CISSS):

R-1 **Conduct** an exhaustive review of the organization of the care and services provided on the fourth floor of the Centre so that residents' needs and pace of life are paramount, in keeping with a living environment approach;

The CISSS must, by October 31, 2015, inform the Québec Ombudsman about the results of this process and the concrete measures established further to the review;

R-2 **Undertake** a process to evaluate and improve the attitude and behaviour of each of the members of the personnel assigned to the fourth floor of the Centre;

The CISSS must, by October 31, 2015, inform the Québec Ombudsman about the results of this process and the concrete measures established further to the process;

R-3 **Conduct** a multidisciplinary reassessment of each of the means of control used with the residents of the fourth floor of the Centre, assuring that they are applied so that the rules and the basic rights of the residents are respected;

The CISSS must, by September 15, 2015, inform the Québec Ombudsman about the results of this process and the concrete measures established further to the reassessment;

R-4 **Obtain** correction of the situation concerning the use of means of control on the fourth floor so that, in applying them, the nursing and managerial staff respect the rules and the basic rights of the people concerned;

The CISSS must, by October 31, 2015, inform the Québec Ombudsman about the concrete measures established for this purpose.

R-5 **Create** a procedure to ensure sustainability of the correction referred to in R-4 so that the use of means of control is always carried out in a way that respects the rules and the basic rights of the people concerned;

The CISSS must, by October 31, 2015, inform the Québec Ombudsman about the procedure established for this purpose.

R-6 **Produce** an interdisciplinary response plan for the behavioural difficulties of each of the fourth-floor residents who require such a plan, while ensuring that the recommended approach and interventions are based on in-depth knowledge of the residents' life experience and on the best practices in the field;

The CISSS must, by September 15, 2015, inform the Québec Ombudsman about the results of the concrete measures established further to production of the plan.

R-7 **Introduce** an interdisciplinary framework to facilitate collaboration, communication and consistency with regard to the interventions and care provided to the residents by the various members of the clinical team;

The CISSS must, by October 31, 2015, send the Québec Ombudsman a copy of the interdisciplinary framework and inform it about the concrete measures established to ensure compliance with the framework.

R-8 **Prevent and prohibit** any reprisals regarding or harassment of residents and their friends and family or members of the personnel who express dissatisfaction, concerns or misgivings;

The CISSS must, by August 31, 2015, inform the Québec Ombudsman about the concrete measures taken for this purpose.

R-9 **Foster** the participation of friends and families in planning and organizing the care and services provided to residents of the Centre;

The CISSS must, by October 31, 2015, inform the Québec Ombudsman about the concrete measures taken for this purpose.

R-10 **Conduct** an administrative investigation into the management practices behind the observed flaws in the quality of the care, services and approach used with fourth-floor residents and mandate a committee formed of independent experts to carry out the investigation.

The CISSS must, by October 31, 2015, inform the Québec Ombudsman of the results of this exhaustive examination by indicating the concrete measures stemming from it.

Expected follow-up

As stipulated in the *Act respecting the Health and Social Services Ombudsman* (CQLR, c. P-31.1), within 30 days of the receipt of this report, the Québec Ombudsman must be informed of the intended follow-up to the recommendations by the institution or, if the institution has decided not to act upon the recommendations, of the reasons for such a decision.