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COMMITTEE ON HEALTH AND SOCIAL SERVICES

The living conditions of adults living in residential and long-term care centres

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Introduction

Over the past few years, the organization of services and care for seniors has received a great deal of attention. With its Home Support Policy, Chez soi: le premier choix (home is the option of choice), public authorities favoured remaining at home as the first choice of location to receive services, and, as such, met the desire of seniors in loss of autonomy to remain in their natural living environment for as long as possible.

However, despite having access to home support services, as well as the support of the people around them, several seniors have to be transferred to a facility better suited to their needs because of deteriorating health conditions. In such cases, their options include residential and long-term care centres (CHSLD). Indeed, CHSLDs are an important link in the organization of accommodation services.

However, we noted an increase of clientele in such centres as a result of increased home care services, which help seniors stay in their living environment for a longer period. In addition, by the time seniors reach the point where they need to move to a CHSLD, their independence has already decreased a great deal. This is also complicated by tighter admission requirements in CHSLDs. Moreover, seniors have growing needs and, seeing how the average age of residents is increasingly high, a growing number of seniors have multiple health issues. Simultaneously, residents under the age of 65 present with a growing disability rate. It goes without saying that this is generating major difficulties, which CHSLDs will have to overcome in order to provide a quality living environment for their residents.

Furthermore, even though cases of senior abuse and neglect in CHSLDs have been reported in the media, it is far from being the case in the vast majority of these centres. Unfortunately, due to this bad press, their successes often go unnoticed. Such issues cause concern about the living conditions of CHSLD residents not only among seniors and their relatives, but also among the general public.

Concerned by this issue, the Committee on Health and Social Services adopted, on May 14, 2013, an order of initiative to study the living conditions of adults living in CHSLDs. The Committee chose to undertake this task by involving relevant stakeholders.

This document has been prepared to provide food for thought for the Committee. First, it briefly lays down the guidelines on CHSLDs. Then, it describes the current situation, i.e., types of institutions, number of places available, admittance criteria, and profile of residents. The final section of the document identifies the challenges of organizing and providing care and services with the purpose of offering quality living conditions to residents. In order to describe these challenges, the Committee largely based itself on the “determinants of living conditions” proposed by the Association québécoise d’établissements de santé et de services sociaux and the Regroupement provincial des comités des usagers.

The Committee hopes that its efforts can been seen as a model for measures to improve the living conditions of CHSLD residents.

Legal Foundations, Policies and Ministerial Orientations[1]

Policies and ministerial orientations are based on the *Charter of Human Rights and Freedoms*[2], the *Civil Code of Québec*[3] and the *Act Respecting Health Services and Social Services*.[4] Their purpose is to ensure that CHSLD residents are provided a quality living environment.

Legal Foundations

Charter of Human Rights and Freedoms

Section 1 pertains to fundamental rights:

> "Every human being has a right to life, and to personal security, inviolability and freedom."

Section 4 pertains to the safeguard of dignity:

> "Every person has a right to the safeguard of his dignity, honour and reputation."

Civil Code of Québec

Section 10 pertains to the integrity of the person:

> "Every person is inviolable and is entitled to the integrity of his person. Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent."

Act Respecting Health Services and Social Services

Section 83 of the Act defines the mission of CHSLDs:

> "The mission of a residential and long-term care centre is to offer, on a temporary or permanent basis, an alternative environment, lodging, assistance, support and supervision services as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services to adults who, by reason of loss of functional or psychosocial autonomy can no longer live in their natural environment, despite the support of their families and friends."
>
> "To that end, every institution which operates such a centre shall receive, on referral, the persons who require such services, ensure that their needs are periodically assessed and that the required services are offered within its facilities."

Section 3 specifies the guidelines guiding the management and provision of health services and social services:

> "1° the person requiring services is the reason for the very existence of those services;
>
> 2° respect for the user and recognition of his rights and freedoms must inspire every act performed in his regard;

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[1] Primary Source: Ministère de la Santé et des Services sociaux, *Un milieu de vie de qualité pour les personnes hébergées en CHSLD : orientations ministérielles*, October 2003, 24 p.
[2] R.S.Q., c. C-12.
[3] C.C.Q.
[4] R.S.Q., c. S-42.

> 3° the user must be treated, in every intervention, with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety;
>
> 4° the user must, as far as possible, play an active role in the care and services which concern him;
>
> 5° the user must be encouraged, through the provision of adequate information, to use services in a judicious manner."

Section 5 pertains to the right to services:

> "Every person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate."

Policy on Health and Well-Being and Ministerial Orientations

The Policy on Health and Well-Being[5]**,** adopted in 1998, proposes objectives to reduce the health and social issues most affecting the population. It recalls the importance of:

- Promoting the development of the potential of people.
- Supporting living environments and making them healthy and safe.
- Improving living conditions.

Ministerial orientations relating to health and social services[6] cover the philosophy and practices that should prevail in residential and long-term care centres. They are accompanied by seven guiding principles placing residents and their family at the heart of the organization of care and services in residential and long-term care centres.

[TRANSLATION]

1. The characteristics, needs and expectations of residents form the basis for any decision in terms of organization, intervention and development.
2. The institution must encourage maintaining and building the capacity of residents, as well as their personal development, taking into account their personal willingness.
3. The quality of the practices depends, first and foremost, on the ongoing concern for quality of life.
4. The institution must encourage and support the residents' interaction with their family, and foster their involvement in the decision-making process.
5. Residents are entitled to a quality living environment in which quality care and services are provided.
6. Every resident is entitled to a living environment that respects his identity, dignity and privacy, that ensures his safety and comfort, and that allows him to give meaning to his life and to exercise self-determination.

