

**Report of the Local Commissioner of Complaints and Quality
of the Integrated Health and Social Services University Network
for West-Central Montreal
2016-2017
Rosemary Steinberg, MSW**

The following report is submitted to the Board of directors in accordance with section 32.9 of the Law Respecting Health and Social Services of Quebec, Ch. S-4.2. It is also being submitted on behalf of the medical examiners of the CIUSSS du Centre-Ouest-de-l'île-de-Montréal.

Introduction

As this is my last report to the Board of Directors of the CIUSSS, I am taking this opportunity to thank the Board for the support and sense of confidence I have received throughout my tenure. I must point out, in particular, Dr. Lawrence Rosenberg, President and CEO, and Alan Maislin, President of the Board, for the availability, support and good counsel they have provided as I have tried to navigate the often delicate and sometimes challenging complaint process.

I must also thank my team of Helen Vassiliou, Kimberly Dagenais, Hanh Vo assistant CLPQS (Commissaire locale aux plaintes et à la qualité), Claude Malette and Maude Laliberté, delegates, for their hard work, strong commitment to user rights and for always going the extra mile in face of often challenging situations and people. I cannot under-emphasize my appreciation for Dr. Paul Warshawsky, Medical Examiner of the JGH, for his always sound advice and flexibility in going beyond his role.

Finally, I must thank all of the managers and staff of the CIUSSS for their patience, collaboration and openness, when I have had to examine a complaint or manage a challenging situation. Their dedication to quality, commitment to patients and users and respect for professional standards have made my job not only easier, but has also contributed to this being the most rewarding experience of my 40-year career. As the consolidation of the structure of the CIUSSS continues to evolve, it is clear that the strengths of the original establishments continue to flourish. These strengths include a commitment to quality, respect for the multicultural diversity, compassion, professionalism and commitment to ethical and professional standards of practice.

There are also certain challenges that are always part of the reality of a large organization that must be noted. With the more complex and transversal structure, there is an increased bureaucracy that can create additional delays in the accomplishment of certain tasks and confusion in determining who is responsible and able to correct certain situations. This contributes to a greater sense of frustration on the part of staff who may have been used to a simpler and more direct resolution of problematic situations.

The importance of highlighting this to the Board is to underline the importance of ensuring that the middle managers of the organizations receive the support, guidance and tools they need to help their staff find new and creative ways to resolve their daily issues.

The role of the senior managers and administrators in this regard is fundamental. I would encourage, as much as possible, that efforts be made to ensure a presence of these groups at all sites, and that staff have the opportunity to meet and exchange with those who are responsible for the decisions that will impact daily on their work. Furthermore, since Human Resources has already begun offering opportunities for growth, development and career advancement remains a primary source of work satisfaction and personal growth.

As my staff and I try to address daily complaints, we see and hear that staff across the CIUSSS are working very hard under increasing pressures. Managers are increasingly responsible for results and to ensure a bottom line in terms of productivity, safety and quality of care. This makes it more difficult for managers to have the time to step back and reflect on the good practice and good care that is provided.

The impact of this is two-fold. First, it does not encourage a working environment that fosters reflecting on your practice as part of quality improvement. Rather, it risks making the focus on poor practice, which must always be addressed, leaving fewer opportunities to reward or promote good practice. Second, this type of exchange is part of nourishing a creative environment that encourages innovation. The absence of that environment of creativity and innovation is a loss for users and staff alike.

I and all of the members of my team receive regular requests from staff and managers to assist them in finding resolutions to certain issues. While this is, I believe, a positive reflection of the role and credibility our office has come to play, the ultimate goal of the Commissioner should always be focusing on problem solving with the objective of becoming obsolete. Staff in our CIUSSS need to feel supported by their middle and senior managers, and should be encouraged to use them in their active problem-solving. A commitment to helping find a solution or, at least, a clear explanation is sometimes all that is required to help staff feel more supported in their daily work.

Finally, it would be remiss of me not to mention the pressures that the media and social media seem to have added to our work. Hardly a day goes by when a user or family member does not threaten to go to either, if their particular needs (or demands) are not met.

Many complaints that I receive refer to social media sites such as “Rate my doctor”. Complainants quote these comments as if they are incontrovertible facts, instead of being the anonymous individual expressions of dissatisfaction, satisfaction or any other emotion the writer seeks to express.

