ANNUAL REPORT

MANAGEMENT REPORT

REVIEW AND OUTLOOK

19 20

APRIL 1ST, 2019 - MARCH 31ST, 2020

Québec

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Approved by the Board of Directors on August 26, 2020

SECTION 1—MESSAGE FROM THE PRESIDENT AND CEO

MESSAGE FROM THE PRESIDENT OF THE BOARD OF DIRECTORS AND THE PRESIDENT & CEO

This year, the Montreal West Island Integrated University Health and Social Services Center (IUHSSC) is celebrating its fifth anniversary. The past five years have been characterized by an unwavering drive to provide safe and quality care and services to our population, as well as an effort to promote efficiency and simplify access to care, all while striving for constant growth and improvement.

The *Annual Management Report* and the *Departmental Highlights* describe our clinical, administrative, financial, teaching and research achievements.

The following are some of the highlights from this past financial year, which was cut short by the coronavirus pandemic that forced us to revise our priorities.

Funding secured for the implementation of the *Agir tôt* program that targets early detection and management of developmental delays in children aged 0 to 5 made it possible to hire additional professionals to work in our CLSCs and our youth rehabilitation centres, as well as reduce wait times for children and their families to receive services.

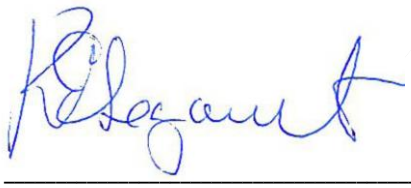
We announced a major project at the Douglas Mental Health University Institute that aims to modernize the institution's aging infrastructure in order to better meet its clinical and teaching needs. These renovations will allow us to provide our excellent mental health care services to many individuals in need in a modern, safe, and humane environment.

We also announced the construction a new facility in Dorval that will house 72 residents with intellectual disabilities, autism spectrum disorders, or physical disabilities in a comfortable living environment that is reminiscent of home and encourages an active lifestyle.

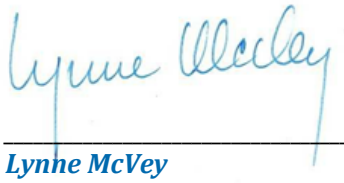
We continue to be fully committed to improving access to care and services and encourage citizens to become an integral part of the decision-making process. Our citizen-partner approach allows members of the community to get involved in large-scale projects or to sit on Montreal West Island IUHSSC committees.

During the inaugural IUHSSC Recognition Gala, our culture of excellence where everyone is that encourages everyone to excel was on full display. This event will be held annually and recognizes the innovative projects and impressive outcomes that achieve our mission and match our organizational values of agility, respect and partnership.

We would like to take this opportunity to thank our exceptional employees, managers, doctors, researchers, community partners, and volunteers for their hard work and dedication to caring for our population and clients.



Mr. Richard Legault, President of the Board of Directors



Lynne McVey
President & CEO

THE BEGINNING OF THE PANDEMIC:

It is difficult to ignore the virulent pandemic linked to the new coronavirus (COVID-19) that has spanned the globe in recent months. Our organization and the community we care for have unfortunately not been spared.

From the outset of this health crisis, the management and staff of the CIUSSS de l'Ouest-de-l'Île-de-Montréal stepped up their efforts, drew on their energies, and, above all, demonstrated exemplary commitment and courage to take care of our community, and especially the most vulnerable people. Many initiatives were quickly put forward, some of which remain ongoing. As such, infrastructure projects and the purchase of mobile trailers and garage shelters for our community hospitals were accelerated to increase our capacity to better serve our customers. There was an urgent need to recruit help, and in addition to the ministerial Je contribue platform, our organization created its own rapid hiring mechanism, We're Stronger Together. This allowed us to recruit many individuals who were ready to lend a hand. Similarly, our personnel demonstrated the agility that is one of our organization's core values. That agility allowed us to redeploy a good number of employees to sectors where the understaffing was being felt most acutely. In fact, several members of our staff have volunteered for redeployment.

The executive management of our CIUSSS quickly implemented a series of tools to keep both its staff and the public up to date on important information related to the pandemic. This included daily information sessions on the Zoom platform for our staff as well as a daily email, A Word from the CEO, sent out to our entire workforce. That information was also promptly published on our intranet site.

The public also had a variety of information channels available to them. These included the Info-CIUSSS telephone line, available at all times, as well as our website and social media platforms (Facebook and LinkedIn), which were continuously updated.

We also want to highlight the exemplary collaboration of our community partners. Several meetings with local mayors and elected officials allowed us to better align the actions of the CIUSSS de l'Ouest-de-Île-de-Montréal with those of our community.

We are convinced that all of these initiatives have had a real impact. In fact, they have undoubtedly helped save many lives.

We will spare no effort to be well prepared for a second wave of the pandemic. We have learned a great deal in recent months—now we are making improvements to the initiatives we have successfully deployed and aim to continue improving our delivery of quality care and services to the population.

SECTION 2—DECLARATION REGARDING THE RELIABILITY OF DATA AND RELATED CONTROLS

I am responsible for the information contained in this annual management report.

Throughout the year, reliable information systems and control measures were used to ensure that we attain the objectives set out in the management and accountability agreement with the Minister of Health and Social Services.

The results and data of the Centre integré universitaire de l'Ouest-de-l'Île-de-Montréal 2019–2020 Management Report:

- accurately reflect the mission, mandates, responsibilities, activities and strategic directions of the organization;
- present the objectives, indicators, targets and outcomes obtained;
- present accurate and reliable data.

I declare that to the best of my knowledge, the information enclosed in this annual management report and management controls associated with these data are reliable and reflect the situation as it existed on March 31, 2020.

Lynne McVey
President & CEO

SECTION 3—PRESENTATION OF THE INSTITUTION AND HIGHLIGHTS

3.1 THE INSTITUTION

MISSION AND SERVICES OFFERED

The Centre intégré universitaire de santé et de services sociaux (CIUSSS) de l'Ouest-de-l'Île-de-Montréal is an institution that provides integrated health care and services to the population of the West Island and Dorval-Lachine-LaSalle, and to the clients of its facilities that provide general and specialized care across the Island of Montréal and in various regions of Québec.

The mission of the CIUSSS de l'Ouest-de-l'Île-de-Montréal is to provide a true integration of the services it delivers to the population.

- The institution is at the heart of a territorial service network (TSN) made up of local service networks (LSN) in the West Island and Dorval-Lachine-LaSalle.
- It is responsible for delivering health care services to the population in its health and social service territory, including a public health component.
- It has a responsibility to the people in its health and social service territory.
- As part of its multiple missions, it oversees the organization of services in its territory and collaboration with establishments of the territories on which its facilities are located within the framework of those missions to ensure complementarity, taking into consideration the needs of the population, its clienteles, and its territorial realities.
- It enters into agreements with other facilities and partner organizations of its TSN (university hospitals, medical clinics, family medicine groups, network clinics, community agencies, community pharmacies, external partners, etc.).

Source: ministère de la Santé et des Services sociaux

Through the missions of its founding facilities, the CIUSSS de l'Ouest-de-l'Île-de-Montréal carries out the five major missions defined in the Act Respecting Health Services and Social Services to achieve better service integration for its target population and clientèles. Between April 1, 2019, and March 31, 2020, the institution operated:

- 4 local community service centres (CLSC);
- 4 hospital centres (CH): 3 hospitals providing general and specialized care, and 1 psychiatric hospital;
- 8 residential and long-term care centres (CHSLD);
- 1 child and youth protection centre (DPJ);
- 2 rehabilitation centres: 1 for people with intellectual disabilities or a pervasive development disorder (CRDITED) and 1 rehabilitation centre for youth with adjustment problems.

UNIVERSITY DESIGNATION AND PRIMARY SERVICES

University-designated because of its location in a health region where a university offers a complete undergraduate program in medicine, the CIUSSS de l'Ouest-de-l'Île-de-Montréal includes two university-designated facilities, i.e. Douglas Mental Health University Institute and St. Mary's Hospital Center, as well as two research centres— Douglas Institute's Research Centre (FRQS-accredited and second among top-performing centres in its area of expertise in Canada) and St. Mary's Research Center.

This year there were 1 398 university trainees across all CIUSSS de l'Ouest-de-l'Île-de-Montréal facilities: 827 residency-level medical student residencies and 571 non-medical internships (social services, health care, engineering, administration, human resources, etc.).

The CIUSSS de l'Ouest-de-l'Île-de-Montréal is also a member of McGill University's Réseau Universitaire Intégré de Santé (RUIS-McGill)*, offering several specialized and highly specialized services within the covered region.

REGIONAL AND SUPRAREGIONAL VOCATION

Some facilities of the CIUSSS de l'Ouest-de-l'Île-de-Montréal are designated bilingual and can provide all of their services in English.

In addition to the primary programs offered, the CIUSSS de l'Ouest-de-l'Île-de-Montréal also has a provincial mandate to provide ultra-specialized care and services for eating disorders as well as youth protection services and English-language residential and rehabilitation services to all youth in the province who require these services. The CIUSSS de l'Ouest-de-l'Île-de-Montréal also provides second-line mental health services to the Aboriginal communities of Nunavik and the Cree of James Bay.

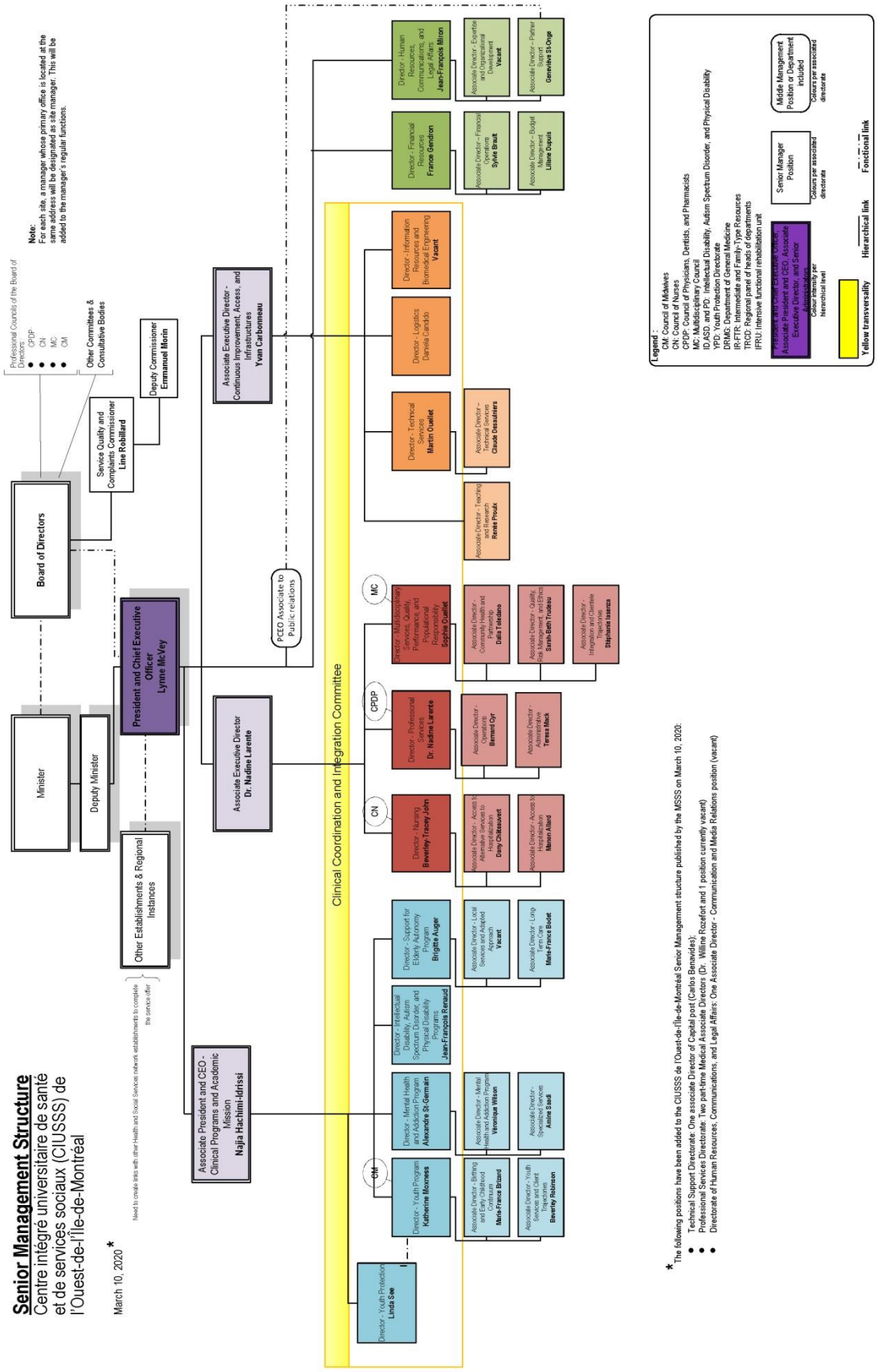
The residential treatment program for operational stress injuries at Ste. Anne's Hospital provides mental health care and superspecialized residential services to Canadian Armed Forces Veterans as well as members of the Royal Canadian Mounted Police.

The CIUSSS de l'Ouest-de-l'Île-de-Montréal was created on April 1, 2015.
As of March 31, 2020, it comprises the following facilities:

West Montréal Readaptation Centre (WMRC)
Dorval-Lachine-LaSalle Local Services Network (LSN)
• CLSC de Dorval-Lachine • CLSC de LaSalle • CHSLD de Dorval • CHSLD de Lachine • CHSLD de LaSalle • CHSLD Nazaire-Piché • Residential Unit at Hôpital de LaSalle • Hôpital de LaSalle
West Island Local Services Network (LSN)
• CLSC de Pierrefonds • CLSC du Lac-Saint-Louis • CHSLD Denis-Benjamin Viger • Lakeshore General Hospital
Grace Dart Extended Care Centre (GDECC)
St. Mary's Hospital Center (SMHC)
Batshaw Youth and Family Centres (Batshaw)
Ste. Anne's Hospital (SAH)
Douglas Mental Health University Institute (DMHUI)

* The territory of the RUIS McGill covers 63% of the territory of the province and includes the following regions: Nunavik, James Bay Cree territory, Nord-du-Québec, Abitibi-Témiscamingue, Outaouais, the west of the Montérégie, and the western part of the island of Montréal.