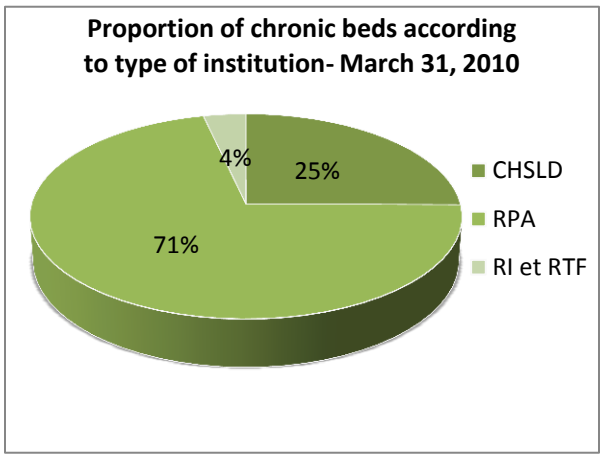
[5] Government of Québec, *Politique de la santé et du bien-être,* 1998, 192 p.
[6] Ministère de la Santé et des Services sociaux, *op.cit.*

7. The institution must identify coping mechanisms for professional, administrative and organizational practices promoting the set of guiding principles.

Progress Report

Types of CHSLD

CHSLDs cater to the needs of individuals with significantly decreased independence. However, three other types of accommodations were created to better satisfy the needs and expectations of an expanding customer base: intermediate resources (IR), family-type resources (FTR) and retirement homes (RH). It should be noted that, as at March 31, 2010[7], CHSLDs accounted for 25% of total spaces available in permanent housing.



As at March 31, 2013, 202 institutions[8] in Quebec had a CHSLD purpose. Schedule I provides a regional distribution of CHSLDs, which come in several types, each with unique characteristics. First, public and private CHSLDs under agreement have the same eligibility terms and conditions and operating procedures. The services that are offered in these facilities are selected by the ministère de la Santé et des Services sociaux. Contrary to a public CHSLD, private CHSLDs under agreement have a managing owner, who is licensed and subsidized by the MSSS. In addition, they are authorized to manage a specific number of spaces; as at March 31, 2012, there were a combined total of 38,261 long-term care beds available to individuals with decreased independence in those types of institutions.

Private CHSLD not under agreement are independent and autonomous privately-owned businesses. They hold a license from the MSSS, but they are not subsidized. These centres have their own admission criteria; the owners set the fees and have full discretion over the operation of their establishment. Some of them enter into an agreement with the health and social services agency serving their territory. As such, the agency gets a specific number of beds under the same conditions as those of public or private CHSLDs under agreement.

Since October 2010, a CHSLD has been operating under a public-private partnership in Saint-Lambert, in the Montérégie region. The region's agency of health and social services entered into an agreement for 200 spaces with a private company. In line with the residents of other types of CHSLDs, these beds are intended for people with serious needs, and are assigned by the agency, subject to the same accommodation fees paid in any public or a private institution under agreement. Four similar centres are currently in construction; in the end, 298 spaces will be added to the current total.

[7] The Committee chose to use the most recent data available during the drafting of this document. Accordingly, dates may vary from one type of data to the other.
[8] An institution may include one or several facilities with a CHSLD purpose.

Access to a CHSLD

As at March 31, 2013, 3,826 people were waiting for a place in a CHSLD. Out of that number, approximately 7% were under the age of 65 years. It should be specified that almost 34% of them came from the Montreal region (Schedule II).

A place in a public or private CHSLD under agreement is granted following a mandatory assessment, subject to terms and conditions that vary according to the health and social services agency. For example, at the Agence de la Capitale-Nationale, the application is first assessed by a social worker, who then transfers the file to a steering committee for a decision on whether or not to admit the applicant at the CHSLD. As for the Agence de la Gaspésie-îles-de-la-Madeleine, applications are received by a local coordinator. Case managers or stakeholders—who are specifically trained to determine care profiles—assess the applicant's functional independence, and a local coordinator subsequently targets services and directs the file according to the needs of the applicant.

In sum, whether it's through an access point, or through contact with a worker, access to a CHSLD must involve an assessment of the applicant and a determination of his functional independence profile.[9] The application is then placed on a waiting list until a bed becomes available. Spaces are granted to persons requiring a minimum of three hours of care per day, and their situation must require high-intensity care. Finally, the local community-based outreach services centre makes the initial contact with the applicant.

Health and social services agencies can also develop special programs. As such, the Agence de Montréal set up a housing program for assessment in 2009. The purpose of this program is to assess the needs of seniors having to leave a hospital's long-term care unit. The person is moved from the hospital to the permanent residence—in an assessment bed for a few weeks— and then to a transitional bed, while a permanent space becomes available at the chosen location.

In addition, almost each region reserves a number of beds for residents suffering from mental health issues, as well as temporary beds, and some health and social services agencies offer transitional beds. These are intended for individuals who need immediate care, but who have yet to secure a permanent place in a CHSLD. Schedules III and IV present two tables describing accommodation offers throughout Québec and its regions, i.e., the number of facilities and the number of beds available.

[9] Profiles under the Système de mesure de l'autonomie fonctionnelle (functional autonomy measurement system) (Iso-SMAF) include individuals with similar disabilities requiring similar services at similar costs. They are summarized in Schedule VI.

