Intervention report (excerpts)

Intervention at Orchidée 1 and Orchidée 2, intermediate resources

Québec City, May 26, 2016

The intervention

The Québec Ombudsman received a report about failings in the quality of care and services provided to the residents of Orchidée 2, an intermediate resource located in the Montréal region. The report concerned the following elements:

- screaming on a regular basis by the residents in this intermediate resource;
- the staff's refusal to keep users properly hydrated during the summer;
- the fact that residents cannot go outdoors.

Given the gravity of the events reported as well as new flaws observed by Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Sud-de l'Île-de-Montréal, to which the resource reports, within the framework CIUSSS's correction plan begun in October 2015, the Québec Ombudsman decided to intervene regarding Orchidée 2. In light of this information, reasonable doubt remained as to the resource's ability to ensure the safety of the users who live there.

Further to the information collated during the investigation and that transmitted by the institution, the Québec Ombudsman decided to broaden the investigation to include Orchidée 1.

The institution in question is Centre de réadaptation en déficience intellectuelle et en troubles envahissants du développement (CRDITED) de Montréal of CIUSSS du Centre-Sud-de-l'Île-de-Montréal. For the sake of clarity, it will be referred to as the "institution" throughout.

Conclusion

The Québec Ombudsman received a report exposing failings in the quality of the services provided by Orchidée 2, an intermediate resource. The intervention it also carried out at intermediate resource Orchidée 1 as a result of its findings brought into focus similarities and a cause-and-effect correlation in the service organization at these two resources.

The action plans established by the institution, no less than the Québec Ombudsman's observations, showed the recurrence or shifting of problems of service delivery at both resources. Despite the owner's protestations of having made a sustained effort to correct the problems noted, the investigation shed light on inconsistencies and contradictions in the statements taken, but, more significantly, on the fact that the manager was hard pressed to find sustainable solutions that would not impinge on service quality at the other resource which she was in charge of.

In practice, in terms of the caregiver/user ratio at these resources, financial considerations override satisfaction of users' needs. This situation gives rise to deficient risk management for a highly vulnerable client population. Residents would be better served by a comprehensive and permanent approach instead of piecemeal adjustments.

Even though the institution saw some improvement in services, the investigation by the Québec Ombudsman showed that the bulk of these improvements concerned housekeeping and the application of food protocols. The roster of interventions by the institution indicates that, as at January 2016, many of the corrections had yet to be implemented.

In summary, these facts show that given the complexity of users' needs, the number of employees available for all of the obligations that must be met is insufficient, the result being substantial flaws in the satisfaction of users' needs and respect of users' rights.

While no user was found to have suffered irreparable physical harm, the fact remains that the harmonization of practices for monitoring the quality of the services provided in intermediate and family-type resources is a major issue given the client population's vulnerability.

Recommendations

Given the preceding, the Québec Ombudsman recommended that CIUSSS du Centre-Sud-de-l'Île-de-Montréal:

R-1 **Provide** the personnel at Orchidée 1 and Orchidée 2 with new training on their responsibilities with respect to the acts delegated to them pursuant to sections 39.7 and 39.8 of the *Professional Code*;

R-2 **Provide** training so that employees know and comply with the formal procedure for the provisions of the reference framework for intermediate and family-type resources regarding the responsibility to disclose incidents and accidents as well as to keep a record of them;

R-3 **Assess** users when they are being matched with an institution so as to ensure that the environment chosen meets their respective needs adequately and that the services provided comply with contractual obligations;

R-4 **Ensure** that the fire evacuation procedure is available to employees.

By June 10, 2016, inform the Québec Ombudsman of the measures taken to implement these recommendations.

Expected follow up

In accordance with the *Act respecting the Health and Social Services Ombudsman* (CQLR, c. P-31.1), within 30 days of receipt of this report, the institution concerned must inform the Québec Ombudsman of the actions to be taken as a result of the recommendations or, if the institution has decided not to act upon them, of the reasons for such a decision.