It is my experience that, more often than not, these sites are used to express anger, disappointment or disagreement. Anonymity allows the writer to be uncensored, and the focus of the post is undefended. The difficulty in this is that as they grow in popularity,

they affect the reputation and confidence of, in particular, physicians and establishments. It is not my practice to accept these “testimonials” because they are unsubstantiated and anonymous, but I do worry about their impact. It is my hope that Communications can develop a strategy to neutralize the negative impact of this. Similarly, the use of cellular phones to tape unsuspecting staff and unaware users must be strongly discouraged by everyone who witnesses it.

A word about statistics

It is important to point out that while statistics regarding complaints are generally seen as a central point of this annual report, there are some caveats that must be understood. Statistics themselves tell only a part of a story and must be taken within their context if they are to help improve the quality of care and services.

The system that is currently used to register, categorize and compile the information about statistics, SIGPAQS, predates the creation of the CIUSSS. It was initially designed for individual establishments to report their complaints. While the data of all the CIUSSS sites were merged last year, the statistics do not accurately reflect either the organogram of our CIUSSS or its mission. The statistics more accurately reflect where the complaint was received—i.e., where the user was active when the care was provided.

For example, the MAH (Mécanisme d'accès à l'hébergement) is an important structure and function of the CIUSSS, as it is responsible for evaluating and orienting requests for the placement of elderly, handicapped and vulnerable users. However, complaints about the decisions taken by the MAH, are generally reflected in the statistics of the establishment where the user was active at the time that the request for placement was effected—e.g., the CLSC or hospital. The only time the MAH is cited as the focus of the complaint is when the complaint comes from someone not otherwise served by the CIUSSS.

Similarly, complaints regarding rehabilitation services or homecare services are registered at the site where the service or care was provided, and not within the Direction or program that provided it (e.g., CLSC vs. SAPA). One of the challenges of the person who replaces me will be to take a fresh look at the organogram and the structure that we currently use (and can adapt) within SIGPAQS to determine where there is a more effective way to impute this type of complaint information.

There will shortly be an initiative launched through the MSSS, with the collaboration of the Regroupement des commissaires aux plaintes et à la qualité du Québec, that will seek to update this system. It will undoubtedly address some of these issues, but for the moment, caution must be applied in interpreting these statistics.

Another important example is the GMF (Groupe de médecine familiale). One of the major objectives of the MSSS and our CIUSSS has been to provide greater access to family physicians through the creation of the GMF. Our CIUSSS has been very successful in meeting those objectives. However in spite of the contractual partnership of the GMF,

there has been no clear distinction of responsibility with regard to user dissatisfaction. Therefore, the recourse for users of professional services will be to the Professional Order or College, but there is no recourse for complaints regarding staff who are not members of such organizations. However, given the number of GMFs within our CIUSSS, without an injection of resources, it would also be impossible for the existing complaint office to examine those potential complaints.

As I have said in previous reports, assistances are equally important to complaints, and should carry the same weight. They often take more time to complete and can be more complex than certain complaints. There is significant latitude for the person registering the complaint or request for assistance to decide how to register, since the definition is selected through a personal lens. Furthermore, assistances can easily be transformed into complaints if the user remains dissatisfied and wishes to pursue further actions or to take advantage of their recourse.

It must also be acknowledged that while the work in resolving a request for assistance can be equal to or greater than the work required to resolve a complaint, the administrative requirements of a complaint are more time-consuming and formalized. This can affect one's decision to register a concern as a complaint or an assistance. However, when users clearly establish their desire to make a formal complaint, this is respected.

Assistances are often the result of users being unable to navigate the system. As the CIUSSS "matures" as an organization and the structure and manpower become more permanent and consolidated, this function may lessen as key people within the organization will be better able to accompany or direct users through the trajectory of their care and services. I also believe that the Office of Patient Experience can, in the future, play an important role in this regard by identifying, training and supporting patient navigators and through their continued patient satisfaction surveys.

In my annual report as Commissioner of CSSS de la Montagne in 2007-2008, I reported 92 complaints in three CLSCs. This year, there are 88 complaints noted in the five CLSC in the CIUSSS. I do not believe that the lower number reflects greater satisfaction of users; rather, it is a lack of presence of the Commissioner (or delegate) on the site. This is not a reflection on other staff being insensitive to the needs and pre-occupations of users. It is simply the reality that availability ensures ease of access, more opportunities for the promotion of rights, and an environment that integrates the role of the commissioner of complaints as a positive force for change.