Various types of accommodation for individuals with decreased independence				
Types of accommodation		**Number of hours of care per day**	**Profile of Residents**	
			Iso-SMAF[10]	**Nature of loss of independence**
Seniors' Residence		n/a	n/a	n/a
Family-type Resource		Less than 1.5	2 and over	Supervision or assistance required for household chores Mobility impairment and difficulty performing activities of daily living. Moderate intellectual disability
Intermediate Resource		1 to 3	7 and over	Severe intellectual disability and minor behavioural problems Severe intellectual disability, and need for supervision and monitoring for mobility and activities of daily living Need for assistance with mobility and activities of daily living
CHSLD	**Public**	3 and over	11 and over 9-10 subject to conditions	Predominant intellectual disability and significant behaviour problems Substantial inability in mobility and mental functions Occasional incontinence Individuals with very little independence, bedridden or dependent for activities of daily living Individuals living their final days
	Private under agreement			
	Private not under agreement			
	Public-private partnership (PPP)		10 and over	

Costs and fees

According to the ministère de la Santé et des Services sociaux, the average annual cost for a place in a CHSLD amounted to $74,973 in 2011-2012.[11] However, in 2012, the Auditor General of Québec conducted a study on accommodation services for seniors with loss of independence.[12] The report reached the conclusion that the above-mentioned amount is an estimate for institutions as a whole. The Auditor General specified that not all costs incurred have been taken into consideration. Following this analysis, the amounts disbursed by health and social services agencies and institutions now vary from one centre to the other. For example, the Auditor General explained that the amounts disbursed ranged from $61,551 to $90,820 among the 23 public CHSLDs surveyed. A similar variation was noted in the case of private centres under agreement.

[10] Profiles under the Système de mesure de l'autonomie fonctionnelle (functional autonomy measurement system) (Iso-SMAF) are summarized in Schedule VI.

[11] Considering the annual cost of $74,973 and the maximum fee of $1,742 per month for a room in a permanent residence, residents pay a maximum amount totalling close to 28% of the total cost.

[12] "Personnes âgées en perte d'autonomie : services d'hébergement ", *Report of the Auditor General of Québec to the National Assembly for 2012-2013 : Value-for-money Audit,* Spring 2012, chap. 4, p. 54.

With respect to fees, it should first be noted that private CHSLDs not under agreement set their own rates. The Régie de l'assurance maladie, for its part, sets the requested contribution in public and private CHSLDs under agreement in accordance with the Financial Contribution Program for Accommodated Adults. In 2013, the monthly fees were the following:

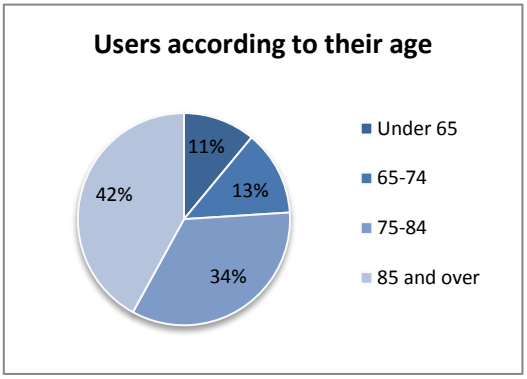
- Private room: $1,742.70
- Semi-private room: $1,456.80
- Room with 3 or more beds: $1,083.00

Monthly rates include the provision of products and services, as determined by the ministère de la Santé et des Services sociaux, namely meals and some products and services necessary for personal hygiene. However, the user must pay for hairdressing services, personal care products, newspapers etc. These costs are therefore added to the monthly amount disbursed for the facility.

Moreover, for residents who cannot afford these rates in full, the amount of the contribution is determined on the basis of the person's ability to pay. Family deductions may apply; for example, if the accommodated person has a dependent child.

Residents

As at March 31, 2012, there were 37,424 persons living in a public or private CHSLD under agreement. According to the figure on the right, a great majority of users were aged 75 and over. This was similar in all regions of Québec.[13]



In addition, in 2012-2013, public and private centres under agreement have admitted a total of 67,960 persons. The difference between this figure and the number of spaces filled or vacancies is due, among other things, to the fact that a bed can be occupied by more than one user during the course of the year. In effect, a space formerly occupied by a deceased resident is assigned to someone else, which is why sometimes two, three, or even four people can occupy a same bed over the course of a year. Still in 2012-2013, CHSLDs have reported 12,235 deaths. Nearly 55% of deceased residents were over the age of 85, while 5% were under the age of 65. In 2011-2012, residents stayed an average of 837 days at the residence.

It should be recalled that persons accommodated in a CHSLD present with significant to moderate decreasing independence. In addition, some of them are either physically, psychologically or socially disabled. The Corporation d'hébergement du Québec presented seven types of residents in its document entitled *Centres d'hébergement (CHSLD) : principes généraux.* They are:

1. Residents suffering from cognitive impairment, with or without behavioural problems

[13] See Schedule V.

This group is growing steadily. In 2008, it made up between 60% and 80% of accommodated persons with various levels of impairment. Close to 50% of them suffered from dementia of the Alzheimer type.

2. Residents with multiple severe physical health problems

   This group includes people affected by a cardiovascular accident (CVA), cardiac insufficiency, diabetes and obesity, among other things, that may require a high and complex level of care, as well as particular accommodation.

3. Residents with moderate to severe motor disabilities and limitations with respect to walking and moving around.

   They are unable to move on their own, or have difficulty walking to a point where their travel radius is extremely limited. This group of residents includes people living their final days.

4. Residents over the age of 85.

   The older a person gets, the more their independence decreases, requiring a range of treatments associated with aging. This population accounted for 42% of residents in 2012.

5. Residents with serious behavioural problems related to a psychiatric diagnosis

   This is a restricted group of residents, for whom integration can turn out complicated, and may require a limited environment and special measures. This type cannot be placed in the same category as residents presenting with cognitive impairment or dementia.