ORGANIZATIONAL CHART ON MARCH 31, 2020



* The following positions have been added to the CIUSSS de l'Ouest-de-l'Île-de-Montréal Senior Management structure published by the MSSS on March 10, 2020:

- Technical Support Directorate: One associate Director of Capital post (Carlos Benavides);
- Professional Services Directorate: Two part-time Medical Associate Directors (Dr. Willine Rozefort and 1 position currently vacant)
- Directorate of Human Resources, Communications, and Legal Affairs: One Associate Director - Communication and Media Relations position (vacant)

3.2 THE BOARD OF DIRECTORS, COMMITTEES, BOARDS, AND ADVISORY BODIES

3.2. 1 BOARD OF DIRECTORS

Mr. Richard Legault	**President** Human, property and information resources competency
Ms. Isabelle Brault	**Vice-President** Governance and ethics competency
Ms. Lynne McVey	**Secretary** President and Chief Executive Officer
Ms. Nada Dabbagh	Regional Pharmaceutical Services Committee (RPSC)
Ms. Micheline Béland	Users' Committee (UC)
Mr. Allen Van der Wee	Risk management, finance and accounting competency
Mr. Rafik Greiss	Auditing, Performance and Quality Management Competency and English Language Committee
Ms. Maya Nassar	Council of Nurses (CN)
Dr. Christian Zalai	Council of Physicians, Dentists and Pharmacists (CPDP)
Ms. Marianne Ferraiuolo	Multidisciplinary Council (MC)
Dr. Nebojsa Kovacina	Regional Department of General Medicine (RDGM)
Ms. France Desjardins	Expertise with community organizations
Ms. Judy Martin	Expertise in youth protection
Ms. Caroline Storr-Ordolis	Expertise in rehabilitation
Mr. Gary Whittaker	Expertise in rehabilitation
Ms. Diane Néron	Expertise in mental health
Ms. Joanne Beaudoin	Experience as a social services user
Dr. Philippe Gros	Affiliated universities
Dr. Samuel Benaroya	Affiliated universities

Code of Ethics and Professional Conduct for Members of the Board of Directors

No disciplinary body determined any disciplinary issues or sanction during the year.

The Code of Ethics and Professional Conduct for Members of the Board of Directors is attached as Appendix 1 to this report.

3.2. 2 COMMITTEES, BOARDS AND ADVISORY BODIES

Governance, Ethics, Human Resources, and Administration Committee

Ms. France Desjardins	**President**
Ms. Isabelle Brault	
Mr. Rafik Greiss	
Ms. Judy Martin	
Mr. Richard Legault	President of the Board of Directors
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Audit Committee

Mr. Rafik Greiss	**President**
Ms. Joanne Beaudoin	
Ms. Diane Néron	
Mr. Allen Van der Wee	
Mr. Gary Whittaker	
Mr. Richard Legault	*Ex Officio* Member, President of the Board of Directors
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Public Advisory and Service Quality Committee

Ms. Judy Martin	**President**
Ms. Micheline Béland	
Ms. Caroline Storr-Ordolis	
Ms. Line Robillard	Service Quality and Complaints Commissioner
Mr. Richard Legault	*Ex Officio* Member, President of the Board of Directors
Ms. Lynne McVey	President and CEO

University Affairs Committee

Dr. Samuel Benaroya	**President**
Ms. Joanne Beaudoin	
Ms. Nada Dabbagh	
Dr. Philippe Gros	
Ms. Caroline Storr-Ordolis	
Mr. Richard Legault	*Ex Officio* Member, President of the Board of Directors
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Partnership and Population-based Committee

Ms. Maya Nassar	**President**
Ms. Micheline Béland	
Ms. Marianne Ferraiuolo	
Dr. Nebojsa Kovacina	
Mr. Gary Whittaker	
Mr. Richard Legault	*Ex Officio* Member, President of the Board of Directors
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Communications Committee

Mr. Richard Legault	**President** *Ex Officio* Member, President of the Board of Directors
Ms. Isabelle Brault	
Ms. France Desjardins	
Ms. Nada Dabbagh	
Ms. Diane Néron	
Mr. Gary Whittaker	
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Care and Services Committee

Ms. Isabelle Brault	**Co-President**
Dr. Christian Zalai	**Co-President**
Ms. Nada Dabbagh	
Ms. Marianne Ferraiuolo	
Ms. Judy Martin	
Mr. Richard Legault	*Ex Officio* Member, President of the Board of Directors
Ms. Lynne McVey	*Ex Officio* Member, President and Chief Executive Officer

Review Committee

Ms. France Desjardins	**President**
Dr. Gary Inglis	
Dr. Chryssi Paraskevopoulos	

Evaluation Committee for Disciplinary Measures

Ms. Isabelle Brault	**President**
Dr. Samuel Benaroya	
Ms. Micheline Béland	
Dr. Nebojsa Kovacina	
Mr. Richard Legault	President of the Board of Directors

Users and Residents Committee

Ms. Micheline Béland	**President** Dorval-Lachine-LaSalle Users Committee
Mr. John Brkich	**Treasurer** Grace Dart Extended Care Centre Residents Committee
Mr. Elgadi Abdelkarim	President of the Users Committee of the Douglas Mental Health University Institute
Ms. Catherine Bubnich	Member of the Lakeshore General Hospital Users Committee
Ms. Johanne Comeau	Member of the CHSLD Nazaire-Piché Residents Committee
Ms. Jeanine Lemire	Member of the CHSLD Dorval Residents Committee
Mr. Claudel St-Pierre	Member of the CHSLD Denis-Benjamin Viger Residents Committee
Ms. Dianne Sabourin	President of the West Montréal Readaptation Centre Users' Committee
Mr. Wolf Solkin	President of the Ste. Anne's Hospital Users Committee

Council of Physicians, Dentists, and Pharmacists (CPDP)

Dr. Hélène Daniel	**President** St. Mary's Hospital Center
Dr. Alfred Homsy	**Departments Vice-President, Representative—DLL** Hôpital de LaSalle
Ms. Hélène Paradis	**Committees Vice-President, Representative—Pharmacy** Lakeshore General Hospital
Dr. Joan Mason	**Secretary, Representative—DMHUI** Institut universitaire en santé mentale Douglas
Dr. Fadi Habbab	**Treasurer, SMHC Representative** St. Mary's Hospital Center
Dr. Marie-Christine Godin	**Representative—CHSLDs** Centre d'hébergement de Dorval
Dr. Liliane Fortier	**Representative—CLSC** CLSC de Dorval-Lachine
Dr. Tom Kaufman	**Representative—ODI** Lakeshore General Hospital
Dr. Christian Zalai	**Representative—ODI, Representative to Board of Directors—Specialists** Lakeshore General Hospital
Dr. Catherine Duong	**Representative—DLL** Hôpital de LaSalle
Dr. Reuben Martins	**Representative—DMHUI** Douglas Mental Health University Institute
Dr. Steven Herskovitz	**Representative—CHSM** St. Mary's Hospital Center
Dr. Nadine Larente	**Director of Professional Services**
Ms. Lynne McVey	**President and CEO**

Council of Nurses (CN)

Ms. Maya Nassar	**President** Youth Program Directorate
Ms. Dencia Jean-Paul	**Vice-President—Co-opted** Nursing Directorate
Ms. Beverley-Tracey John	**Secretary** Nursing Directorate
Ms. Joy Théodore	**Treasurer** Access, Quality, Performance, and Project Bureau Directorate
Ms. Karine Mayas	Support for Elderly Autonomy Program Directorate
Mr. Gilles Nekam	Nursing Directorate (Preceptorship Advisor—Mental Health)
Ms. Diane Babin	Nursing Directorate
Ms. Evelyne Beauchamp	Co-opted—substitute Professional Services Directorate
Ms. Isabelle Carrier	Co-opted Mental Health and Addiction Programs Directorate
Ms. Ramatou Nzie	Co-opted Intellectual Disability, Autism Spectrum Disorder, and Physical Disability Programs Directorate
Mr. Éric Labonté	Co-opted Professional Services Directorate

Executive Committee of the Council of Midwives

Ms. Trista Leggett	**President**
Ms. Catherine Mason	**Vice-President**
Ms. Rachida Amrane	**Secretary**
Ms. Christiane Léonard	Person in charge of Midwives Services
Ms. Zaza Meskine	Midwifery
Ms. Lynne McVey	President and CEO

Multidisciplinary Council

Ms. Stephanie Côté	**Interim President** Ethics Advisor
Mr. Joseph Thierry René	**Interim Vice-President** Social Service Worker
Mr. Jerry Belony	**Interim Treasurer** Special Education Teacher
Ms. Alvine Fansi	**Interim Secretary** Planning, Programming, and Research Officer
Mr. Sébastien Tremblay	**Interim Communications Officer** Educator
Ms. Julie Van	**Communications** Medical electrophysiology technician
Ms. Flora Marsella	Member Recreologist
Mr. Martin Carrière	Member Social worker
Ms. DaVonne Parsons	Interim Member Educator
Ms. Marie-Claude Lajoie	Interim Member Physical rehabilitation therapist
Ms. Venise Calluzzo	Assistant to the Director, Multidisciplinary Services Directorate
Ms. Sophie Ouellet	Director of Multidisciplinary Services
Ms. Lynne McVey	President and CEO

Risk Management Committee

Dr. Willine Rozefort	**Co-President (Clinical)** Associate Director of Professional Services
Ms. Sarah-Beth Trudeau	**Co-President (Administrative)** Associate Director of Performance, Quality, and Client experience
Ms. France Palucci	**Secretary** Administrative Agent—Multidisciplinary Services, Quality, Performance, and Populational Responsibility Directorate
Ms. Emélie Castonguay-Leclerc	Head of Quality, Certification, and Risk Management
Mr. Vladimir Guriev	Senior Advisor—Risk Management
Ms. Karine Mayas	Executive Committee of the Nurses (CN) Representative
Ms. Stephanie Iazensa	Associate Director of Integration and Clientele Trajectories Multidisciplinary Services Directorate (MSD) Representative
Mr. Bernard Cyr	Associate Director, Operations—Professional Services Directorate Representative
Ms. Chantal Manoukian	Associate Chief Pharmacy Department—Council of Physicians, Dentists, and Pharmacists (CPDP) Representative
Mr. Jérôme Ouellet	Associate Director, Nursing Directorate
Mr. Mathieu Brodeur	Assistant to the Director, Support for Elderly Autonomy Program Directorate
Ms. Martine Beaurivage	Assistant to the Director, Intellectual Disability, Autism Spectrum Disorder and Physical Disability Directorate
Ms. Linda See	Director of Youth Protection
Mr. Marc Boutin	Assistant to the Director, Mental Health and Addiction Programs Directorate
Ms. Katherine Moxness	Director of the Youth Program
Vacant	Physician, Council of Physicians, Dentists, and Pharmacists (CPDP) Representative
Ms. Merilyne Ng Ah Chey	Users' Committee member
Vacant	Users' Committee member

Other Committees and Advisory Bodies

Other committees and advisory bodies are also in place within the organization, including the Operational Coordination Committee; the Clinical Ethics Committee; the Research Ethics Committee; the Permanent Control Measures Committee.

3.3 HIGHLIGHTS

Highlights from our directorates are available as a separate volume that is an integral part of this annual management report. Both documents comply with the circular on annual management reports by public and private institutions and regional authorities.

SECTION 4—PERFORMANCE RESULTS FOR THE MANAGEMENT AND ACCOUNTABILITY AGREEMENT

CHAPTER III: SPECIFIC EXPECTATIONS

Results with regard to the specific expectations of the agreement on management and accountability

Specific Expectation	Description of Specific Expectation	Progress	Comments
Public Health			
Implement, by March 30, 2020, the *Programme québécois de soins buccodentaires et de soins d'hygiène quotidiens de la bouche* at all public CHSLDs and government-regulated private CHSLDs across the province of Québec.	For CISSS and CIUSSS: • Can participate in an information meeting with a team from the MSSS to properly understand the frame of reference for implementing this program. • Must provide their deployment plan to the MSSS. • The staff of the care team (nurses, nursing assistants, and beneficiary attendants) the hired professionals (hygienists, dentists, and denturologists) must complete an online training course. • Must submit a list of all the professionals hired as they are hired, as per the funding granted to the institutions. • Account for allocated expenses: care team training, the salaries of the hygienists, their travel, the purchase of portable equipment, the purchase of hygiene care equipment, and dentists' and denturologists' fees. Other indicators are being developed and may be requested with regard to activities carried out by dental professionals.	Due July 15, 2019 Due October 21, 2019 Due January 20, 2020 Due July 13, 2020	Implemented Implemented Implemented Implemented
Programs dedicated to individuals, families, and the community			
Best practices of institutions for the prevention and reduction of users in alternate level of care— NOS (2.1)	Both merged and unmerged institutions have an obligation to prevent and reduce alternate levels of care. As such, they must complete a status report on the implementation of good practices to prevent and resolve the phenomenon of ALC users.	Due September 13, 2019 Due March 31, 2020	Cancelled (This expectation has been withdrawn by the MSSS—EGI Bulletin vol. 15, No. 11) Cancelled (This expectation has been withdrawn by the MSSS—EGI Bulletin vol. 15, No. 26)

Specific Expectation	Description of Specific Expectation	Progress	Comments
Programs dedicated to individuals, families, and the community (cont'd)			
Improvement in the quality of hygiene care provided in CHSLDs (2.2)	The current assessment, the intervention plan, and interdisciplinary work will allow teams to provide personalized choices based on a variety of factors (habits, safety, level of collaboration and autonomy, clinical portrait). A status report on optimizing the organization of hygiene care and on the results for the second complete weekly hygiene care are requested of the institutions.	Due October 29, 2019 Due May 12, 2020	Implemented Cancelled (This expectation has been withdrawn by the MSSS for P13- EGI Bulletin vol. 16, No. 8)
Territorial Plan for the Improvement of Access and Continuity (PTAAC) (2.3)	Institutions must fill in and submit template supplied by the MSSS for tracking its implementation (PTAAC).	Due September 1, 2020	In progress
ASD ACTION PLAN (2017–2022) (2.4)	Institutions must complete the tracking tool for the ASD Action Plan 2017–2022.	Due October 29, 2019 Due February 17, 2020 Due August 1, 2020 (Delay extended to August 12, 2020)	Implemented Implemented Implemented
Deploying the *Agir tôt* program (2.5)	The project uses a digital platform to boost screening for potential developmental difficulties or delays in children before they start kindergarten and improves the intervention services provided to these children and their families, within the framework of the following programs: • Vaccinations (detection and completion of a form by the nurse; • *Youth in Difficulty (JED)* program (early stimulation); Intellectual Disability, Autism Spectrum Disorder, and Physical Disability Program (ID-ASD-PD) (specific and specialized services).	Due on January 30, 2020	Implemented
Provide residential settings adapted to the needs of people with an ID, ASD or PD (2.6)	Institutions transmit data on waiting lists and the types of residential settings in which their ID-ASD-PD clientèle reside.	Due October 29, 2019 Due July 3, 2020	Implemented Implemented