Users in a vulnerable situation, particularly those in a dependent situation—i.e., the elderly and the physically or intellectually challenged—find it more difficult to complain, because they are unable to or may fear the repercussions. While legislative protections exist in the LSSS, these are not enough to sooth those fears. Thus, it is very likely that complaints and dissatisfactions are under-reported. This is further confirmation of the importance of promoting users' rights and facilitating access to the complaints person, such as increasing the presence of the commissioner (or staff) on site.

However, this could also be influenced by a greater on-site presence of managers and/ or more efforts to create an environment where bringing forward concerns is viewed as valuable and everyone’s responsibility. Bill 115 (an Act to combat maltreatment of seniors and other persons of full age in vulnerable situations) was recently adopted by the National Assembly. It obligates our CIUSSS to implement measures to encourage the disclosure of such situations within each site, and it makes certain disclosures mandatory. No doubt, this will increase the work of the commissioner, and it increases the need for greater availability of the commissioner or staff on those sites.

As the system becomes more complex, resolution of issues also becomes more complex. If the hierarchy of decision-making is not clear at each level, there is less clarity in finding solutions and clarifying the route that people need to take to resolve their concerns. Not only does this create more frustration, but the dissatisfaction is less likely to be properly channeled.

This has been reflected even in the examination of complaints, as it has taken longer in some instances to receive the information required to conclude a complaint. There has also been some reluctance by certain managers to share information, because they were not aware of the role, responsibilities and authority of the Complaints Commissioner and the delegates.

Presentations have begun to address this, but they need to be continued by the person replacing me.

Complaints, interventions and assistance

A complaint may have more than one motive, and statistics generally reflect several motives.

| Year | Complaints* | Interventions | Assistance | Consultations** | Recourse to Protector | Medical complaints |
|------------------|--------------------|----------------------|-------------------|------------------------|------------------------------|---------------------------|
| 2016-2017 | 378* | 16 | 1,015 | 75 | 12 | 74 |
| 2015-2016 | 330 | 7 | 1,243 | 36 | 7 | 89 |
| 2014-2015 | 569 | 25 | 1,074 | 29 | 13 | 98 |

* Four complaints were rejected after summary evaluation.

** Consultations at the JGH have not been registered systematically, but should be in future for a more accurate picture.

CLPQS complaints by mission

| Year | Acute care | Long-term care | Rehabilitation | CLSC |
|------------------|-----------------|----------------|----------------|----------------|
| 2016-2017 | 59.79% (226) | 14.81% (56) | 2.11% (8) | 23.28% (88) |
| 2015-2016 | 76.36% (256) | 10.30% (34) | 2.74% (9) | 10.6% (35) |
| 2014-2015 | 69.37% (399) | 9.68% (55) | 4.0% (23) | 16.9% (96) |

Breakdown by motive of CLPQS complaints

| Year | Quality of care | Interpersonal relations | Access | Financial | Physical environment | Specific rights |
|------------------|-----------------|-------------------------|--------|-----------|----------------------|-----------------|
| 2016-2017 | 31% | 23.4% | 17.35% | 6.9% | 6.3% | 13.45 |
| 2015-2016 | 32.4% | 26.5% | 19.4% | 6.15% | 8.7% | 6.7% |
| 2014-2015 | 26.6% | 14.6% | 37.7% | 3.9% | 9.5% | 8.21% |

Measures resulting from CLPQS complaints

More than one measure can result from one complaint.

| Measure type | Quality of care | Interpersonal relations | Access | Financial | Physical environment | Specific rights |
|---------------------|-----------------|-------------------------|--------|-----------|----------------------|-----------------|
| Individual * | 23 | 38 | 23 | 11 | 11 | 9 |
| Systemic ** | 21 | 16 | 15 | 5 | 18 | 5 |
| Total | 44 | 54 | 38 | 16 | 29 | 14 |

* Individual measures relate to a specific member of staff.