6. Residents with intellectual disability

   These residents present with a congenital, acquired, structural, or lesional deficiency of the mental function. This type cannot be placed in the same category as residents presenting with cognitive impairment, dementia, or a psychiatric diagnosis.

7. Residents under the age of 65 presenting with significant disabilities not related to aging

   They include residents fitting the geriatric profile of severe and persisting limitations in performing activities of daily living, as a result of physical or sensory disabilities. This is a heterogeneous and poorly understood group, which accounted for 11% of residents in 2012. These residents can be very young and compelled to stay at a health care facility for the rest of their lives.

These various resident profiles generate variable and numerous needs and expectations in terms of health care, space and activities. We must also take gender, cultural origin and religious beliefs into consideration, as they have their significance. The resident's mother tongue should also be considered, as it presents challenges in the delivery of care to an aging person.

Staff

The staff contributes to making CHSLDs a pleasant living environment for residents, and they fall under three categories. First, there are those qualified to provide care and services to residents. These consist of workers who provide help and support, specialized services such as nursing, medical and rehabilitation services, and workers who conduct utilitarian, recreational, social, and spiritual activities. Among them are orderlies, registered practical nurses, nurses, doctors and psychologists. Then, there is the support staff, such as food and maintenance employees. And at

last, but not least, there is the administrative staff. In addition, one administrative team can sometimes be in charge of more than one facility. However, the number of staff members varies according to the size of the facility.

Some institutions must turn to private agencies in order to fill the necessary positions for the proper functioning of the centre. These include orderlies, registered practical nurses, and nurses. Efforts are being made in health and social services agencies to reduce the use of independent labour because of the cost involved. In the interest of service continuity, employee turnover is avoided as much as possible, as it impacts the quality of life of residents.

Challenges

Accessibility

The *Act respecting Health Services and Social Services* states that "every person is entitled to choose the professional or the institution from whom or which he wishes to receive health services or social services".[14] It also provides that this right shall be exercised "within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material and financial resources at its disposal".[15]

However, the right to choose is far from being absolute because, in reality, it is conditional, particularly with respect to admission criteria in place in various CHSLDs. One must come to the realization that waiting periods vary from one institution to the other, thus easily influencing the user's choice. In addition, once applicants are admitted, they usually have no more than 48 hours to take possession. This time limit can seem restrictive for people with significant health problems.

In the case of accommodation in a public or private centre under agreement, it was noted that applicants must sometimes stay in other resources before they can be integrated into a permanent facility. These facilities include hospitals or temporary beds. However, an applicant is likely to end up at a transitional facility or an assessment bed if his condition requires immediate accommodation. For some people, this process can create uncertainty. Finding a stable location should be the final in a series of moves for the user, as a result of access based on the level of independence.

Regional disparities must also be taken into account. Large cities offer many choices such as language diversity, openness to several religions, and numerous specializations. Rural areas and outlying regions, for their part, have more limited choices, which might affect users with specific needs and expectations. Moreover, the total number of beds available, across Québec, in public and private CHSLDs under agreement is decreasing in favour of private residences. Indeed, the number of beds available in centres as at March 31 has decreased by close to 4% from 2006 to 2010. As for private residences, the number of available beds has increased by 30% for the same period. Some recent data seem to infer that this phenomenon is steadily accelerating.

Things to think about

What should determine a user's choice of residential facility?

How can the conditions to access a centre be improved?

What can be done to reduce the waiting period?

Is the care provided in rural areas enough to satisfy the needs of users?

Are the transitional measures preceding admission in a CHSLD adequate?

[14] R.S.Q., c. S-4.2, s. 6.
[15] R.S.Q., c. S-4.2, s. 13.

Funding

Under the Act, the ministère de la Santé et des Services sociaux sees to the funding of the health and social services system. Funding is allocated equitably among the regions, according to the population they serve. Once the funds are allocated among the regions, health and social services agencies can allocate these funds to institutions.

The Régie de l'assurance maladie du Québec sets the rates in public and private CHSLDs under agreement. Other types of accommodation—such as seniors residences—are governed by market forces. A place in such accommodation can cost thousands of dollars a month. Accordingly, those with limited financial resources do not have access to the residence of their choice, even though the latter responds to both their needs and expectations, both in terms of services and location.

As such, a way to vary how services are funded, is to create partnerships with private firms to build new institutions; therefore, creating more spaces. Moreover, it should be recalled that a public-private partnership centre was opened in 2012, and four more will be built shortly.

Several mechanisms have been established to ensure, among other things, that alternative funding will not justify an imbalance in the quality of services provided from one facility to the other. Said mechanisms to supervise the quality of services provided are listed on page 17.

Things to think about

What do you think of the current funding of public and private CHSLDs under agreement?

What is your opinion on the rates of CHSLDs?

Physical organization

In a majority of cases, residents will live at the CHSLD for the rest of their days. Therefore, choosing a CHSLD should thus be planned from a living environment perspective.

A location must be physically organized in order to meet the needs and expectations of residents as best as possible, even more so because it is well-known that our living environment affects our behaviour and quality of life. In this regard, the poor condition of some centres can present major challenges.

In addition to allowing residents to take possession and to personalize their alternate living environment, the physical environment must also encourage residents to maximize their functional and psychosocial independence during daily activities, which is why it must be free of architectural constraints and obstacles—such as stairs, narrow doors and corridors—preventing independent travel and integration.

In addition, the physical environment must be designed in a way to promote respect for resident identity, privacy, and private life with their family and with the staff. It must also ensure their safety, as well as their physical and psychological well-being. Examples of situations that may impede on resident privacy include rooms with multiple occupancy, and the lack of private or semi-private areas.

Moreover, the physical environment affects how the staff carries out its work. In an adequate environment, the workplace will be conducive to maintaining the health and safety of the staff. It goes without saying that good working conditions have an impact on the quality of life of users.