Specific Expectation	Description of Specific Expectation	Progress	Comments
Programs dedicated to individuals, families, and the community (cont'd)			
Follow-up on added staff at CHSLDs (2.7)	Using a GESTRED form, the institutions concerned must report on staff added to interdisciplinary teams in CHSLDs.	Due June 12, 2019	Implemented
University, Medical, Nursing, and Pharmaceutical Affairs			
Consolidate the organization of care and services provided to people with Alzheimer's (and other neurocognitive disorders) and their loved ones (4.1).	A status report on the achievements of each CISSS and CIUSSS must be produced by March 31, 2020. The status report template provided by the MSSS in previous years should be used for this.	Due September 14, 2020	In progress
Progress on the *Plan d'action par établissement réalisé sur la base du Plan d'action national 2016-2018—Continuum de services pour les personnes à risque de subir ou ayant subi un AVC (4.2).*	Self-evaluation on the progression of the Action Plan submitted October 31, 2016, comprising the actions and objectives in the National Action Plan. The progression of the work on March 31, 2020, and the reasons for which the objectives of the institution's Action Plan were not attained must be assessed.	Due June 30, 2020	Cancelled (This expectation has been withdrawn by the MSSS—EGI Bulletin vol. 16, No. 12)
Contribute to the province's deployment of telehealth (4.3)	Institutions must demonstrate their contribution to the deployment of telehealth in Québec by ensuring that the local tactical committee fulfils its mandate; that actions are carried out within the framework of the Telehealth Action Plan 2018–2020; and that the directory of clinical services covered by telehealth are up to date. They must do so by completing and returning each of the three templates sent by the MSSS to the institutions during periods 6 and 13.	Due October 29, 2019 Due July 24, 2020	Cancelled (This expectation has been withdrawn by the MSSS—EGI Bulletin vol. 15, No. 14) Implemented
Progress on the *Plan d'action par établissement réalisé sur la base du Plan d'action national 20172018—Continuum de services, phase hyper aiguë, pour les personnes ayant subi un infarctus aigu du myocarde avec élévation du segment ST* (IAMEST) (4.4)	Self-evaluation on the progression of the Action Plan submitted June 22, 2017, comprising the actions and objectives in the National Action Plan. The progression of the work and the reasons for which the objectives were not attained must be assessed.	Due September 30, 2020	In progress

Specific Expectation	Description of Specific Expectation	Progress	Comments
Financing, Infrastructures, and Budget			
Implement the *Plan de résorption du déficit de maintien des actifs immobiliers* by March 31, 2020, in accordance with the targets set out by the institution for each deficient building concerned (7.1)	The differential between the Facility Condition Index (FCI) of a building and the established threshold of 15%, must decrease at least proportionally to the maintenance deficit reduction target to be attained by March 31, 2020, for a deficient building inspected in 2015 (lot # 1) or in 2016 (lot # 2), and by March 31, 2022, for a deficient building inspected in 2017 (lot # 3). If the maintenance deficit reduction target of a building inspected in 2015 is 80% and the differential between the FCI and the SE is 3%, the FCI of this building must decrease by at least 2.4% (80% of 3%), i.e. minimally reduced to 15.6%, by March 31, 2020. Calculation the FCI is based on the residual value of the maintenance work, which implies systematically maintaining the list of needs. To do so, the institution must make the necessary connections between PCFI projects and list the required work that constitutes these projects. The MSSS target is a definitive resorption of the building maintenance deficit. Consequently, for all buildings with maintenance deficit reduction targets of 100% by March 31, 2020, the value of the maintenance work to execute must result in an FCI that is clearly lower than the threshold established at the end of the five-year cycle following the inspection.	Due August 7, 2020	Implemented
Coordination, planning, performance, and quality			
Civil Security (8.1)	Consolidate the basic civil security mechanisms so that the institution can assume its role in deploying of the PNSC health mission. As such, the institution must: • Have an up-to-date civil security plan with a 24/7 call schedule, internal civil security committee, and a system for alerting and mobilizing resources; • ensure that personnel assigned to civil security have received the basic training recommended by the MSSS; • • establish or strengthen partnerships with civil security.	Due September 14, 2020	In progress
Managing Civil Security Risks—Health and Social Services (8.2)	To comply with the expectations, the institution must continue with its civil security risk management approach (GRSC) and at least treat one risk identified as a priority.	Due September 14, 2020	In progress

Specific Expectation	Description of Specific Expectation	Progress	Comments
Coordination, planning, performance, and quality (cont'd)			
Business Continuity Plan—Health and Social Services (8.3)	To comply with the expectation, the institution must initiate the development of a Business Continuity Plan (BCP) of institutional scope. To do so, the institution's upper management must approve a project charter that includes: • the duration of the project; • the execution schedule set out in the *Guide pratique pour l'élaboration d'un plan de continuité des activités en établissement*; • the governance structure. The latter must identify who is responsible for the project and the tactical committee that will collaborate in developing the BCP.	Due December 23, 2019 Due September 14, 2020	Implemented In progress
Revision of the Program of access to health services and social services in the English language for the English-speaking population (8.4)	In the spring of 2018, the institutions received the new frame of reference for programs to develop access to English-language health and social services. Access programs for each institution, developed on the basis of the reference framework, will be submitted to the regional Committee for Access Programs for feedback, adopted by the Board of Directors, and then sent to the MSSS (*Ententes de gestion et Secrétariat à l'accès aux services en langue anglaise*).	Due March 31, 2020	Postponed (This expectation has been postponed to a later date by the MSSS) Implemented despite postponed
Information Technologies			
Maintaining the Provisions of Directive on Cybersecurity (9.2)	As per the directives on cybersecurity, the institution must adhere to its provisions. These specific expectations will be included in the information security reporting tool requested each year in the information security report. Thus, during the year 2019–2020, the report transmission dates are no later than May 31, 2019, for the fiscal year ending March 31, 2019; and May 31, 2020, for the financial year 2019–2020. 1. Maintain an up-to-date inventory of all information assets; 2. Carry out vulnerability testing; 3. Efficiently manage threats; 4. Conduct an information security risk analysis; 5. Sound management of data backups and restoration	Due June 30, 2020	Implemented

Results for the Specific Management and Accountability Agreement

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Oncology			
Strategic Plan 19–23 1.09.33.01-PS Percentage of patients undergoing oncology procedures within 28 calendar days	**77.5**	90	**76.8**
1.09.33.02-EG2 Percentage of patients undergoing oncology procedures within 56 calendar days	**98.5**	100	**99.0**
Comments: • Surgery rescheduled at the surgeon's request, as the surgery was not considered urgent given the context. • Issues concerning bed availability due to the pandemic. • We have noticed that some surgeons hold on to surgery requests for a few weeks before submitting them to the scheduling office. This creates a delay in scheduling those surgeries. A communication was sent to all surgeons informing them to submit their requests as soon as the consent form has been signed and the surgery has been confirmed. • Another existing problem was that certain surgeons did not specify that the surgery was cancer-related, only to be informed some weeks later that the case is cancer-related and must be performed within the normal time frame. We have advised surgeons on the importance of filling out the request correctly and checking the *Cancer* checkbox if the patient is confirmed.			

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Public Health—Nosocomial Infection Prevention & Control			
Strategic Plan 15–20 1.01.19.01-PS Percentage of general and specialized hospital centres with nosocomial infection rates in line with rates established—Clostridium difficile-associated diarrhea (facilities providing CHSGS mission-class services)	**100**	100	**100**
Strategic Plan 15–20 1.01.19.02-PS Percentage of general and specialized hospital centres with nosocomial infection rates in line with rates established—methicillin-resistant Staphylococcus aureus (MRSA) (facilities providing CHSGS mission-class services)	**66.7**	100	**66.7**
Strategic Plan 15–20 1.01.19.04-PS Percentage of general and specialized hospitals with nosocomial infection rates in line with established rates—nosocomial bacteremia associated with vascular access routes in hemodialysis (facilities offering CHSGS mission-class services)	**100**	100	**100**
Strategic Plan 15–20 1.01.26-PS Compliance rate for best hand hygiene practices in institutions	**72.5**	80	**73.2**

Comments:

- Maintaining good IPC, hygiene, and sanitation practices in managing C. Difficile cases made it possible to achieve these results.
- Rigour and respecting good practices help keep rates below the established rate.
- The Hôpital de LaSalle identified 2 MRSA bacteremia, for a rate of 0.96 cases/10 000 patient days, whereas the established incidence rate for this type of installation is at 0.41/10 000 patient days. No epidemiological connection was seen between the two cases and no particularity was reported to explain the rate.
- Despite the audits carried out and the efforts invested, the established target for hand-washing rates (80%) was not attained; however, the rate did increase when compared with the preceding year.
- The rates have remained stable for the past three years, with sometimes marked improvements, particularly with regard to controlling CDAD.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Extended Homecare Support			
1.03.05.01-EG2 Total long-term home care services hours provided through various modes of service provision	**NA**	880 471	**1 014 926**
Strategic Plan 15–20 1.03.11-PS Number of people receiving long-term home care services (adults under SEAPD and ID-ASD-PD programs or services).	**5 920**	5 883	**5 744**
Strategic Plan 15–20 1.03.12-PS Percentage of people receiving long-term home care services with an updated evaluation and an intervention plan (adults under SEAPD and ID-ASD-PD programs or services).	**59.2**	90	**54.2**

Comments:

- 1.03.05.01: The addition of human resources through the investments in home care services has significantly increased the intensity of our clients' services.
- 1.03.11: Implementation of monthly meetings between Finance, the Support for Elderly Autonomy Program Directorate, and the Performance team, along with an exercise focused on data quality made it possible to collect precise data. We are continuing in this direction to meet this target.
- 1.03.12: We have difficulty with this indicator, despite having implemented a structured and structuring clinical approach around the theme *a dynamic clinical approach that suits the user's life plan*, and despite using the reports that have been developed by our CIUSSS performance team for provincial use. Results are monitored every period. Stakeholders cite the fact that they prioritize hospital discharges over drawing up an interdisciplinary plan. For the 2020–2021 period, an action plan will be implemented with a goal assigned to each stakeholder, which will help achieve the target.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Support for Elderly Autonomy			
Strategic Plan 15–20 1.03.07.00-PS Percentage of hospital environments having implemented of the approach tailored to seniors.	**NA**	66.7	**NA**
Strategic Plan 15–20 1.03.07.01-PS Percentage of hospital environments having implemented components 1, 2, and 6 of the approach tailored to seniors.	**0**	100	**NA**
Strategic Plan 15–20 1.03.07.02-PS Percentage of hospital environments having implemented components 3, 4, and 5 of the approach tailored to seniors.	**33.3**	66.7	**NA**
Strategic Plan 15–20 1.03.10-PS Percentage of networks of integrated services for seniors (NISS) established in an optimal manner.	**100**	100	**NA**
1.03.13-EG2 Percentage of new CHSLD residents with an ISO-SMAF profile between 10 and 14	**66.5**	80	**67.3**
1.03.16-EG2 Percentage of people receiving long-term care services in a public CHSLD with an updated evaluation and an intervention plan	**87.8**	90	**87.3**

Comments:

- Excluding private CHSLDs not under contract at which we have no control over admissions, our result is 80.86%, exceeding the target of 80%. 1.03.16-EG2
- We are close to the target of 90%, at 87.62%. However, these results do not include the CHSLD Nazaire-Piché (to come, as we had difficulty obtaining the information given a lack of available resources).

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Disabilities			
Strategic Plan 15–20 1.05.15-PS Average waiting time for access specialized services for children aged 5 years with an ASD.	**360.3**	156	**384.8**
1.45.04.01-EG2 Rate of requests handled in a CLSC based on standard time limits in accordance with the *Plan d'accès aux services pour les personnes ayant une déficience physique* - ALL AGES - ALL LEVELS OF PRIORITY.	**68.4**	90	**71.7**
1.45.05.01-EG2 Rate of requests handled in a CLSC based on standard time limits in accordance with the *Plan d'accès aux services pour les personnes ayant une déficience intellectuelle ou un trouble du spectre de l'autisme* - ALL AGES - ALL LEVELS OF PRIORITY.	**86.5**	98	**66.1**
1.45.05.05-EG2 Rate of requests handled in a CRDI based on standard time limits in accordance with the *Plan d'accès aux services pour les personnes ayant une déficience intellectuelle ou un trouble du spectre de l'autisme* - ALL AGES - ALL LEVELS OF PRIORITY.	**47.6**	90	**54.5**

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Disabilities (continued)			
Strategic Plan 19–23 1.45.45.05—Proportion of young children with a significant developmental delay who received services from the physical or intellectual disability and autism spectrum disorder programs on time	**NA**	90	**36**
Strategic Plan 15–20 1.46-PS Percentage of youths aged 21 years or older with a disability or an ASD who have just completed their education and have access to a daytime activity or work integration support	**90.9**	90	**80.3**
Strategic Plan 19–23 1.47—The number of residential spaces available to people living with a physical or intellectual disability or an autism spectrum disorder.	**NA**	606	**629**

Comments:

1.05.15-PS: By reorganizing specialized services, we have been able to take on patients at a younger age. This allows them to receive specialized services for a longer period before they begin school. This may have an impact on the wait times for other children not receiving this service. Furthermore, improved first-line services resulting investments through the *Agir Tôt* program, should reduce the pressure on specialized services, as children will not be systematically referred to the second line, as they had been previously.

1.45.04.01-EG2: Working collaboratively with the MSSS on the range of ID-ASD-PD services (specialized vs specific services) should make it possible to establish a more fluid service trajectory for PD clients. That said, we can see a slight improvement. Those could be linked to the investments made through the *Agir Tôt* program for children 0–5 years old.

1.45.05.01-EG2: The difficulty in filling several social worker positions (maternity leave, retirement, etc.) is one factor that can help to explain the decrease in the rate of applications being processed within the required deadlines.

1.45.05.05-EG2: A slight improvement has been noted and we intend to continue with the measures implemented to support this. Several efforts are in progress within the department to better integrate specific and specialized services (same manager for both teams, implementation of the range of services).

1.45.45.05: We will analyze the situation to better understand this indicator and work on avenues for improvement.

1.46-PS: The decrease in the percentage is attributable to information related to the planning of daytime activities or work integration, which could not be validated for certain young adults (consent not obtained, no response from the respondent, etc.).