** Systemic measures relate to the overall system.

Recourse taken to Protector, by motive

| Year | Quality of care | Interpersonal relations | Access | Financial | Physical environment | Specific rights |
|-----------|-----------------|-------------------------|--------|-----------|----------------------|-----------------|
| 2016-2017 | 8 | 4 | 2 | 1 | 2 | – |

Medical Complaints by mission (number and percentage of whole)

| Year | Acute care | Long-term care | CLSC |
|-----------|----------------|----------------|--------------|
| 2016-2017 | 67 (90.54%) | 5 (6.76%) | 2 (2.70%) |
| 2015-2016 | 84 (94.4%) | 4 (4.5%) | 1 (1.12%) |
| 2014-2015 | 85 (87%) | 7 (7%) | 6 (6%) |

Breakdown by motive of medical complaints

| Year | Quality of care | Interpersonal relations | Access | Financial | Physical environment (including security) | Specific rights |
|-----------|-----------------|-------------------------|--------|-----------|---|-----------------|
| 2016-2017 | 78.6% | 7.1% | 9.5% | – | – | 4.8% |
| 2015-2016 | 65.85% | 24.4% | 9.8% | – | – | – |
| 2014-2015 | 63.8% | 17.39% | 8.7% | – | – | 10.14% |

Percentage of complaints concluded within a 45-day delay

| Year | CLPQS | Medical examiner |
|-----------|-------|------------------|
| 2016-2017 | 62.5% | 7.5%* |
| 2015-2016 | 69% | 25% |
| 2014-2015 | 79.7% | 22.7% |

* Another medical examiner was recently named by the Board of Directors, a measure that will help this percentage to improve.

Review Committee requests received

| Year | JGH | CHSLD | CLSC | Total | Completed |
|-----------|-----|-------|------|-------|------------------------|
| 2016-2017 | 7 | 1 | | 8 | 11 (3 carried over) |
| 2015-2016 | 3 | – | – | 3 | 0 |
| 2014-2015 | 3 | 2 | | 5 | 5 |

Observations, suggestions and recommendations

Medical Examiner (Dr. Paul Warshawsky)

Quality of care and consent to care

1. Several complaints involved informed consent. It is clear that there can be many variations in and components to a patient's understanding of the medical information that is provided. However, it is equally important that there be an adequate recording of that consent. A note stating that "informed consent was received" is vague and lends itself to a debate about what constitutes "informed". I believe it is fair to expect that the major risks and benefits of any procedure be explained to a patient prior to the procedure. There should be a record in the medical chart indicating that this risk/benefit discussion occurred. I am recommending that each department within the hospital consider this issue and develop an approach and policy appropriate to its department.

Commissioner of Complaints and Quality of Services

Access to services

2. Telephone access across the CIUSSS remains challenging. Users of service continue to report difficulty in achieving easy or simple access to make, change or confirm appointments, and to request information about services. Most of these complaints are generated at the JGH and the CLSCs. This is an obstacle to access to services, which can generate frustration, but can also limit access for vulnerable individuals.

The brunt of these complaints falls on the frontline receptionist, who is not always well equipped to handle the volume or the acrimony with which users' frustration is often expressed. The ongoing implementation of the central appointment desk at the JGH may help to facilitate access for appointments, but at present, complaints seem to be continuing at the same rate. Efforts to develop other tools, such as web-based or

email access should be pursued. The soon-to-be-implemented Respect Campaign will better equip receptionists to respond, but ongoing encadrement for these frontline members of staff will be needed to sustain their ability to retain the learning. Furthermore, as their tasks change and increase, they will need help in prioritizing their tasks in a way that is consistent with the values and objectives of the overall CIUSSS.

3. Families requiring care and services from our CIUSSS often find themselves receiving services from more than one department or directorate. The resolution of certain issues, such as case management, confidentiality or even eligibility for specific government programs, will involve cooperation and collaboration by all members of staff who provide the service.

While this generally does work well, there are occasions when the lack of a “pivot” staff member interferes with resolving issues or identifying and implementing effective solutions. I am recommending that a senior manager be designated as the “arbiter” in this type of situation. I believe that the ADG (Associate Executive Director & Director of Quality, Evaluation, Performance and Ethics) is extremely well placed to perform that function. A simple mechanism should be set up, implemented and made known across the CIUSSS that allows a member of staff to bring a contentious situation to the ADG’s attention, and she can negotiate the best resolution with the directors.