In its orientations, the ministère de la Santé et des Services sociaux proposed creating micro-environments to provide a place adapted to the particular needs of residents, by structuring the premises into small blocks or units containing no more than 12 people. This form of design would help group clients based on their characteristics.

Things to think about

How is the concept of living environment applied in CHSLDs?

How can existing centres be improved to better meet the needs of residents?

Are there examples of CHSLDs that have adapted their environment to the needs of residents or groups of residents having similar problems?

Specific clientele

Seniors, or very elderly people, form the large majority of CHSLD clients. However, their neighbours are under 65, and they, too, have severe and persisting limitations in performing activities of daily living.

As stated in the orientations, this age group is relatively restricted, poorly understood, and extremely heterogeneous. Indeed, residents under the age of 65 present with various conditions. For example, they may have suffered from a cardiovascular accident (CVA), severe physical trauma, or they may be suffering from a degenerative condition such as multiple sclerosis.

This group includes people in their thirties and forties, sometimes even less, who will be living in a CHSLD for the rest of their days, and who find themselves in a living environment largely made up of very elderly residents with an unsuitable daily life structure. These people have their own needs to meet.

In addition, other types of clients also have special needs. They include allophones and anglophones living in French-speaking CHSLDs as well as Aboriginals who must live in a residential facility far from their community.

If it appears difficult for several people living in a CHSLD to keep their identity, how hard must it be for those belonging to the latter category? Not only are they more likely to feel isolated, but providing the care and services they require becomes more complex.

Things to think about

What are the major problems to arise from residents under the age of 65 living together with very elderly residents?

What are the positive experiences concerning persons under the age of 65 living in a CHSLD?

What specific challenges are Aboriginals, allophones and anglophones living in a CHSLD faced with?

What measures have been taken to deal with their problems?

Caregivers

As stated by the Regroupement provincial des comités des usagers, relatives of accommodated persons play many roles. They are caregivers, representatives and defenders of human rights, liaison officers for the staff, accountants, attendants during outings or medical appointments, etc. Moreover, in the case of people suffering from cognitive impairments, they can also act as [TRANSLATION] “keepers of the memory” and, sometimes, as [TRANSLATION] “keepers of the person's identity”[16].

As for the ministerial orientations, they specify that encouraging and supporting continued interaction of accommodated persons with their family should be one of the guiding principles governing organizational choices. The orientations foster the person’s involvement in the decision-making process as soon as they are admitted at the residence.

Indeed, maintaining the relationship between accommodated persons and their relatives would be a determining factor that would facilitate their adaptation to a new living environment, as well as their inclusion and socialization throughout their stay. In this sense, involving relatives in the development and periodic review of action plans should be encouraged. This is in fact provided for in the Act.

Things to think about

What would help develop a strong partnership between the relatives of a resident and the CHSLD staff? What would impede such development?

How can the relationship between a resident and a relative be maintained? What could keep the relationship between a resident and a relative from being maintained?

[16] Maryse Soulières and Geneviève Ouellette, *L’hébergement pour les personnes en perte d’autonomie au Québec : des enjeux et de parcours difficiles pour les personnes concernées*, Regroupement provincial des comités des usagers, December 4, 2012, p. 41.

Are there any positive experiments in this regard?

Care and services

CHSLDs must ensure the well-being of their residents on a daily basis. In this regard, medical, psychosocial, and pharmaceutical services, as well as leisure and food services, and basic care, notably, should be easily accessible and of good quality.

Moreover, the ministère's orientations mention that means are necessary to facilitate intermittent access to required services or to specialized services:

[TRANSLATION]

> All avenues must be explored, whether for medical specialists, speech therapists and audiologists, respiratory therapists, optometrists, sexologists, alternate approaches (such as, massage therapy or zootherapy), geriatric psychiatrists, neuropsychologists, etc. These avenues include agreements with other institutions, sharing transient professional resources, acquisition of services from professionals working in the private sector […][17].

Not only must the provision of care and services meet the needs and expectations of the residents, but it should also foster the creation of long-term bonds between the residents and the centre staff. These objectives concern each and every person employed by a CHSLD. The institution must ensure that there is stability among its staff, as it is critical to deliver on its commitments. A high staff turnover, accompanied by the use of staff from private agencies, can exert significant influence on the nature and continuity of care and services. These factors affect the links that may created between the residents and the staff; therefore, on the quality of the living environment.

In addition, one of the core principles governing the provision of care and services consists in making optimum use of the resident's capacity. Indeed, the staff, in its interventions, must encourage accommodated persons to be as autonomous and independent as possible, which is why the interventions should promote the resident's intellectual, emotional, social and physical stimulation; otherwise, the resident's functional independence might deteriorate in the short term.

Finally, it is well-known that over-medication can have adverse effects on the health and well-being of seniors. Over the years, various alternative approaches have been developed, such as music therapy, art therapy and animal therapy. Such interventions promote both the well-being and the independence of the resident.

[17] Ministère de la Santé et des Services sociaux, *op.cit., p. 15.*

Things to think about

What changes can be made to the care and services provided to residents in order to improve their quality of life?

How is the continuation of care and services in CHSLDs ensured?

Are there any positive experiments in this regard?

How do CHSLDs apply the principle according to which the staff must make optimum use of the resident's capacity?

What innovative ways have been introduced to stimulate the functional independence of CHSLD residents?

What obstacles prevent the introduction of alternative approaches in CHSLDs?

Are there any positive experiments in connection with this type of approach?

Care and services quality monitoring

It's no secret that continuing to improve the quality of care and services provided to users is a priority. A set of mechanisms has been established to achieve this goal and to ensure respect for users' rights. Here are some of them.