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Addiction			
Strategic Plan 15–20 1.07.06-PS Implementation rate for addiction detection and early intervention services	**85.7**	90	**88.1**
Strategic Plan 19–23 1.07.07—Number of people who received addiction-related services	**1 026**	1 428	**919**

Comments:

- **1.07.06:** Certain training sessions on the detection of addictions in the Support for Elderly Autonomy Program could not be held and were postponed to 2020–2021. Additionally, deployment of the new local addiction service has led to changes in the roles and trajectories of the addiction service offering, which are currently being deployed. The overall plan will be updated in the fall, to be validated by the general management and 100% deployed for 2020–2021.
- **1.07.07:** Discussions with the MSSS on the course and validity of previous source data. We are not able to reproduce the RAMQ data extraction which allowed us to obtain the 2018–2019 result and, if necessary, to make the corrections. Awaiting news from the MSSS with regard to the means of obtaining this data extraction and, if necessary, to make the corrections. One must take into consideration the impact of COVID-19 on proximity and detection services. New resources added by the MSSS in 2018–2019 and 2019–2020 (4.8 FTE) have made it possible to deploy front-line proximity services in addiction. In 2020–2021, we will be reviewing the mandates of our various programs and services (SSG, SM, JED, SAPA, etc.) to increase the number of detections.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Mental Health			
Strategic Plan 15–20 1.08.13-PS Number of places available in Intensive Case Management recognized by MSSS	**306**	397	**360**
Strategic Plan 15–20 1.08.14-PS Number of places available in Assertive Community Treatment recognized by MSSS	**360**	360	**360**

Comments:

- **1.08.13:**
  - 3 positions (of a planned 4) were deployed in 2019–2020 based on the transformation of positions in day hospitals (54 places). The fourth position, initially planned for 2019–2020 will be added in April 2020.
  - One last position will remain to be added in 2020 to reach the target set at 397.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Emergency Medicine			
Strategic Plan 19–23 1.09.01-PS Average length of stay for patients on a stretcher in Emergency	**17.08**	12	**18.44**
Strategic Plan 19–23 1.09.16-PS Average waiting time in the Emergency Room for walk-in patients	**159**	145	**175**
Strategic Plan 15–20 1.09.43-PS Percentage of the clientèle receiving emergency medical care in less than two hours	**57.8**	80	**54.3**
Strategic Plan 15–20 1.09.44-PS Percentage of the ambulatory clientele with lengths of stay at the emergency room of less than four hours	**45.0**	80	**41.8**

Comments:

- As part of the project to shorten emergency room stays, we created three working groups and proposed the development of alternatives to hospitalization at the CIUSSS ODIM (1. Clinical reception; 2. Access 24 hours/5 days; 3. Redirecting non-urgent (P4 and P5) patients to reduce Emergency Room visits. We have also created the position of medical coordinator responsible for patient flow within our organization.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Palliative and End-of-life Care			
Strategic Plan 15–20 1.09.05-PS Number of users in palliative or end-of-life home care	**845**	963	**725**
Strategic Plan 15–20 1.09-45-PS Number of beds reserved for palliative and end-of-life care	**29**	38	**29**
Strategic Plan 15–20 1.09.46-PS Percentage of home deaths among deceased users who received palliative and end-of-life care at home	**15.2**	14.7	**24.5**

Comments:

- **1.09.45-PS**: Work has begun with the borough of LaSalle to open a palliative care residence (9 beds to be developed). The project will be finalised in 2020–2021.
- **1.09.05-PS**: We are on track to meet this target. We expect to start a project on palliative care (from the service offer to the implantation) at home for the year 2020–2021. Several partners are involved, including physicians.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Physical Health—Front-line Services			
Strategic Plan 15–20 1.09.25-PS Total number of FMG	**5**	6	**6**
Strategic Plan 19–23 1.09.27-PS Percentage of the population registered with a family doctor	**73.2**	85	**74.5**
Strategic Plan 19–23 1.09.27.01-PS Percentage of people registered with a family doctor in a GMF	**178 904**	189 088	**189 489**
Strategic Plan 15–20 1.09.48-PS Number of network family medicine groups (GMF-R or super-clinic)	**3**	4	**3**

Comments:

- **1.09.27-PS**: The provincial target of 85% is not applicable by region. This target remains a challenge to reach for the Montréal region.
- **1.09.48-PS**: The COVID-19 pandemic has lead to a delay in moving this file forward.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Surgery			
Strategic Plan 15–20 1.09.32.00-PS Number of surgery requests pending for over 1 year—All surgeries	**8**	0	**26**
Strategic Plan 19–23 1.09.32.10-PS Number of surgery requests pending for over 6 months	**257**	197	**544**

Comments:

- As of March 13, we cancelled all elective surgeries at our three hospital centres because of the COVID-19 pandemic. Only oncological surgery and emergency procedures were carried out.
- Additionally, we still have some issues with non-availability that is not properly identified in the system. Corrective measures have been implemented.
- Criteria and directives are in place to manage the waiting list, taking into consideration the issues we have in our hospitals and consistently prioritizing oncological and emergency surgeries.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Physical Health—Medical Imaging			
Strategic Plan 15–20 1.09.34.04-PS Percentage of medical Imaging requests pending for less than three months, for obstetric ultrasounds.	**100**	100	**100**
Strategic Plan 15–20 1.09.34.05-PS Percentage of medical Imaging requests pending for less than three months, for the echocardiograms.	**58.1**	80	**51.8**
Strategic Plan 15–20 1.09.34.06-PS Percentage of medical Imaging requests pending for less than three months, for the breast ultrasounds.	**93.8**	100	**94.8**
Strategic Plan 15–20 1.09.34.07-PS Percentage of medical Imaging requests pending for less than three months, for other ultrasounds	**98.7**	100	**97.9**
Strategic Plan 15–20 1.09.34.08-PS Percentage of medical Imaging requests pending for less than three months, for computerized axial tomographies.	**93.5**	100	**93.8**
Strategic Plan 15–20 1.09.34.09-PS Percentage of medical Imaging requests pending for less than three months, for MRIs.	**78.9**	100	**86.9**

Comments:

A. Factors explaining the achievement or non-achievement of the commitment, the corrective measures implemented to favour its achievement:

- **1.09.34.04**: One of six commitments has been 100% delivered, namely obstetric ultrasounds. The result of 100% shows that there are no issues with delays in the 3 hospitals concerned. It should be noted that this result is all the more significant because the Hôpital de LaSalle and St. Mary's Hospital Center are two major obstetrics centres in Montréal, with a very high volume of ultrasound scans.
- **1.09.34.06, 1.09.34.07, 1.09.34.08**: Three commitments have been 90%-100% delivered, namely breast ultrasounds, "other" ultrasounds, and tomodensitometries.
  - Some examinations are very low volume (breast ultrasounds), so the percentage results are very volatile.
  - The CT scans saw a slight improvement over the previous year. This result can be attributed to the device having been replaced and the availability the old device (which remained in place) as a stand-in solution during equipment breakdowns and preventive maintenance.
- **1.09.34.05 and 1.09.34.09**: Two commitments were met to less than 90%, namely cardiac ultrasounds and magnetic resonances.

The factors explaining these results for magnetic resonances are as follows:

- The evening hours remain closed at Hôpital de LaSalle due to the shortage of technologists.
- There was a slight decrease during the final weeks of the year, as some patients were refusing tests due to the COVID-19 pandemic. They preferred to have the procedure after the pandemic had passed.
- Closure of several time slots during the year due to a shortage in technologists (sickness, vacation, etc.)

- Several complex examinations require injections that cannot be given in the evenings and on weekends.

Corrective measures implemented to help reach these targets include:
- Recruiting two specialized MRI technologists.
- Reviewing examination protocols.
- Proposing extended hours for technologists to cover injections.

The factors explaining these results for cardiac ultrasounds are as follows:
- Shortage of trained technologists. Training technologists for medical ultrasounds required 2 months and a subsequent year of working experience.
- Trained, autonomous technologists left.
- Issues with the availability of cardiologists during cardiac ultrasounds.
- An aging population on the West Island of Montréal and in the Vaudreuil region, and an increase in demands from vulnerable populations.

Corrective measures implemented to help reach these targets include:
- A technologist is currently in training at the Lakeshore General Hospital
- Intensify recruitment of technologists
- Work in progress with the Chief of Cardiology to find solutions with regard to the cardiologists' schedule.

B. Assessment of the Change in Results Compared to the Results of the Previous Year:

Two of eight results deteriorated in comparison to the previous year. The primary reasons are those mentioned in point A.
- The shortage of human resources (technologists and physicians);
- The cancellation of appointments by patients due to the COVID-19 pandemic;
- The increase in demand from vulnerable clientèles.

C. Known Issues Regarding Data Quality and Indicator Methodology:

In cardiac ultrasound, the waiting list has not been cleared, because we cannot call the patient to find out if they have had their exam elsewhere. If they have not, we still cannot offer them an appointment.
For other examinations, there are no known issues related to data quality. We are working with two PACS managers to improve and harmonize data quality.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Material Resources			
2.02.02-EG2 Degree to which the steps required to eliminate grey areas in health and sanitation have been completed	**33.3**	100	**33.3**

Comments:

- Target not attained in 2 of 3 focus sites;
- Work interrupted during the COVID-19 pandemic;
- Corrective measures implemented:
  - Relaunch of the working committee;
  - Some work was carried out by certain departments so as to be able to share with the working group;
- Virtual meetings of the working committee.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Human Resources			
Strategic Plan 15–20 3.01-PS Ratio of salary insurance hours	**7.46**	7.42	**7.04**
Strategic Plan 19–23 3.05.02-PS Overtime Rate	**5.94**	5.49	**6.68**
Strategic Plan 15–20 3.06.00-PS Rate of use of independent workforce	**5.48**	4.02	**5.57**
Strategic Plan 19–23 3.05.03—Work attendance ratio	**NA**	89.69	**89.69**

Comments:

3.01-PS: Ratio of salary insurance hours

- In addition to the benefits from longer-term actions that have been implemented over the past years or in the process of implementation, several significant actions in 2019–2020 allowed us to meet the target for this year and ensure sustainability for the year to come. Restructuring of the department, additional staff, and training are the main factors that contributed to attaining the salary insurance target. This favourable result is aligned with the commitment the department made at the beginning in the period and demonstrates the causal link with the approaches implemented.

3.05.02-PS: Overtime Rate

- The target for this indicator had not been met at the time of this report. Several corrective measures were implemented, in addition to those from previous years and those mentioned with regard to salary insurance, which are ongoing and will resume a more intense pace once the COVID-19 pandemic allows some return to normal activities. The measures implemented in the context of the current pandemic will also be reviewed and adapted when possible to support meeting the target for this indicator.

3.06.00-PS: Rate of Use of Independent Workforce

- The target for this indicator had not been met at the time of this report. Several corrective measures were implemented, in addition to those from previous years and those mentioned with regard to salary insurance, which are ongoing and will resume a more intense pace once the COVID-19 pandemic allows some return to normal activities. The measures implemented in the context of the current pandemic will also be reviewed and adapted when possible to support meeting the target for this indicator.

3.05.03: Work attendance ratio

- In addition to the benefits from longer-term actions that have been implemented over the past years or in the process of implementation, several significant actions in 2019–2020 allowed us to meet the target for this year and ensure sustainability for the year to come. Restructuring of the department, additional staff, and training are the main factors that contributed to attaining the salary insurance target. This favourable result is aligned with the commitment the department made at the beginning in the period and demonstrates the causal link with the approaches implemented.

Indicator	Result on March 31, 2019	Commitment 2019–2020	Result on March 31, 2020
Multi-Program			
Strategic Plan 15–20 7.01.00-PS Percentage of initial psychosocial services provided within 30 days (CLSC mission)	**49.1**	75	**48.1**
Strategic Plan 15–20 7.02.00-PS Implementation rate of the *Stratégie d'accès aux Services de santé et aux services sociaux pour les personnes en situation d'itinérance ou à risque de le devenir*	**30**	100	**60 (Bulletin EGI vol. 16 No. 18)**

Comments:

7.01.00

- **SM:** It is not possible to obtain significant and validated data for this indicator. It should be noted that the psychosocial services that feed this indicator work in the General Social Services, Mental Health, Youth, and Support for Elderly Autonomy Programs. The MSSS's *Direction clinique services sociaux généraux* confirmed the withdrawal of this indicator for the coming years due to questions of relevance and given the difficulties in obtaining reliable data.
- **JED:** We have made significant efforts to fulfil the commitment, but a shortage of psychoeducators has hampered those efforts. When we break down the results in 5910 and we separate the two professions, that is social workers and psychoeducators, the percentage of first services within a delay of 30 days is on average 31.8 days for social workers, which is an improvement. However, several psychoeducator positions remain vacant, creating a breakdown in services. Consequently, the average delay for first services in psychoeducation is 88 days. Furthermore, staff turnover is creating instability within the teams (adjustment, orientation, training, and integration of new employees)
    - Monitoring of cases in psychoeducation for clients aged 6 to 17 years old is usually a second service in response to an internal referral by the social worker involved in the case. Significant efforts are being deployed to increase our performance indicators and promote better access to services.
    - With the arrival of the *Agir tôt* in 5910, cases that were transferred to our departments had a significant impact on our waiting list, as well as increasing the delays in access for users.
    - A pilot project focused on the integration of first-line services for youth in difficulty and on second-line EO, announced by the ministerial directive dated May 21, 2020, is ongoing, creating a more fluid service trajectory. The objective is to create a service corridor between youth in difficulty and EO.
    - Group activities are ongoing (Triple P, Parenting skills), promoting a faster and more efficient response to the needs of our clients.

Corrective measures implemented:

- We continue to collaborate closely with the Human Resources, Communications, and Legal Affairs Directorate to post job openings quickly and meet with appropriate candidates.
- We are currently revising our service offer in psychoeducation with the aim of hiring professionals from other disciplines, such as specialized educators.
- We have developed a closer collaboration with community organizations within the territory of the CIUSSS de l'Ouest-de-l'Île-de-Montréal to improve our interventions with families. We have developed a partnership in social pediatrics for users of our territory.
- A review process is underway with our Quality and Performance Department to better understand and apply the MSSS formula, and thus allow effective monitoring and rapid corrections.
- Provide training so that data is entered into the system correctly and thereby avoid errors that sometimes distort our results. Implementation of a better framework to ensure quality data.
- **SEAPD:** This indicator covers several other directorates, including the MHAPD and the DPJ. The Support for Elderly Autonomy Program Directorate is also involved at 33%. As the target was set at 75%, the Support for Elderly Autonomy Program Directorate can be said to have attained the target, for its part.

7.02.00 Homelessness: Certain elements of the strategy (phases 6 and 8) could not be carried out as the screening tool (IRIS) has not been released by the MSSS. No institution was able to complete the deployment of this strategy according to the timetable for deployment. The MSSS has consequently rescheduled the target.