Navigating the system

4. We have been seeing an increase number of situations in acute care, where family members have been refusing to accept the discharge plans that have been proposed for the patient. This is resulting in the creation of an adversarial relationship, as threats of legal action are more frequently part of the discussion and options. This phenomenon is difficult to understand completely, but it may reflect a decreased sense of trust in the healthcare system, as well as a rejection of placement options as being too far, too inadequate or inappropriate, according to the family’s opinion. Media reports that highlight deficiencies in the system nourish a perception that hyper-vigilance is needed to assure the good treatment of loved ones. Hyper-vigilance in health care leads to greater dissatisfaction and increased debate among staff and users or the users’ representatives.

However, it is true that medicine, the network and the role of the hospital have evolved, and perhaps we are not adequately explaining this at the community level. The goal of hospitalization is to return patients to their homes or to a home environment as soon as it is clinically safe. Hospitals are not the place for patients to rest or become stronger; they are acute-care centres that are designed to provide acute care during a short-term stay. Once that care is provided, patients have a responsibility to leave the hospital (Art. 14, LSSS). More than being a legal requirement, however, the home environment is ultimately safer and more conducive

to recovery and a better quality of life. This also ensures better access to acute care for those in need.

Perhaps a communication campaign outlining the goals, risks and benefits of hospitalization would help. There should also be a clarification that while “choice of establishment” still is part of the Quebec law regarding Health and Social Services, it is neither an unconditional nor an absolute right (Articles 6 and 13 of LSSS).

Recent efforts at the JGH to reach a “Zero patients in Emergency for 24 hours”—which have successfully ensured that patients do not remain unnecessarily in the Emergency Department—may also have a secondary impact in assisting in this effort because of the inclusion of predicting discharge within 48 hours of admission. This makes the discharge planning process part of the plan of care from the beginning, as it should be. However, the challenge on the floors, particularly where rotations are frequent, will be to ensure transmission of information between teams, as well as the continuity of that information and that plan to the families and patients. This is particularly challenging where the physicians and residents rotate frequently and for off-service patients, who in some instances report feeling like “orphans”. Plans should change only because the condition or situation of the patient changes, and not because the professional changes.

A tool to identify this plan to all involved needs to be developed and maintained.

5. Users report that their frustration is exacerbated when they speak to someone from staff who expresses their own lack of knowledge about who is responsible for a particular service or cannot direct them to the person who can provide certain information. Reception staff should regularly receive information about updated departmental organograms and staff lists. It would be very helpful and more efficient to have one identified service (e.g., Communications) to assist them in obtaining the information. Recently, a new process to update the telephone repertoire of staff was initiated, and that will be helpful if all of those responsible understand the importance of updating the information.

Other CIUSSS’s across Montreal have implemented a central information number, which users can contact to obtain information about how to gain access to services and whom to contact for various concerns. It would be valuable to explore with the other CIUSSS’s whether and how this was effective. The quality of the work and the work satisfaction of these frontline staff will also be positively affected when they feel more supported.

6. We have entered the third year of the CIUSSS. While many gains have been made in continuity of care, minimizing duplication, developing better partnerships among teams within and outside the CIUSSS, and improving access to primary health care, there is still some work to be done.

This becomes increasingly evident as patients' trajectories take them through various services (e.g., acute care to rehabilitation to home care to community, etc.), and the expectations that are set for the receiving service by the referring service do not match the experiences of the users. This serves to diminish the trust in the overall CIUSSS. It is very important that each service work hard not only to understand the mandate and capacity of the next, but confirm before sending the user what the user has a right to expect.

Also, staff from various services do not always share the same opinion about the needs of the user. While these disagreements are natural and almost always resolved, the debate should not occur in the presence of the user or the family. I believe that differences of opinion need to be addressed before discharge-planning meetings as much as possible. When there is continued discord, it becomes even more important that the hierarchy step in and seek solutions and consensus.

Finally in this regard, there should be greater openness to a transversal case-management process, particularly for the elderly and fragile. They often move between community, acute care and rehabilitation, but the overall case management should remain where the person is most likely to return or to remain.

Interpersonal relations

7. The transversal structure of our CIUSSS is not only confusing at times, but does not always facilitate the creation of a teamwork environment within each directorate. It can also make it difficult for staff to understand the need for certain changes and, thus, difficult for them to integrate and adopt these values and objectives into their service delivery. This is sometimes reflected in their communication with users, as their frustrations may come through in having to frequently explain to users the rationale and impact of changes.