- The Ombudsman acts as Health and Social Services Ombudsman.
- The Complaints and Service Quality Commissioner is in charge of enforcing user rights and to ensure they are complied with.
- The Public Advisory and Quality Committee is in charge of monitoring the recommendations made by the Complaints Service Quality Commissioner or by the Health Services Ombudsman.
- User committees from each institution or facility promote the improvement of the quality of user living conditions and assess their satisfaction rate in connection with the services provided.
- Departmental teams visit CHSLDs to assess the quality of services provided to accommodated persons.[18]
- The accreditation process is defined as a self-assessment and external assessment process, which is used by health and social services institutions to assess the quality of the care and services they provide.
- Professional bodies supervise the practise of their profession by inspecting their members, and, in doing so, protect the public.

[18] This consists of a planned on-site observation procedure and information exchange with the residents and their relatives, the members of the Users and Residents Committees, the representative of the Public Curator of Québec, volunteers, and the staff and management of the institution.

Things to think about

Are the various mechanisms established sufficient to ensure the quality of care and services provided in CHSLDs?

Are there particular difficulties in implementing these mechanisms in CHSLDs?

Are there any other ways to improve the quality of care and services provided in the CHSLDs?

Work organization

The purpose of ministerial orientations is to introduce a quality living environment for accommodated persons. In order to do this, CHSLDs are forced to [TRANSLATION] “rethink their organizational habits”, as stated by the ministère de la Santé et des Services sociaux. From now on, care and services must be provided based on the recipient’s needs and not simply on the task at hand, as favoured by the traditional institution system.

Indeed, this type of work organization hinders the capacity of CHSLDs to provide a quality living environment. Due to the rigidity of such approach, the staff focuses on the task at hand, and pays more attention to physical and medical care rather than to focus on the psychological and social dimension of the accommodated person. As such, in order to comply with strict schedules, the staff is often compelled to perform the work hastily instead of going at the resident’s pace. The traditional institution system was not designed to meet the needs of the residents or to comply with their lifestyles.

Moreover, implementing a truly alternate living environment for accommodated persons must foster the involvement of every staff members. Indeed, taking a participatory approach is likely to favour a shared overall perspective of health care organization focused on the quality of life and the well-being of residents.

Things to think about

How to improve the work organization based on the needs of residents in every CHSLD?

What are the main obstacles preventing the implementation of this type of work organization?

Are there any success stories in this regard?

Staff training

Training staff is an essential step toward creating a quality living environment. As pointed out by the ministère de la Santé et des Services sociaux, the training process must be part of an exhaustive and ongoing process. Any person employed by the institution, such as managers, the medical staff, and the support staff, as well as the volunteers and the families must be involved in the process.

Close attention should be given to the training of orderlies because they are in charge of the great majority of direct resident care. They are the ones who work with users the most often.

In addition, the training must cover all aspects of the person, whether physically, psychologically, socially or emotionally. Not only does training the staff improve their skills, but it also promotes a better working environment.

Finally, training is a central issue in a context where the responsibilities of the staff are increasing since working with certain types of residents poses significant challenges for the staff, especially residents suffering from dementia. An incomplete training would affect the quality of care and services, and, in some cases, could lead to inappropriate practices by the staff.

Things to think about

Is basic training geared toward the entire workforce suited for the various clienteles of CHSLDs?

Is ongoing training for all types of staff part of the planning process in CHSLDs?

Do basic training and ongoing training cover all aspects of the person, whether physically, psychologically, socially or emotionally?

Are the hiring criteria concerning training sufficiently demanding?

What are the consequences of insufficient training?

Are the basic training and ongoing training methods suited for the developing profile of the residents?

Conclusion

Following this consultation on the living conditions of adults living in a CHSLD, the Committee on Health and Social Services would like to make the following recommendations, which the Committee hopes will generate innovative solutions to improve the care and services provided.

The Committee's recommendations obviously do not exhaust all aspects of the issue. Moreover, you are invited to examine not only the questions raised by the Committee, but also any other topic likely to provide fuel for the discussion and to help improve the services provided in CHSLDs.

The Committee also intends to build on the reflection that was set in motion to support public administrations, CHSLD staff and all those involved, in their efforts to improve the living conditions of people living in a residential and long-term care centre.

Schedule I

Number of institutions with a CHSLD purpose based on region as at March 31, 2013

Region	Public	Private under agreement	Private not under agreement	Total
Bas-Saint -Laurent	8	0	3	**11**
Saguenay–Lac-Saint-Jean	6	1	1	**8**
Capitale-Nationale	9	6	6	**21**
Mauricie–Centre-du-Québec	8	1	0	**9**
Estrie	8	1	1	**10**
Montréal	30	15	16	**61**
Outaouais	5	0	0	**5**
Abitibi-Témiscamingue	5	0	1	**6**
Côte-Nord	6	0	0	**6**
Nord-du-Québec	1	0	0	**1**
Gaspésie–Îles-de-la-Madeleine	5	0	0	**5**
Chaudière-Appalaches	5	4	0	**9**
Laval	1	4	4	**9**
Lanaudière	2	2	1	**5**
Laurentides	8	1	1	**10**
Montérégie	11	4	8	**23**
Nunavik	2	0	0	**2**
Terres-Cries-de-la-Baie-James	**1**	**0**	**0**	**1**
Total	**121**	**39**	**42**	**202**
%	60 %	19 %	21 %	**100 %**

Source: Ministère de la Santé et des Services sociaux, *Répertoire des établissements (M02 historique).*