Legend

	Annual commitment fulfilled 100%
	Annual commitment fulfilled to more 90% but less than 100%
	Annual commitment fulfilled to less than 90%

Other results for certain indicators of the MSSS Strategic Plan

Indicator	Result on March 31, 2020	Comments
Strategic Plan 19–23 1.08.16-PS Number of people waiting for a mental health service	877	**1.08.16:** Although the target was not indicated in the 2019–2020 EGI, the MSSS has set the total number of users waiting for services at 1401. The target was a 25% reduction in the waiting list, compared to the reference period (P5 = 1 868). We have clearly reached the target (53% reduction). For 2020–2021, the MSSS will set the reduction target at 50% compared with the reference period (934 users). We believe we can maintain the result of 877 for 2019–2020.
Strategic Plan 19–23 1.03.05.06—Total number of people receiving home care services	15 220	The total number of individuals who received home care services in 2018–2019 was 14 802.
Strategic Plan 19–23 1.03.05.05—Total number of home care services hours provided	1 079 770	Number total number of home care services hours provided in 2018–2019 was 920 523.
Strategic Plan 19–23 1.06.19—Percentage of initial CLSC services for youth in difficulty provided in 30 days or less	37.3 (Bulletin EGI vol. 16 No. 10)	On May 21, 2020, we received a ministerial directive. It requested that frontline services for youth in difficulty prioritize Evaluation-Orientation (EO) cases, either by transferring their files to Youth in Difficulty (JED) upon reception or through JED-EO co-intervention. To implement this new directive, the two departments participated in the development of a procedure and a description of the interventions. This new approach will provide families with a continuity of services and help reduce the EO waiting list.

SECTION 5 – RISK AND QUALITY MANAGEMENT ACTIVITIES

ACCREDITATION

The CIUSSS de l'Ouest-de-l'Île-de-Montréal is accredited by Accreditation Canada.

Accreditation Canada's visit for sequential cycles 1 and 2 took place in November and December 2019. In response to their recommendations, the CIUSSS de l'Ouest-de-l'Île-de-Montréal is developing and implementing comprehensive harmonized programs and practices for various organizational practices, including medication reconciliations, antimicrobial management, the User Safety Plan, prevention of Psychiatric Emergency Department overcrowding, hand hygiene compliance rates for registered users, at-home risk assessments, prevention of venous thromboembolisms, and infusion pump safety.

The directorates are actively preparing for the next accreditation visit to the CIUSSS de l'Ouest-de-l'Île-de-Montréal.

SAFETY AND QUALITY OF CARE AND SERVICES

Consolidating a safety-oriented culture is a priority for the organization.

IN ACTION

The following actions are carried out continuously to promote the declaration and disclosure of incidents and accidents:

- Harmonized policies and procedures with regard to reporting and disclosure implemented;
- Role of Senior Advisor—Risk Management created;
- Assistance to various directorates within the organization in terms of declaration and disclosure of incidents;
- Regular follow-up with managers and directorates pertaining to quality of declarations, analyses, and sharing of recommendations;
- Technical support with regard to the use of SISSS software at private resources and government-regulated private institutions on the territory of the CIUSSS de l'Ouest-de-l'Île-de-Montréal.
- Roll-out of activities during Canadian User Safety Week;
- Development and distribution of integrated risk management tools;
- Maintenance and updates on web sections dedicated to risk management;
- Preparing risk analyses for multiple organizational projects and certain directorates;
- Decentralization of declaration input in various sectors;
- Training in risk management, safety culture, and declaration and disclosure of incidents provided to 237 individuals (personnel, managers, owners of residential resources);
- Management committees' visits to the directorates were organized to promote declaration and disclosure;
- Survey on safety culture organized.

MAIN RISKS IDENTIFIED THROUGH A LOCAL MONITORING SYSTEM

Local registry of incidents and accidents shows 13 101 events were declared in 2019–2020, an increase of 1% from the previous year (12 970 events). However, it should be noted that data for 2018–2019 include all data saved, whereas data collection for 2019–2020 is still ongoing at the date of this annual report.

There were 1 174 reported accidents (9% of all reported events). The three main types of incidents identified are treatment/intervention 394 (3% of all reported events), medications 310 (2.3% of all reported events), and other 234 (1.1% of all reported events).

There were 11 475 reported accidents (87.5% of all reported events). The three main types of accidents identified are falls 5 659 (43.2%), medication 2 040 (15.6%), and other 1 954 (15%). Injuries of known and unknown origin, running away, self-mutilation, error relating to the file, bedsores, etc.

There were 452 events (3.4%) not categorized as either an incident or an accident in the local register of incidents and accidents.

ACTIONS UNDERTAKEN BY THE RISK MANAGEMENT COMMITTEE AND MEASURES IMPLEMENTED BY THE INSTITUTION

The Risk Management Committee met four times between April 1, 2019, and March 31, 2020.

In 2019–2020, the CIUSSS de l'Ouest-de-l'Île-de-Montréal Risk Management Committee was restructured. To ensure that a range of professionals was represented, the Committee's mandate was revised.

The Committee followed up on quarterly reports on incidents, accidents, sentinel events, and related corrective measures during Committee meetings.

The content of the quarterly reports was improved in accordance with suggestions from Committee members. Monitoring and quality indicators have been introduced to track the dynamics of the event declaration and disclosure process.

The Risk Management Committee supports CIUSSS de l'Ouest-de-l'Île-de-Montréal teams who give their staff the opportunity to attend training sessions on the declaration, disclosure, and concepts of risk management.

In addition, representatives from the directorates shared their experience with projects that have an impact on user safety.

Lastly, the Quality, Certification, and Risk Management Department presented information concerning the risk management process: training on strengthening safety culture; producing statistical reports; survey results on safety culture; and, mapping the monitoring process for the Risk Management Committee's recommendations.

The Committee put forth the following recommendations:

1. Ensuring that managers follow up on completing the analyses within 14 days of the declaration;
2. Decentralizing the declaration of events (declaration via the SISSS application), in accordance with the abilities of the departments/units;
3. Regularly ensure monitoring of indicators and the quality of the declaration and analysis process;
4. That all directorates of the CIUSSS de l'Ouest-de-l'Île-de-Montréal review the risks for which they are responsible in the user safety plan and organizational risk table, and that the Quality, Certification, and Risk Management Department support the directorates in the analysis and assessment of those risks.

The CIUSSS de l'Ouest-de-l'Île-de-Montréal has implemented measures with regard to the primary risks for incidents/accidents previously identified, as well as the prevention and control of nosocomial infections. These include:

- Deploying the organizational project implementing medication reconciliation.
- Implementing the *Programme québécois des soins sécuritaires en domaine de prévention et contrôle des infections*.

PRINCIPAL FINDINGS—APPLICATION OF USER CONTROL MEASURES (ART 118.1 ARHSSS)

- A steering committee was formed in collaboration with the Project Office to coordinate all of the work (implementation of the protocol deployment plan, developing data compilation tools, harmonizing data entry, and integration of training data entry).
- A PowerPoint overview of the protocol was of the protocol created and presented to the managers concerned. Clinical and administrative chiefs were surveyed to determine how to best support their assimilation of the protocol. Meetings at each level of management encouraged the organization of training sessions.
- Due to the emergency measures implemented because of the COVID-19 pandemic, a Grand Round scheduled to take place on March 19, 2020, has been postponed to a later date.
- Consultations were conducted with the teams involved in the project to develop computerized tool better suited to current needs. The parameters used take into consideration the Ministry's survey criteria. Pilot units tested its functionality. A register is being created on the intranet that is accessible to the staff.
- The protocol has been sent to all directorates. It is available in both official languages. A letter informing physicians, directors, managers, and staff has also been sent. An information article intended for them was also published in an in-house publication.
- A printed bilingual pamphlet entitled Respecting Individual Liberty and Promoting Safety: Challenges We Must Face Together is currently available to users and their loved ones within the various departments of the CIUSSS. A comparative analysis was carried out by consulting different institutions with regard to the deployment of the CIUSSS and CISSS protocols. The responses obtained indicate that the CIUSSS de l'Ouest-de-l'Île-de-Montréal is one of the institutions that has implemented the best initiatives for deploying the protocol.
- A training continuity plan has been implemented. Certain aspects of the deployment of the protocol were delayed following the offloading of clinical activities in the context of the pandemic. The protocol is known and used at the CIUSSS, but to varying extents, depending on the facility and department. The remainder of the process has been rescheduled for the autumn of 2020.
- We continually focus on the ongoing decrease in control measures and on promoting alternative measures. Our statistics for the year 2019–2020 show a progressive decrease in the use of control measures across all CIUSSS de l'Ouest-de-l'Île-de-Montréal missions. This decrease is due to several factors, particularly the awareness of professionals with regard to their obligations in this area; the training provided to staff (51 sessions); the continuous promotion of replacement measures; and, innovative therapeutic approaches.
- Thanks to the commitment of the entire staff—despite the challenges presented by personnel changes, the pandemic, and staff shortages—we can fairly conclude that we are succeeding in our pursuit of objectives centred on strict compliance with established standards while constantly promoting the dignity of all users. Training and the use of alternative measures are the very foundation of our interventions and our vigilance.

MEASURES IMPLEMENTED BY THE INSTITUTION OR ITS PUBLIC ADVISORY AND SERVICE QUALITY COMMITTEE FOLLOWING RECOMMENDATIONS FORMULATED BY THE FOLLOWING BODIES

Service Quality and Complaints Commissioner (SQCC)

In accordance with the Regulation respecting the complaints procedure and pursuant to the mandate of the Public Advisory and Service Quality Committee, the Service Quality and Complaints Commissioner periodically report all improvement resulting from the application of the complaints procedure to this committee.

The implementation of these improvement measures is monitored rigorously with each of the bodies and directorates concerned. The complaint and intervention file are closed once the measures have been implemented. This approach is part on an ongoing goal of improving the quality of care and services provided to users and their loved ones.

Systemic measures are focused on adapting care and services (such as adding staff or services, informing and educating stakeholders, reducing delays, improving communications); adapting the environment and the environment (such as technical and material adjustments, improving security measures and protection); and, the adoption/revision/application of rules and procedures (such as clinical or: administrative protocols).

At the 2019–2020 year end, 34% of the systemic improvement measures were in the process of being implemented. Among the 146 improvement measures, 97 measures had been implemented, and 49 measures were underway.

These are some of the improvements implemented:

- With regard to the YP mission, a young woman turned to the SQCC to register a complaint concerning the comfort of her living environment. The air-conditioning unit had a defective part that took a long time to receive. A reminder was sent to those concerned and the problem was corrected within a reasonable time.
- For the seniors' housing mission, the way of recording absences will be modified to improve communications. The resident themself will need to record in the registry when they are going off-site and sign the entry. Furthermore, new posters have been installed at the reception desk to inform residents and visitors how to contact a manager.
- For the hospital centre mission, a meeting was held with the admissions staff to remind them of their duty to identify themselves and the need to address users in their chosen language. Staff were also given a code of ethics.
- The Medical Imaging Department is planning the acquisition of a voice-recognition system to facilitate medical imaging transcriptions. This will help reduce the delays in receiving medical imaging reports.

Ombudsman

The CIUSSS de l'Ouest-de-l'Île-de-Montréal received 7 reports from the Ombudsman in the fiscal year 2019–2020, including 22 recommendations. Following are the recommendations were received regarding various directorates of the organization:

- Establish a procedure whereby the Archives Department monitors medical records at all times when they are being consulted.
  - Follow-up: Implemented
- Remind St. Mary's Hospital Center (SMHC) Obstetrics Department nurses of the importance of providing bedside monitoring at 15-minute intervals during the first stage of labour.
  - Follow-up: Implemented

- Ensure that a procedure is established for the SMHC Psychiatry Unit in the case that a user files a complaint against a staff member.
  - Follow-up: Implemented
- Ensure that the targeted staff of the SMHC Psychiatry Unit are aware of the procedure adopted, so that it is applied properly.
  - Follow-up: Implemented
- Take the necessary measures to ensure that users are informed of the options available to them when they feel that they have been victims of incivility, harassment, or violence at an installation.
  - Follow-up: Implemented
- Remind SMHC Psychiatry Unit staff of the ombudsperson's role and the collaboration expected by the ombudsperson expects during an investigation, particularly with regard to Article 14 of the *Act respecting the Health and Social Services Ombudsperson*.
  - Follow-up: Implemented
- Ensure that nursing staff of the Douglas Mental Health University Institute's the Brief Intervention Unit locate users who have been assessed as posing a threat in rooms near the nursing station to allow for better monitoring.
  - Follow-up: Implemented
- Develop a procedure on the measures to implement at the Douglas Mental Health University Institute in cases of assault involving a user;
  - Follow-up: Implemented
- Distribute this procedure to the managers, the Chief of Emergency, and the coordinators of the Douglas Mental Health University Institute.
  - Follow-up: Implemented
- Remind all nursing staff at these facilities (emergencies and psychiatric units) that non-consenting sexual acts committed by one user toward another user must not be trivialized and must be the subject of an investigation, so that the necessary measures are quickly implemented to ensure user safety.
  - Follow-up: Implemented
- Declare and analyze each incident and accident involving a resident.
  - Follow-up: In progress
- Take the necessary means to remind the interveners they must adhere to the Batshaw Youth and Family Centers' rules requiring that each intervention carried out as well as the development of an intervention plan must be described in detail in the users' files within the prescribed period.
  - Follow-up: Implemented
- Ensure that personal effects required by a user who is not able to adequately keep watch on those effects, are systematically monitored by the Lakeshore General Hospital's emergency staff, in particular by:
    - developing a policy regarding the safekeeping of personal effects;
    - developing a personal effects inventory form that includes a list of personal effects required by the user.
  - Follow-up: Implemented
- Ensure that the policy regarding the safekeeping of users' personal effects and the use of the personal effects inventory form, by providing the necessary support to emergency personnel at the General Hospital of Lakeshore.
  - Follow-up: Implemented

- Review the relevant elements of the Falls Prevention Program with the relevant professionals and the nursing staff from Unit 3 North of Lakeshore General Hospital, including the following:
    - Evaluation after a fall;
    - Supervision after a fall;
    - Circumstances for reassessment of fall risk;
    - Identification of preventive measures based on risk factors;
    - Inter-professional analysis after a fall.
  - Follow-up: Implemented
- Remind the nursing staff from Unit 3 North of Lakeshore General Hospital to review the entire file, including assessments from other professionals, when assessing fall risk.
  - Follow-up: Implemented
- Remind the staff of Unit 3 North of the Lakeshore General Hospital to use the proper grid (short-term care).
  - Follow-up: Implemented
- Adjust the monitoring grids (short-term and long-term) so that they show the type of contention measure applied at all times.
  - Follow-up: Implemented
- Continue deployment of the training program on control measures within the institution.
  - Follow-up: Implemented
- Ensure that users hospitalized in Unit 3 North of the Lakeshore General Hospital have their hair washed:
    - Upon request by the family;
    - When a user's stay is extended.
  - Follow-up: Implemented
- Determine the practice to be used for closing the mouth of a deceased person, based on recognized practices that respect the dignity of the deceased.
  - Follow-up: Implemented
- Inform the personnel concerned, particularly those of Unit 4 North of the Lakeshore General Hospital, of the practice to be used for closing the mouth of a deceased person.
  - Follow-up: Implemented

All of the ombudsman's recommendations have been implemented by the CIUSSS de l'Ouest-de-l'Île-de-Montréal.