I believe that this propagates an impression of a “top-down” decision-making process and does not encourage or facilitate the transmission of information from staff who must carry out the tasks or implement the decisions. I believe that senior and middle managers should be encouraged to have a greater presence at all sites and, whenever possible, to assemble their staff at meetings where members of staff can express their concerns, opinions and suggestions.

Also, there should be regular meetings of middle management staff, both intra- and inter-division, that allow for an exchange of information and familiarity. These meetings can also be used as an opportunity for training sessions.

I believe that this would make all members of staff feel more respected and more involved, and thus better equipped to be more respectful in their interactions. This would give staff a regular outlet for their own concerns and might help generate more creativity in solving problems for their clients or patients. Staff on the front lines have valuable information from and experience with the users of the services.

8. As mentioned in the introduction, everyone is working very hard to provide the best quality of care they can. Reception staff are the first contact that most people have with the organization, but they receive relatively little active encadrement (supervision, consultation, evaluation and teaching).

There are frequent changes and increased pressures on all levels. This often results in staff being less patient and less able to be as helpful as they would normally be, and this detracts from their work satisfaction. A wide-reaching Respect Campaign will soon be launched to provide staff with the skills they need to manage high-pressure situations and to develop options for themselves when facing challenging users. To have a sustained impact, it is important that this campaign be followed up by ongoing consultations and supervision.

Quality of care

9. As described in the previous section, the success of the development of the GMF has given rise to certain problems. When a complaint is registered about a service that is delivered in the GMF, it is unclear what the authority is of the Commissioner in this “public-private partnership”. Telephone access is critical, but the staff and technology do not belong to the CIUSSS, and thus do not come under the aegis of the Commissioner.

It is even unclear within the jurisprudence what is the responsibility of the Commissioner with regard to complaints about contracted CIUSSS staff who provide care in the GMF. Finally in this regard, access to the clinical record of a user who wishes to make a complaint is also not clear or simple.

Given that the CIUSSS-GMF relationship is a contractual one, it is recommended that the contract be modified to include the examination of complaints and the issue of access to medical records, both for the Commissioner and for the users themselves who have a right to access those records.

I would further recommend that the same principle of clarifying responsibility and authority for complaints can and should be extended to any program that is framed by a contractual relationship, such as RI’s (Intermediate Resources).

10. There continue to be some difficulties in ensuring quality from private agencies, particularly those used in home care. The efforts currently in place through SAPA (Soutien à l’autonomie des personnes âgées) to reduce the number should continue. However, as long as private agencies remain part of the service delivery, they should be held accountable through their contracts for ensuring a consistent and acceptable level of care. Furthermore, there should be a clear process of responding to complaints that users do register, with a responsibility of their management to respond.

Risk management and Security

11. The risk management (RM) process in the CIUSSS is a key element in improving the quality and security of care. A great deal of effort has been invested by the Quality team in ensuring greater continuity in the application of risk management principles and procedures. I strongly support the Quality team in this endeavour and would like to suggest that staff be encouraged to more actively participate in the RM process by providing them an outline of their responsibilities, timeframe and follow-up steps.

There are three key moments in the RM process where I believe particular attention is required: managing the event, disclosing the event, and following up and concluding the event. The goal in all of these is to ensure immediate and appropriate care, and transparent and supportive disclosure and identification of measures that are designed to prevent a repeat. In each of these steps, the responsibilities of staff and managers should be clarified and an outline of those responsibilities provided. It is not always clear who has to conclude the process, because of the number of people involved. I believe that concluding the process, i.e., informing the user and/or family of the measures, is best undertaken by the manager of the unit or department where the accident occurred.

12. The security and loss of personal items and valuables remains a source of dissatisfaction and cost for users and the CIUSSS. The ADG responsible for Quality, Evaluation, Performance and Ethics has integrated into her three-year improvement plan an objective to improve this situation.

Users whose personal items are lost often express the view that this demonstrates a lack of caring or respect, and that their trust in the system has faltered as a result. Users should feel safe and secure within the walls of the establishments where they receive care.

While I believe that achieving a 100% rate of security is impossible, it is also clear that there are particular junctures in the trajectory of care in any healthcare establishment that are less secure than others. This includes any instance where a patient is transferred or transported. I believe that the CIUSSS can improve the security of personal belongings by promoting an environment that reminds staff, patients and family of the need for vigilance with regard to possessions. Families should be strongly and repeatedly encouraged to take valuables home, and the belongings of particularly vulnerable users should be registered in a formal and consistent way.