Schedule II

Number of people awaiting a bed in a CHSLD as at March 31, 2013

Region	Under 65 years old	Over 65 years old	Total	%
Bas-Saint -Laurent	3	16	**19**	0.5 %
Saguenay–Lac-Saint-Jean	2	25	**27**	0.7 %
Capitale-Nationale	47	733	**780**	20.4 %
Mauricie–Centre-du-Québec	9	85	**94**	2.5 %
Estrie	2	38	**40**	1.0 %
Montréal	125	1,161	**1,286**	33.6 %
Outaouais	11	113	**124**	3.2 %
Abitibi-Témiscamingue	7	87	**94**	2.5 %
Côte-Nord	3	55	**58**	1.5 %
Gaspésie–Îles-de-la-Madeleine	1	10	**11**	0.3 %
Chaudière-Appalaches	9	89	**98**	2.6 %
Laval	0	140	**140**	3.7 %
Lanaudière	5	135	**140**	3.7 %
Laurentides	12	184	**196**	5.1 %
Montérégie	49	670	**719**	18.8 %
Total	**285**	**3,541**	**3,826**	**100 %**

Source: Ministère de la Santé et des Services sociaux, June 2013.

Schedule III

Number of facilities and beds in Québec for 2013 based on type of CHSLD

		Type of CHSLD			
		Public	**Private under agreement**	**Private not under agreement**	**Total**
Number of facilities		359	62	46	**467**
Permanent beds	Standard	31,576	7,163	3,233	**41,972**
	Mental Health	1,552	210	0	**1,762**
	Total	33,128	7,373	3,233	**43,734**
Temporary beds	Temporary	774	22	0	**796**
	Transitional	642	0	0	**642**
	Mental Health	35	0	0	**35**
	Total	1,451	22	0	**1,473**

Source: Website of the ministère de la Santé et des Services sociaux, M02 Database, reference dated June 21, 2013. Data compiled by Service de la recherche de l'Assemblée nationale du Québec.

Schedule IV

Number of facilities and number of beds available in CHSLDs for 2013 according to the region

Region	Facilities	Permanent beds	Temporary beds[19]
Bas-Saint -Laurent	18	1,320	30
Saguenay–Lac-Saint-Jean	22	1,264	24
Capitale-Nationale	48	4,628	85
Mauricie–Centre-du-Québec	32	2,646	33
Estrie	15	1,464	55
Montréal	138	17,443[20]	757
Outaouais	14	1,063	22
Abitibi-Témiscamingue	13	701	49
Côte-Nord	11	400	11
Nord-du-Québec	3	32	6
Gaspésie–Îles-de-la-Madeleine	10	606	13
Chaudière-Appalaches	32	1,694	51
Laval	15	1,606	68
Lanaudière	18	1,624	121
Laurentides	16	1,733	36
Montérégie	60	5,492	112
Nunavik	2	18	0
Total	**467**	**43,734**	**1,473**

Source: Website of the ministère de la Santé et des Services sociaux, M02 Database, reference dated June 21, 2013. Data compiled by Service de la recherche de l'Assemblée nationale du Québec.

[19] Temporary beds include transitional beds and temporary beds reserved to persons suffering from mental disorder.

[20] Of these 17,443 beds, 2,034 are listed in institutions around the Montréal region managing facilities in other health regions. As such, a number of those beds are sent outside of the Montréal area. The same is true for Laval.

Schedule V

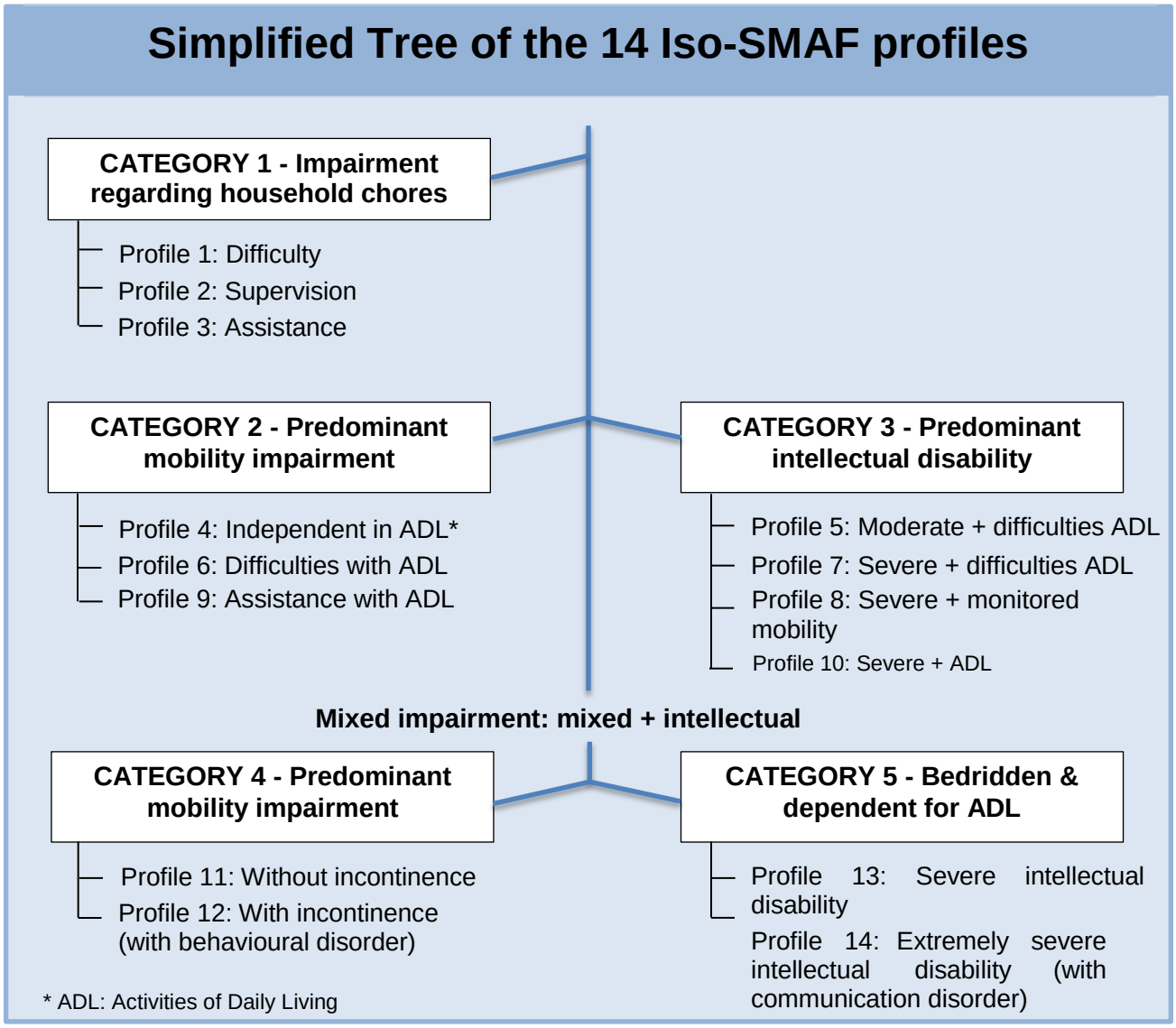
Number of persons accommodated in public and private CHSLDs under agreement as at March 31, 2012