Coroner

The CIUSSS de l'Ouest-de-l'Île-de-Montréal received three reports from the coroner in the fiscal year 2019–2020, including 4 recommendations. Following are the recommendations we received regarding various directorates of the organization:

1. Ensure that the CHSLD Herron respects the conditions of its certification as concerns the health and safety of its residents.
   - Follow-ups carried out:
     - Support for CHSLD Herron prior to the ministerial visit: two preparatory visits and telephone follow-ups.
     - Support and accompaniment for the CHSLD Herron following the ministerial visit: meeting with CHSLD Herron management and a review of the improvement plan before its transmission to the MSSS.
     - Follow-up on each point to be addressed.
2. Provide supervision and support enhanced quality of care and services in a private CHSLD on the territory of the CIUSSS de l'Ouest-de-Île-de-Montréal.

- Follow-ups carried out:
    - Follow-up meeting on service quality carried out by the Certification and Insurance department, in collaboration with a risk and quality management specialist from our CIUSSS: review incident/accident reports and follow up on recommendations made to CHSLD teams.
    - Observing mealtime activity: the observations and points for improvement were discussed with the general manager and the Director of the Nursing Directorate (ND), particularly training in cardiopulmonary resuscitation and general first aid.
    - An improvement plan was implemented by the ND to that effect.

3. We recommend that the Douglas Mental Health University Institute review its management protocols, particularly with regard to enrolment in the Depression Clinic and its risk assessment for people who have acted out on several occasions.
    - Follow-ups carried out:
        - Stakeholders with solid experience in administering tools for measuring psychiatric disorders and interpreting the results carried out an evaluation. This has helped to establish an order of priority for allocating psychiatric consultations, while taking into account the clinical profile of patients.
        - A care procedure for new patients has been implemented at the Depression Clinic.
4. That the CIUSSS de l'Ouest-de-Île-de-Montréal examines the quality of care provided to the patient, from September 9 to 20, 2018.
    - Follow-ups carried out:
        - During its meeting on September 18, 2019, the Douglas Mental Health University Institute facility's Morbidity-Mortality Committee carefully studied the file in question and then recommended it be redirected to the Executive Committee of the Council of Physicians, Dentists and Pharmacists (CPDP), with a copy to the local Medical Procedures Committee, so that the quality of the medical act is evaluated.

Other Instances

The CIUSSS de l'Ouest-de-l'Île-de-Montréal received an inspection report from the *Ordre des infirmières et infirmiers auxiliaires du Québec*, which contained 29 recommendations. The CIUSSS de l'Ouest-de-l'Île-de-Montréal is following up on those recommendations with the parties concerned.

NUMBER OF PERSONS UNDER PREVENTATIVE CONFINEMENT, PER MISSION

The mission of the CIUSSS de l'Ouest-de-l'Île-de-Montréal, covered by section 6 or section 9 of the Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others (CQLR c P-38.001) is the hospital centre mission. There were no preventative confinements in the CHSLD, CLSC, and CR missions of our institution.

	Total of the institution
Number of Persons Under Preventative Confinement	1 346
Number of requests for provisional custody presented to the court by the institution on behalf of a physician or other professional who practises within the establishment.	207
Number of Temporary Confinement Orders Issued by the Courts and Executed	207
Number of Requests for Confinement under Section 30 of the Civil Code Submitted to Court by the Institution.	744
Number of Individual Users Under Confinement authorized by the courts under section 30 of the Civil Code and executed (including renewal of an authorized detention).	912

COMPLAINTS EXAMINATION AND ADVOCACY

SERVICE QUALITY AND COMPLAINTS COMMISSIONER

The full report of the Service Quality and Complaints Commissioner is available at: www.ciusss-ouestmtl.gouv.qc.ca/en/publications/reports-and-reviews/#c45562.

PROMOTING THE COMPLAINT REVIEW SYSTEM

The Office of the Service Quality and Complaints Commission has worked extremely hard to increase its visibility both inside the CIUSSS de l'Ouest-de-l'Île-de-Montréal and outside. A third visibility campaign took place from May 6 to 24, 2019. A fourth visibility campaign is planned for October 2020. On the other hand, the Office of the Commissioner made multiple presentations and followed up with the Vigilance and Quality Services Committee of our organization.

Highlights:

As of April 1, 2019, the Service Quality and Complaints Commissioner has taken on new responsibilities. Henceforth, anyone operating a private seniors' residence on our territory must inform its residents of their right to file a complaint concerning services rendered—or to be rendered—directly with the Service Quality and Complaints Commissioner. In accordance with the *Regulation respecting the certification of private seniors' residences*. This expanded role adds to the responsibilities conferred upon the Commissioner in 2017 to counter elder abuse under the *Act to combat maltreatment of seniors and other persons of full age in vulnerable situations*.

Improved complaint handling times even though the responsibility for handling complains from PRS was transferred.

Participation in the Brief submitted to the Committee on Health and Social Services of the National Assembly of Quebec on February 18, 2020, with regard to Bill 52. This law, aimed at strengthening the complaint examination system of the health and social services network, particularly for users receiving services from private establishments, was presented by the *Regroupement des commissionaires aux complaints et à la qualité des services du Québec*.

PUBLIC INFORMATION AND CONSULTATION

The CIUSSS de l'Ouest-de-l'Île-de-Montréal is responsible for providing citizens with information about the services offered on its local service network. It fulfils this mission through targeted communication activities. Thus:

The web portal (www.ciusss-ouestmtl.gouv.qc.ca), on line since June 2015, remains very popular with more than 687 000 users this year, an increase of 250 000 from the previous year.

The online platform aims to provide easy access to care and services. It also allows for targeted public information and awareness campaigns on subjects of interest, such as eating disorders, mental health support services (the *Loved Ones Matter* campaign), alerts on various viruses (such as measles or the coronavirus), psychosocial services available during spring flooding, promotion of a practical guide to steer people to the appropriate resources for their health needs. Ministerial public health campaigns on topics including cannabis, advice for the summer, "making the right choice", and influenza and gastroenteritis were also published. The Users Committee is also featured prominently on the website to support member recruitment. The Service Quality and Complaints Commission also has a dedicated section, making it easy for our clientèles access the mechanism for expressing their level of satisfaction. Partners also have a dedicated zone, which was recently updated.

Other communication channels include the Info-CIUSSS (514-630-2123) telephone line and email address informations.comtl@ssss.gouv.qc.ca. These channels have been actively promoted to residents of the CIUSSS de l'Ouest-de-l'Île-de-Montréal territory, and receive approximately 25 calls and 25 emails per week with comments or requests for information.

The CIUSSS de l'Ouest-de-l'Île-de-Montréal also uses social media to inform the public about the services it offers, supporting the activities of its public health and health promotion and healthy lifestyles teams, and to receive questions, comments and citizens' concerns, the CIUSSS de l'Ouest-de-l'Île-de-Montréal also actively uses social media. This year we generated 590 posts, deployed 38 Facebook ad campaigns, and received over 400 messages.

Facebook
- 988 new followers this year, for a total of 10 064;
- Nearly 7 000 unique users

Twitter
- 25 new followers this year, for a total of 5 452;
- 2 594 profile visits

LinkedIn
- 3 108 new LinkedIn followers, for a total of 10 775;
- 8 391 unique visitors

The 31 dynamic screens at the Douglas Mental Health University Institute, the Dorval-Lachine-LaSalle installations and Ste. Anne's Hospital are another source of public information.

Furthermore, the public is invited to attend the discussions of the Board of Directors at each of its regular sessions. The invitation is published at least 15 days before each regular session.

The public and community partners were invited to the annual public information session, held on November 15, 2019, under the theme *Citizens, partners, and the IUHSSC: Together for the Health and Wellbeing of All*. The president of the Board of Directors and the President and CEO attended several meetings with our partners, including 29 with mayors and elected officials.

The CIUSSS de l'Ouest-de-l'Île-de-Montréal carries out its populational responsibility mandate in collaboration with community organizations, the municipalities, the education network, and of course, the citizens, users, residents, and veterans of the community.

Citizen/user partners are allies in improving care and services.

In 2019–2020, 16 organizational projects integrated citizen partners and two pilot projects, composed mainly of citizens and residents, showed tangible in terms of improvements to services to the population.

Our various citizen/user partners contributed more than 950 hours of unpaid work through their participation in the strategic, tactical, and operational committees of the CIUSSS de l'Ouest-de-Île-de-Montréal.

SECTION 6—REPORT ON THE APPLICATION OF THE LAW CONCERNING END-OF-LIFE CARE

As part of the application of the act respecting end-of-life care, and in accordance with the mandate given to it by the CEO, the Interdisciplinary Support Group (ISG) provides clinical, administrative and ethical support to professionals in the field. to respond to a request for medical aid in dying (MAID).

Report on the application of the law concerning end-of-life care (April 1, 2019 to March 31, 2020)

Activity	Information requested	Number
Palliative and End-of-Life Care	Number of end-of-life people receiving palliative care	1,192
Continuous Palliative Sedation	Number of times continuous palliative sedation was administered	11
Medical Aid in Dying	Number of requests for medical assistance in dying received	41
	Number of times medical assistance in dying was provided	16
	Number of times medical assistance in dying was not administered and the reasons	25 • 4 requests where the user died became unable to consent during the process; • 10 requests did not meet the requirements of Section 26.6 of the Act; • 6 requests where the user died before the end of the process; • 5 requests withdrawn by the user.

- The ISG met for each of the MAID requests received that were deemed eligible.
- A member of the ISG provided support to the care team in each MAID request.
- A member of the ISG held meetings with the care team as needed after the administration of MAID.

As per its mandate, the ISG provided clinical, administrative, and ethical support to health professionals responding to a MAID request. It supported the care teams for each MAID request received. To ensure the maintenance of optimal care trajectories in the MAID process at the CIUSSS de l'Ouest-de-l'Île-de-Montréal, the ISG met before each administration of MAID.

SECTION 7—HUMAN RESOURCES

THE HUMAN RESOURCES CHART

HEADCOUNT BY JOB CATEGORY

Number of people employed by the institution on March 31, 2019* and the number of full-time equivalents (FTE)

Job Category (MSSS, unionized)	Number of jobs on March 31, 2019*	Number of TFE in 2018-2019*
1 - Nursing and cardiorespiratory care personnel	2,970	2,315
2 - Labourers, para-technical, and auxiliary personnel	3,306	2,514
3 - Office personnel, technicians and administrative professionals	1,409	1,227
4 - Health and Social Services technicians and professionals	2,065	1,698
5 - Personnel not targeted by Law 30	74	61
6 - Management personnel	344	360
Total	**10,168**	**8,175**

* Most recent year available. Data provided by the Ministry of Health and Social Services.

Number of jobs: Number of occupied jobs in the network on March 31 of the year in question, with at least one hour, paid or unpaid, within three months after the end of the financial year. Individuals who, as of March 31, held a job in more than one institution are counted at each of these jobs.

Number of Full-time equivalents (FTE): Full-time equivalent estimates the number of people that would have been required to perform the same workload, excluding paid overtime, if all had worked full-time. It is the ratio between the number of paid hours—including vacation days, public holidays and other paid leave, as well as overtime taken as compensated leave—and the number of hours required for the job in a year , taking into account the number of working days in the year.

11045168 - CIUSSS de l'Ouest-de-l'Île-de-Montréal	364-day comparison from April to March 2019-03-31 to 2020-03-28		
Job sub-category determined by the TBS	**Hours worked**	**Overtime hours**	**Total hours paid**
1 - Management personnel	592,625	8,430	601,055
2 - Professional personnel	2,208,289	15,345	2,223,633
3 - Nursing personnel	4,239,457	346,284	4,585,741
4 - Office personnel, technicians and related occupations	6,685,728	364,041	7,049,769
5 - Labourers and maintenance and service personnel	1,643,397	42,075	1,685,472
6 - Students and trainees	8,790	119	8,909
Total for 2019-2020	**15,378,285**	**776,295**	**16,154,580**
Total for 2018-2019			**15,826,706**

Target for 2019-2020	**16,067,471**
Variance	**87,109**
% Variance	**0.5%**

The target is set at 16,067,471 hours worked. The institution exceeded this target by 0.5% or 87,109 worked hours. New investments and the reorganization of services over the course of the year explain this difference, along with a growth in our clienteles and service delivery in certain sectors, as well as comparatif des medicaments" across of work to implement the *lettre d'entente sur la stabilité des postes favorisant le rehaussement de postes*.

SECTION 8—FINANCIAL RESOURCES

USE OF BUDGETARY AND FINANCIAL RESOURCES PER PROGRAM

EXPENSES PER PROGRAM—DEPARTMENTS

Schedule	Preceding Year		Current Year		Variation in Expenses	
	Expenses	%	Expenses	%	$	%
Service Programs						
Public Health	5,203,923	0.6%	7,824,602	0.86%	2,620,679	50.36%
General Services – Clinical and Support Activities	24,223,276	2.81%	22,887,507	2.52%	-1,335,769	-5.51%
Support for Elderly Autonomy Program—Residential	148,586,607	17.22%	127,113,157	13.97%	-21,473,450	-14.45%
Support for Elderly Autonomy—Home support and other	6,650,801	0.77%	45,979,880	5.05%	39,329,079	591.34%
Physical Disability	5,820,262	0.68%	9,756,991	1.07%	3,936,729	67.64%
Intellectual Disability & Autism Spectrum Disorder	53,074,930	6.15%	54,638,165	6%	1,563,235	2.95%
Youth in Difficulty	71,197,014	8.25%	79,347,555	8.72%	8,150,541	11.45%
Addiction	0	0%	100,701	0.01%	100,701	0%
Mental Health	103,615,330	12.01%	111,190,152	12.22%	7,574,822	7.31%
Physical Health	239,953,310	27.81%	238,657,945	26.23%	-1,295,365	-0.54%
Support Programs						
Administration	61,002,293	7.07%	64,039,906	7.04%	3,037,613	4.98%
Support to Services	76,391,120	8.85%	77,999,986	8.57%	1,608,866	2.11%
Building & Equipment Management	67,117,245	7.78%	70,428,984	7.74%	3,311,739	4.93%
Total	862,836,111	100%	909,965,531	100%	47,129,420	5.46%

Note: For the fiscal year 2018–2019, the non-exclusive activity centres in support of elderly autonomy were not separated into two components: 1–residential component; and 2–home support and other. To establish this comparison on the same allocation basis as for that used for the current fiscal year 2019–2020, the amount of the previous fiscal year for the residential component should be reduced by $32 790 746, while the amount of the previous year for the home support component should be increased by the same amount.

The financial statements included in the annual financial report (AS-471) are available for consultation on our website at www.ciusss-ouestmtl.gouv.qc.ca.

BALANCED BUDGET

Under sections 3 and 4 of the Act to provide for balanced budgets in the public health and social services network, (CQLR c E-12.0001), the institution must maintain a balance between its revenues and expenses over the course of the fiscal year and must not incur a deficit at the end of the fiscal year.