Complaint examination process

13. The average delay for examining medical complaints at the JGH has been growing and is difficult for the patients and the physicians who are the focus of the complaint. Recently, the JGH added a new medical examiner who will certainly help with the challenge of meeting the delay (45 days) in the LSSS for new complaints. There are

several medical examiners named throughout the CIUSSS. An updating of this list of MDE's will shortly occur and should include the expectation that they not be connected to a specific site, but combine their efforts to address the backlog and prevent it from increasing.

The medical examiners do need administrative support. Previously this was done either through the local DPS (Department of Professional Services) office or the office of the DG of the establishments that have now been regrouped into the CIUSSS. It is important that this support be organized and provided to the medical examiners in a formal way. The present workload of the administrative staff of the Commissioner's office is already strained with the additional administrative responsibilities of the Commissioner.

14. It is clear that over 60% of complaints in the CIUSSS stem from the JGH. There should be a review of workload and a redistribution of responsibilities to reflect that reality. It is also important to keep in mind the observations that were made above—namely, that presence within an establishment can lead to a greater involvement and higher numbers of assistances and complaints. The resources that are now allocated to the Commissioner's office include a temporary managerial position. When that position ends in 2018, the Board and the Vigilance Committee need to ensure that the Commissioner has adequate resources to meet the needs of users in this regard.

The recent adoption of Bill 115 by the National Assembly, as well as the responsibilities of the CIUSSS and the CLPQS in this regard, increase the importance of ensuring adequate resources in the Commissioner's office.

15. The SIGPAQS information system should be better used to assist that CLPQS in keeping track of the application of the complaint procedure. The list of sites and their subsections (departments, floors, etc.) needs to be configured to better reflect the organogram of the CIUSSS, so that better statistics can be offered to managers. While this cannot be done by our CIUSSS alone, the Complaints office will need resources and the cooperation of the directorates to put this measure in place.

Appendix A

Staff of the Complaints Commissioner

Rosemary Steinberg, Commissioner of Complaints and Quality of Services

Hanh Vo, Assistant Commissioner of Complaints and Quality of Services

Claude Malette, Delegate Office of Commissioner of Complaints and Quality of Services

Maude Laliberté, Delegate Office of Commissioner of Complaints and Quality of Services

Helen Vassiliou, Administrative Staff

Kimberly Dagenais, Administrative Staff (0.6)

Marie-Madeleine Chaslas, Administrative Staff (0.2)

Medical Examiners

Dr. Paul Warshawsky
Dr. Harvey Sigman
Dr. Markus Martin
Dr. Rubin Becker
Dr. Alexander Motard

Revision Committee

Vivian Konigsberg, Chair
Dr. Judy Glass, Chief Emergency Psychiatry, JGH
Dr. Sylvie Boulet, Family Physician, CLSC Côte-des-Neiges, Point de service Outremont

Appendix B

List of sites as detailed in the SIGPAQS system

MAH (Mécanisme d'accès à l'hébergement)
SAPA (Soutien à l'autonomie des personnes âgées)
Centrale Info-Santé
Centre de réadaptation MAB-Mackay
Centre de réadaptation Constance-Lethbridge
Centre gériatrique Donald Berman Maimonides
Centre Miriam
CHLSD juif de Montréal
Centre d'hébergement Father-Dowd
Centre d'hébergement Henri-Bradet
Centre d'hébergement Saint-Andrew
Centre d'hébergement Saint-Margaret
CIUSSS Centre-Ouest-De-L'île-De-Montréal
CLSC de Côte-des-Neiges
CLSC Benny Farm
CLSC de Métro
CLSC de Parc-Extension
CLSC René-Cassin
CSSS Cavendish
CSSS de la Montagne
GMF (Groupe médecine familiale)
Hôpital Catherine-Booth
Hôpital Mont-Sinaï
Hôpital Richardson
Les Pavillons de Lasalle-Cavendish
Hôpital général juif
Maison bleue de Côte-des-Neiges
Maison bleue de Parc-Extension
Maison des naissances de Côte-des-Neiges
Manoir Renaissance
Point de service Outremont

Private residences

Résidence Salomon

Ressource de la Montagne

Site Plaza

Lev Tov

Maison Paternelle