Region	Under 65 years old	65 to 74	75 to 84	Over 85 years old	Total
Bas-Saint -Laurent	109	143	366	450	**1,068**
Saguenay–Lac-Saint-Jean	155	162	413	472	**1,202**
Capitale-Nationale	306	444	1,318	1,591	**3,659**
Mauricie–Centre-du-Québec	208	315	823	1,217	**2,563**
Estrie	118	180	499	701	**1,498**
Montréal	1,348	1,652	4,187	5,248	**12,435**
Outaouais	134	162	472	540	**1,308**
Abitibi-Témiscamingue	87	91	252	246	**676**
Côte-Nord	45	62	132	165	**404**
Nord-du-Québec	11	3	6	12	**32**
Gaspésie–Îles-de-la-Madeleine	46	55	164	232	**497**
Chaudière-Appalaches	172	220	681	837	**1,910**
Laval	93	151	518	608	**1,370**
Lanaudière	186	273	607	688	**1,754**
Laurentides	206	266	642	722	**1,836**
Montérégie	567	721	1,732	2,192	**5,212**
Total	**3,791**	**4,900**	**12,812**	**15,921**	**37,424**
%	10.1 %	13.1 %	34.2 %	42.5 %	**100 %**

Source: Ministère de la Santé et des Services sociaux, June 2013.

Schedule VI

Functional Autonomy Measurement System (SMAF)



The Système de mesure de l'autonomie fonctionnelle[21] (functional autonomy measurement system) assesses functions under 5 aspects, namely activities of daily living (ADL), mobility, communication, mental functions and household chores ("instrumental" activities). Each function is listed based on specific criteria, in accordance with information obtained from the subject, from comments or from questions to a third party. The table above illustrates the profiles emerging from the 14 groups. There is increased loss of independence from the first to the last profile, as well as 5 different categories of individuals.

[21] From: Dubuc, N., and Hébert, R., *Les profils ISO-SMAF : un système de gestion clinico-administratif pour la planification des services de longue durée dans un système de soins intégrés*, [s l.], [s. d.], 26 p.

Category 1 includes Profiles 1, 2 and 3. The subjects only present with an impairment for household chores in the form of difficulties (Profile 1), need for supervision (Profile 2) or need for assistance (Profile 3).

Category 2 is comprised of profiles in which the impairment mostly concerns mobility with a relative preservation of the mental function. It includes Profile 4, in which the subjects are independent in ADLs; Profile 6, in which the subjects present with difficulties to perform ADLs and Profile 9, in which the subjects need assistance with both mobility and ADLs.

Category 3 is comprised of profiles with a predominant intellectual disability. Subjects under Profile 5 present with a moderate intellectual disability and difficulty performing ADLs, whereas subjects under Profile 7 suffer from a severe intellectual disability with minor behaviour problems. Profile 8 includes subjects presenting with a severe impairment requiring supervision and monitoring for ADLs and mobility functions. As for subjects under Profile 10, they need assistance with ADLs, as they are ambulant and usually present with significant behavioural disorders such as wandering and running away.

Category 4 includes Profiles 11 and 12, under which the subjects present with substantial disabilities in both the mobility and mental functions. Profile 11 includes subjects requiring assistance with mobility and ADLs; they are likely to present with occasional bladder incontinence, but they are usually able to control their bowel function. As for subjects under Profile 12, they are dependent in ADLs, but require supervision with mobility and they are usually incontinent. They also present with significant behavioural disorders that require stricter monitoring; for example, they can become aggressive, both toward themselves and others, wander and scream constantly. Interestingly enough, although subjects under profiles 11 and 12 present with different characteristics, their overall level of impairment is similar, requiring similar hours of care and similar total costs.

Category 5 includes Profiles 13, and 14. It includes the least independent of subjects, who are usually bedridden and dependent for ADLs. Subjects under Profile 14 are living their days, and never leave their bed. These users need exhaustive assistance for all activities of daily living, including eating. They can no longer communicate and present with extremely severe cognitive impairments. However, their behavioural problems are rather minor, and include whining, emotional lability, and apathy, all of which require occasional supervision.

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