For the year that ended March 31, 2020, the institution had a deficit of $6,070,049 and failed to meet its legal obligation to maintain a balanced budget. The operating fund ended with a deficit of $5,040,669, while the capital fund shows a deficit of $1,029,380. The deficit presented is fully covered by fund balances, which initially included surpluses on March 31, 2015.

SERVICE CONTRACTS

Service Contracts involving expenditures of $25 000 or more, concluded between April 1, 2019 and March 31, 2020.

	Number	Value
Service contracts with an individual [1]	18	$1,013,966.06
Service contracts with a contractor other than an individual [2]	119	$47,833,470.85
TOTAL OF SERVICE CONTRACTS	137	$48,847,436.91

[1] An individual, whether in business or not.
[2] Includes private law corporations, partnerships, limited partnerships, or joint ventures.

SECTION 9—MONITORING OF STATE RESERVES, COMMENTS AND OBSERVATIONS ISSUED BY INDEPENDENT AUDITOR

ÉTAT DU SUIVI DES RÉSERVES, COMMENTAIRES ET OBSERVATIONS FORMULÉS PAR L'AUDITEUR INDÉPENDANT				
Description des réserves, commentaires et observations	**Exercices financiers**	**Nature**	**Mesures Prises pour régler ou améliorer la problématique identifiée**	**État de la problé-matique au 31 mars 2019**
1	**2**	**3**	**4**	**5 6 7**
Signification des codes				
Colonne 3				**Colonne 5, 6 et 7**
R : pour réserve O : pour observation C : pour commentaire				R :pour réglé PR :pour partiellement réglé NR :pour Non réglé
PARTIE AS-471 (p.140)				
Rapport de l'auditeur indépendant portant sur les états financiers				
Comptabilisation des contrats de location d'immeubles conclus avec la Société québécoise des infrastructures (SQI) comme des contrats de location-exploitation et non comme des contrats location-acquisition (CROM - Batshaw-ODI-DLL).	2011-12	R	Maintien de la directive du MSSS concernant la comptabilisation des contrats location-acquisition avec la SQI présentement traités comme des contrats de location exploitation, ce qui contrevient à la note d'orientation concernant la comptabilité NOSP-2 '' Immobilisations corporelles louées'' du Manuel du CPA Canada. Le MSSS a annoncé qu'il y aurait un transfert de propriété des immeubles de la SQI vers les établissements. Voir lettre du MSSS du 30 juillet 2018 signée par M.	NR

			François Dion #réf. 18-FI-00733 (information à venir). A ce jour, nous n'avons pas été contactés par la SQI ni le MSSS.	
Rapport de l'auditeur indépendant portant sur les unités de mesure et les heures travaillées et rémunérées				
5910–Services psychocociaux pour les jeunes en difficulté et leur famille **5930-Services ambulatoires de santé mentale en première ligne** **6173-Soins infirmiers à domicile régulier et** **6531- Aide à domicile régulière** L'unité de mesure « B) L'usager » n'est pas conforme au Manuel de gestion financière (MGF) pour ces sous-centres d'activités. Aucune procédure, ni contrôle ne permet de s'assurer qu'un même usager ne soit pas compilé plus d'une fois au sein des différents sites de l'établissement, étant donné que les systèmes des différents sites ne sont pas intégrés.	2015-2016 2018-2019 (CA 5910 et 5930)	R	Nous avons travaillé activement à la résolution de cet enjeu. Pour l'exercice financier 2019-2020, nous sommes en mesure de satisfaire aux exigences pour les SCA 5910-5930-6173-6531. Nous considérons donc cette déficience réglée. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	R
6302 – Consultations externes spécialisées La compilation du l'unité de mesure « A) La visite » n'est pas conforme au Manuel de gestion financière (MGF) pour ce sous-centre d'activités. Le processus de compilation n'est pas uniforme au sein de l'établissement quant à la	2018-19	R	La situation décrite sera résolue lors de la fusion des bases de données. Pour le SCA 6302, il n'existe pas de système d'information pour tous les services. Nous ne sommes donc pas en mesure de croiser l'information. Pour calculer les résultats, nous	NR

façon de considérer ce que constitue une visite pour un problème différent. Aucune procédure, ni contrôle ne permet de s'assurer qu'une seule visite est compilée pour un patient qui pourrait se présenter aux différents sites de l'établissement pour un même problème, dans une même journée, entrainant ainsi un risque de surévaluation de l'unité de mesure.			recevons directement les valeurs calculées par le service clinique concerné, sans possibilité de croiser avec nos autres systèmes. Nous sommes tributaires de l'ajout de système d'information clinique approprié dans les différents services selon le plan des actifs informationnels de la DRIGBM. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	
6307 – Services de santé courants La compilation de l'unité de mesure « A) La visite » n'est pas conforme au Manuel de gestion financière (MGF) pour ce sous-centre d'activités. Aucune procédure ni contrôle ne permet de s'assurer qu'une seule visite est compilée pour un patient qui pourrait se présenter aux différents sites de l'établissement dans une même journée, entrainant ainsi un risque de surévaluation de l'unité de mesure	2017-18	R	La situation décrite sera résolue lors de la fusion des bases de données. Pour le SCA6307, il n'existe pas de système d'information pour tous les services. Nous ne sommes donc pas en mesure de croiser l'information. Pour calculer les résultats, nous recevons directement les valeurs calculées par le service clinique concerné, sans possibilité de croiser avec nos autres systèmes. Nous sommes tributaires de l'ajout de système d'information clinique approprié dans les différents services selon le plan des actifs informationnels de la DRIGBM. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	NR

6870 – Physiothérapie L'unité de mesure « A) Heures de prestation de service » n'est pas conforme au Manuel de gestion financière (MGF) pour ce centre d'activités. Je n'ai pas été en mesure de retracer le document de base attestant de la réalité des heures de prestations et aucune révision ou approbation du document de base n'est en place. Pour l'unité de mesure « B) Jour-traitement », il n'y avait aucune révision ou approbation du document de base servant à la compilation.	2017-2018	R	Le document de base sera conservé et approuvé. Consultation des gestionnaires concernés afin que les heures de prestations soient inscrites aux notes d'évolution et/ou agendas des professionnels et qu'ils approuvent l'inscription de ces heures périodiquement. .Nous considérons donc cette déficience réglée. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	R
7644 – Hygiène et salubrité – Tâches opérationnelles La compilation du l'unité de mesure « A) Le mètre carré » n'est pas conforme au Manuel de gestion financière (MGF) pour ce sous-centre d'activités. Je n'ai pas été en mesure de retracer le document de base attestant de la réalité des mètres carrés.	2018-2019	R	Cette situation est connue: pour certains bâtiments, les documents attestant les dimensions sont inexistants. Notre établissement prévoit une réévaluation des dimensions de tous ses bâtiments par une firme d'architectes dans un avenir rapproché (automne 2020). Nous allons inscrire la demande comme un projet d'immobilisation. .Une fois l'approbation du MSSS reçue, nous allons mandater des professionnels pour valider les superficies et volumes manquants pour l'ensemble de nos bâtiments. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	NR

7703 – Fonctionnement des installations – Autres La compilation de l'unité de mesure « A) Le mètre cube » n'est pas conforme au Manuel de gestion financière (MGF) pour ce sous-centre d'activités. Je n'ai pas été en mesure de retracer le document de base attestant de la réalité des mètres cubes. Également, au cours de l'exercice un changement de mètres cubes a été relevé et le calcul unitaire n'a pas été établi proportionnellement au temps d'utilisation. Finalement, la présentation de ce sous-centre d'activité n'est pas conforme au MGF puisque les frais des locaux loués sont inclus, et ce, malgré le fait que le loyer inclut les frais de fonctionnement.	2017-2018	R	Cette situation est connue: pour certains bâtiments, les documents attestant les dimensions sont inexistants. Notre établissement prévoit une réévaluation des dimensions de tous ses bâtiments par une firme d'architectes dans un avenir rapproché (automne 2020). Nous allons inscrire la demande comme un projet d'immobilisation. Une fois l'approbation du MSSS reçue, nous allons mandater des professionnels pour valider les superficies et volumes manquants pour l'ensemble de nos bâtiments. Cependant, en raison de la pandémie de la COVID-19, l'auditeur indépendant n'a pu effectuer le suivi pour l'exercice terminé le 31 mars 2020.	NR
AUDITEUR				
Déficiences relevées				
Le CIUSSS n'a pas mis en place une procédure interne d'alerte (whistleblowing) pour évaluer les plaintes des parties prenantes sur la comptabilité, les processus internes ou la présentation de l'information financière. L'établissement devrait établir un processus pour recevoir, évaluer et conserver ces plaintes et pour y répondre de façon à protéger les parties prenantes.	2015-16	O	Depuis le 1er septembre 2019, le CIUSSS a un numéro de téléphone sans frais pour la ligne de signalement téléphonique et une adresse courriel. Une plateforme web est aussi disponible. C'est la firme KPMG qui administre ces canaux de communication. La politique sur la divulgation des actes répréhensibles du CIUSSS est en cours d'approbation.	R
Il n'existe pas de politiques et procédures documentées	2015-16	O	La procédure a été adoptée au CCO du 22	R

sur l'octroi et l'utilisation des cartes de crédit dans les établissements du CIUSSS de l'Ouest-de-l'Île-de-Montréal.			janvier 2020 et est maintenant mise en application.	
Il n'existe pas à l'intérieur des systèmes d'appro-visionnement de contrôles informatisés permettant de respecter les niveaux de délégations autorisés par les politiques, règlements et directives de l'établissement ni une reddition de compte automatique. La mise en place de ce type de contrôle permet de s'assurer que les contrôles opérationnels sont appliqués comme prévu et de donner une assurance sur le respect de la Politique de gestion contractuelle concernant la conclusion de contrats d'approvisionnement, de services et de travaux de construction des organismes publics du réseau de la santé et des services sociaux. Sans contrôles de suivi appropriés, les contrôles opérationnels tendent à devenir inefficaces au fil du temps	2015-16	O	À notre meilleure connaissan-ce, il n'y a pas eu de déro-gation à la loi. Nous sommes d'accord que plusieurs contrôles opération-nels ne sont pas automatisés, ce qui rend les processus non optimaux (formulaire papier). Les processus de contrôle interne et d'automatisation sont en place. Ainsi, tous les cadres ont les niveaux d'autorisation établis. Un groupe de travail est en place pour élaborer et évaluer des solutions. La solution en évaluation est de développer et déployer le logiciel Octopus pour remplacer le formulaire papier et pour gérer la chaîne d'approbation. Pour le moment, cette initiative est en évaluation de financement. L'objectif sera de mettre cette initiative en place à l'intérieur de 12 mois suite à l'autorisation du financement et des conditions requises pour développer et déployer cette solution. Nous sommes également en évaluation d'une solution alternative plus simple et rapide. La solution consiste à faire le processus de demande d'achat en deux étapes. Une première étape où le	NR

			requérant demande une autorisation de sollicitation pour répondre à un besoin. Et une deuxième étape où la réquisition est complétée dans GRM suite au processus de sollicitation. De plus, un module de reddition de compte est disponible dans le système. Le module est toujours en évaluation. Nous allons déterminer si le module répond à nos besoins et valider la disponibilité budgétaire au cours 2020-2021.	
Au cours de nos travaux d'audit, notamment par discussions avec la direction et les responsables de la gouvernance, nous avons constaté que le CIUSSS n'avait pas de processus pour repérer, évaluer et répondre aux risques internes et externes. Si ces risques ne sont pas repérés, il se peut que le CIUSSS ne puisse prévenir un évènement ou une éventualité ni réagir à temps. En outre, cette situation pourrait avoir des répercussions sur l'information financière.	2016-17	C	Un tableau des risques organisationnels a été élaboré et est régulièrement mis à jour par la direction adjointe qualité, gestion des risques et éthique. Ce tableau des risques organisationnels est suivi par la Table des cadres supérieurs.	R
Présentation des obligations contractuelles liées aux ententes avec les RI et les RTF La détermination des obligations contractuelles découlant des ententes avec les ressources intermédiaires (RI) et les	2017-18	O	Un travail de collaboration sera formalisé pour assurer la qualité de l'information saisie à la source par les différentes directions dont Direction jeunesse, SAPA, DI-TSA, DSMD et DLOG, entre autre	PR

ressources de type familial (RTF) découle actuellement d'un processus estimatif et peu précis. En effet, lors de notre audit, nous avons constaté que la direction ne tenait pas compte adéquatement des dates réelles d'échéance et de renouvellement des différentes ententes auprès de ces ressources. Une partie appréciable de la population était plutôt soumise à un calcul global sur 3 ans et ce, peu importe les caractéristiques propres aux contrats en place. À la suite à notre intervention et après une analyse approfondie de la direction, une correction de l'ordre de 43,3 M$ a été apportée aux états financiers de l'exercice se terminant le 31 mars 2018.			pour l'inscription des nouveaux contrats, des prolongations, des dates de début et de fin et de façon plus spécifique pour les familles d'accueil de proximité.	
DÉFICIENCES TI RELEVÉES				
Déficiences TI relevées – Gérer l'accès				
Paramètres de gestion des mots de passe : Certains paramètres de mots de passe sont à améliorer, tels que : •Pour les environnements AD Windows (comtl) et GRH-Paie, le changement forcé du mot de passe est à 365 jours; •Pour les applications GRF et GRM, aucune complexité obligatoire de mot de passe ni d'historique de dernier mot de passe; •Pour l'application GRF, la	2017-18	O	Pour GRH-paie, nous sommes en attente d'une nouvelle version du fournisseur de système pour répondre à cet enjeu. Le fournisseur n'a pas encore confirmé la date à laquelle la fonctionnalité sera disponible. Pour GRF, l'application ne permet pas les paramètres de mots de passe complexes. Nous avons procédé à l'instauration de LDAP en 2019-2020 pour	PR

longueur minimale de mot de passe est de six Caractères (la longueur maximale étant de huit caractères) •Pour l'application GRM, il n'y a pas de longueur minimale de caractères.			satisfaire au critère des mots de passe complexes. Pour GRM, les paramètres de mots de passe sont tous appliqués (complexité, longueur, changement périodique).	
Gestion des accès : La gestion des accès visant les applications dans la portée de notre audit* n'est pas uniforme en ce qui concerne la documentation formelle des demandes et des autorisations lors des octrois, modifications ou retraits des droits d'accès. Par ailleurs, il n'y a pas de processus de révision formel et documenté des codes d'utilisateurs et des droits d'accès. Cette situation augmente le risque d'accès non autorisé et de transactions non autorisées dans les systèmes. Un document intitulé ''Procédure Gestion des accès'' présente quelques lignes directrices pour mettre en place un processus de gestion des accès. * GRF, GRH-paie, GRM et SIRTF	2017-18	O	La politique de gestion des accès a été approuvée en décembre 2019. La politique est actuellement diffusée sur l'intranet. Le plan de sensibilisation et formation à la sécurité de l'information comprend des activités de diffusion des nouvelles politiques adoptées en regard de la sécurité de l'information.	PR
Déficiences TI relevées - Surveiller l'accès aux systèmes informatique				
Nous avons constaté qu'il n'y a pas d'approche structurée à l'égard de la surveillance des journaux Risque d'accès non autorisés aux systèmes et aux données, et de déni d'utilisation des systèmes et données.	2015-16	O	Nous avons réalisé un pilote permettant de tester un processus de base de surveillance de journaux et d'évaluer un outil SIEM (Security Information and Event Management). Un rapport a été déposé incluant des recommandations et des	PR

			rapports de contrôle disponibles. L'application des recommandations du rapport nécessite l'affectation de nouvelles ressources humaines au niveau opérationnel de la sécurité de l'information. L'évaluation des ressources requises a été faite pour les environnements financiers. L'évaluation financière reliée à l'acquisition de ce type de solution est à faire. Selon les ressources nécessaires à l'exécution de ce projet, les travaux pourraient être réalisés au courant de l'année financière 2020-2021 Un outil sera implanté et fonctionnel pour les systèmes GRF-GRM-GRH et Paie au 30 avril 2020	
Déficiences TI relevées - Continuité des opérations TI				
Nous avons constaté qu'il n'y a pas de plan de relève formellement documenté et testé. Risque que les opérations de l'organisation soient affectées à la suite d'une situation imprévue. De plus, il y a un certain risque de perte de données sensibles.	2015-16	O	Des travaux sont en cours pour l'implantation d'un plan de relève. Les systèmes Paie-RH et GRF-GRM possèdent chacun leur serveur. Chaque serveur agira comme « backup » de l'autre. L'infrastructure est installée. Les travaux de positionnement et de mise en place des environnements de redondance sont débutés depuis le mois de	PR

			septembre 2019. Les environnements priorisés sont ceux de GRF, GRM et GRH. Les travaux sont en cours de réalisation	

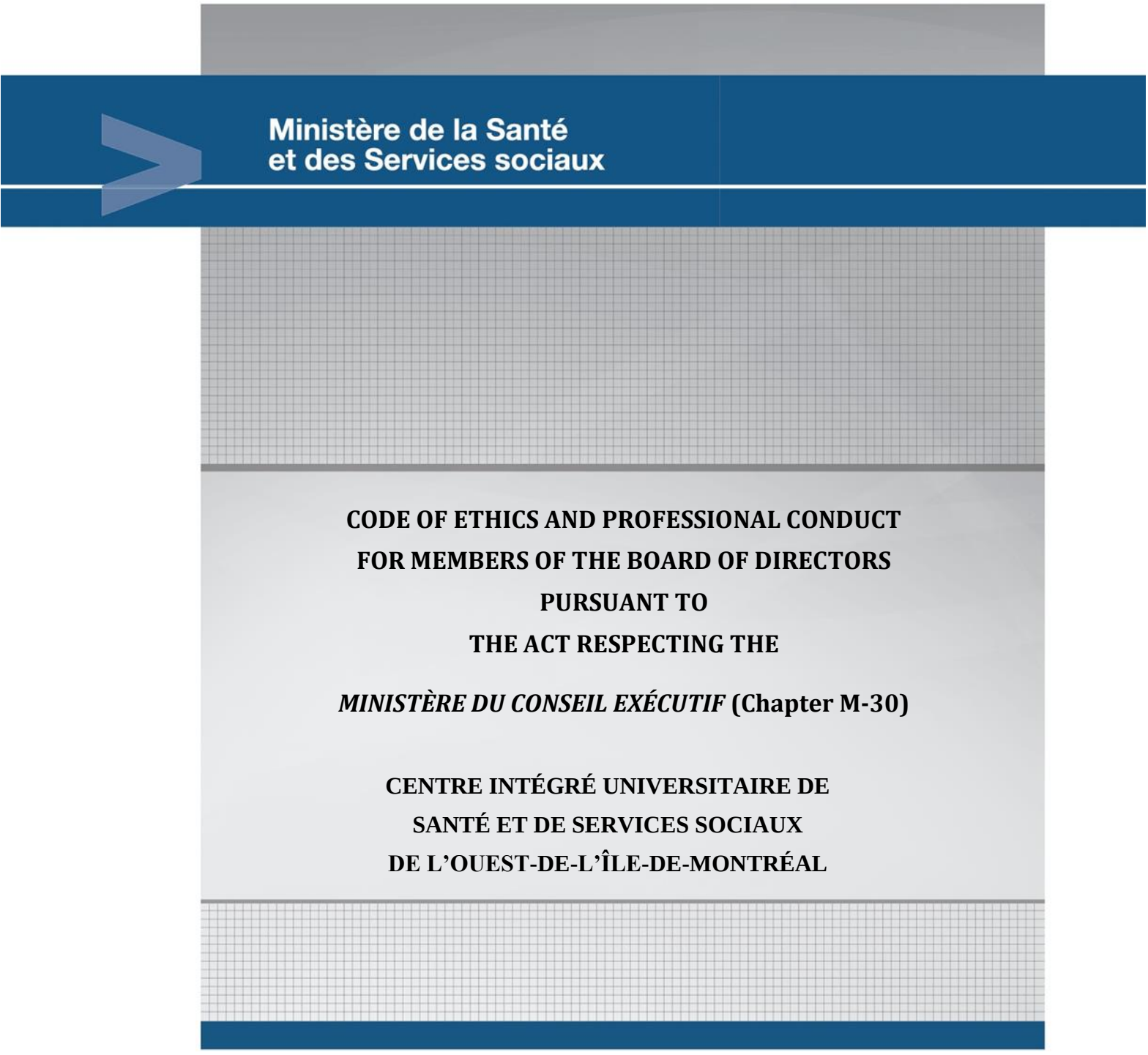
SECTION 10—DISCLOSURE OF WRONGDOINGS

The CIUSSS makes available a unique email address, a toll-free telephone number, and a online platform to all employees and suppliers who are witness to or informed of a situation that may constitute a wrongdoing so that they may communicate their concerns anonymously and confidentially. The policy on the disclosure of wrongdoings has been drafted, but its adoption was delayed due to the health emergency. Consequently, the CIUSSS identified the Associate Directorate for Quality, Performance, and Client Experience as responsible for the process. The Human Resources, Communications, and Legal Affairs Directorate (HRCLAD) and the Financial Resources Directorate (FRD) are collaborating directorates.

Disclosure of Wrongdoing with respect to Public Bodies	Number of disclosures	Number of reasons	Grounded reasons
1. Number of disclosures received by the individual responsible for follow-up on disclosures [1]	34	Not applicable	Not applicable
2. Number of alleged grounds in disclosures received (Point 1)[2]	Not applicable	36	
3. Number of grounds terminated pursuant to paragraph 3 of Article 22		33 (3 under review)	
4. Number of disclosures received by the individual responsible for follow-up on disclosures: For the grounds alleged in the disclosures received (Point 2)—excluding those which were terminated (point 3)—identify which category of wrongdoing they relate to.			
✓ Contravention of a Québec provincial law, a federal law applicable in Québec, or a regulation established under such a law	Not applicable	0	0
✓ A serious breach in ethical standards and professional conduct		0	0
✓ Misuse of funds or property of a public body, including those it manages or holds for others		2 under review	2 under review
✓ Serious mismanagement within a public body, including abuse of authority		1 under review	1 under review
✓ Causing, through an act or an omission, serious injury or risk of serious injury to a person or the environment		0	0
✓ Ordering or counselling a person to commit a wrongdoing previously identified		0	0
5. Number of disclosures received by the individual responsible for follow-up on disclosures		4 (3 under review)	Not applicable
6. Number of disclosures received by the individual responsible for follow-up on disclosures (Point 4) that were founded.		Not applicable	0 (3 under review)
7. Total number of disclosures received (Point 1) that were determined to be founded, that is, that contained at least one disclosure that was determined to be founded			Not applicable
8. Number of times information was communicated in applying the first paragraph of Section 23[3]	0	0	0

1. Number of declarations equals number of declarants.
2. A declaration may contain multiple grounds. For example, a declarant may mention in his declaration that his manager used property of the State for personal gains and who contravened a provincial law by awarding a contract without a call for tenders.
3. List here the transfer of information to the Anti-Corruption Commissioner or any other organization whose duty is to prevent, detect, or suppress crime and legal infractions—such as a police force or a professional order—whether the disclosure is further investigated by the body responsible for follow-up or not.

APPENDIX 1: CODE OF ETHICS



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PREAMBLE

The administration of a public health and social services establishment differs from that of a private organization. It must be based on a relationship of trust between the establishment and the population.

The administration of a public health and social services establishment differs from that of a private organization. It must be based on a relationship of trust between the establishment and the population. This Code thus establishes the ethical principles and obligations of professional conduct for members. Professional conduct refers mainly to the totality of a member's duties and obligations, whereas ethics involves examining the broad principles of conduct to be followed by all board members, and establishing the consequences of each of the possible options in response to situations that they may face. These choices must be based, among other things, on a commitment to sound governance, which implies accountability commensurate to the responsibilities that are assigned to the establishment.

SECTION 1—GENERAL PROVISIONS GENERAL OBJECTIVES

The objectives of the present document are to prescribe rules of conduct for members of the Board of Directors in matters of integrity, impartiality, loyalty, competence, and respect, and to render them accountable by establishing the ethical principles and rules of conduct that are applicable to them. This Code begins by stating the general duties and obligations of each administrator.

The Administrators' Code of Ethics and Professional Conduct:

a) establishes preventive measures, in particular rules concerning declaration of interests;

b) deals with the identification of situations of conflict of interest;

c) regulates or prohibits practices related to member remuneration;

d) specifies the duties and obligations of members even after they leave office;

e) includes enforcement mechanisms, including the designation of persons responsible for enforcing the code, and provides for sanctions.

In the exercise of their duties, all members shall respect the ethical principles and rules of conduct provided in the present Administrators' Code of Ethics and Professional Conduct, as well as in the applicable laws. In case of divergence, rules shall apply according to the hierarchy of the laws involved.

1. LEGAL BASIS

The Administrators' Code of Ethics and Professional Conduct is based mainly on the following provisions:

- The preliminary provision and articles 6, 7, 321 to 330 of the Civil Code of Québec.
- Articles 3.0.4, 3.0.5 and 3.0.6 of the Regulation respecting the ethics and professional conduct of public office holders, of the Act respecting the Ministère du Conseil exécutif (CQLR, chapter M-30, r. 1).
- Articles 131, 132.3, 154, 155, 174, 181.0.0.1, 235, 274 of the Act respecting health services and social services (CQLR, chapter S-4.2).
- Articles 57, 58 and 59 of the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies (CQLR, chapter O-7.2).

- Act respecting contracting by public bodies (CQLR, chapter C-65.1).
- Lobbying Transparency and Ethics Act (CQLR, chapter T-11.011).
- Charter of Rights and Freedoms, CQLR, c C-12.

2. DEFINITIONS

For the purpose of these rules, the following words mean:

Ad hoc review committee: A committee constituted by the Board of Directors to handle potential faults or omissions or to resolve an issue submitted to it and propose a new rule.

ARHSSS: *Act Respecting Health Services and Social Services.*

AMHSN**:** *The Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies.*

Board: Board of Directors of the establishment, as defined by articles 9 and 10 of the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies.

Code: A code of ethics and professional conduct for members, established by the Governance and Ethics Committee and adopted by the Board of Directors.

Confidential information: Data or information whose access and use are restricted to designated and authorized persons or entities. This information includes any personal, strategic, financial, commercial, technological, or scientific information belonging to the establishment, and any information whose disclosure could harm a user or a person working within the establishment. Any information, of a strategic nature or other, that is not known to the public and that, were it known to a person who is not a member of the Board of Directors, would be likely to procure an advantage or to compromise the realization of a project of the establishment.

Conflict of interest: Refers chiefly, without being limited to, any apparent, real or potential situation in which members might risk compromising the objective fulfilment of their duties, due to their judgment being influenced or their independence being affected by the existence of a direct or indirect interest. Situations of conflict of interest may concern, for example, money, information, influence, or power.

Enterprise: Any form of organization of the production of goods and services, or any other business of a commercial, industrial, financial, or philanthropic nature, or any group aiming to promote values, interests, or opinions, or to exercise influence.

Immediate family: For the purposes of article 131 of the Act respecting health services and social services, is considered an immediate family member of a president and executive director, assistant president and executive director, or senior manager of the establishment, their spouse, their child and the child of their spouse, their mother and father, the spouse of their mother or father, as well as the spouse of their child or of their spouse's child.

Independent person: As defined by article 131 of the Act respecting health services and social services, a person qualifies as independent if the person has no direct or indirect relation or interest, for example of a financial, commercial, professional or philanthropic nature, likely to interfere with the quality of the person's decisions as regards the interests of the establishment.

Interest: Refers to any interest of a material, financial, emotional, professional, or philanthropic nature.

Member: A member of the Board of Directors, whether independent, designated or appointed.

Reasonable person: Process by which an individual engages in critical reflection and considers the elements of a situation to reach the most reasonable decision possible in the circumstances[1].

Serious misconduct: The outcome of a fact or a set of facts attributable to a member that constitute a serious violation of his or her obligations and duties, resulting in a breach of faith with the board members.

Spouse: A person related by marriage or civil union, or a common-law partner within the meaning of article 61.1 of the Interpretation Act (CQLR, chapter I-16).

3. SCOPE OF APPLICATION

All members of the Board of Directors are subject to the rules of the present Code.

4. ENTRY INTO EFFECT

The present document comes into effect the moment it is adopted by the Board of Directors. The Governance and Ethics Committee of the Board of Directors is responsible for ensuring the present Code is applied. The Code must be revised by the Governance and Ethics Committee every three years, or as required by legislative or regulatory changes, and must be amended or rescinded by the Board during one of its regular sessions.

5. PUBLICATION

The institution must make the present Code available to the public, notably by publishing it on its Internet site. It must also publish it in its annual management report, stating the number of cases dealt with and the follow-up thereupon, and setting out of any breaches determined during the year by the *ad hoc* review committee, the determination thereof, any penalties imposed by the Board of Directors, and the names of any persons revoked or suspended during the year or whose mandate has been revoked.

[1] BOISVERT, Yves, Georges A. LEGAULT, Louis C. CÔTÉ, Allison MARCHILDON and Magalie JUTRAS (2003). *Raisonnement éthique dans un contexte de marge de manœuvre accrue : clarification conceptuelle et aide à la décision – Rapport de recherche, Centre d'expertise en gestion des ressources humaines, Secrétariat du Conseil du trésor*, p. 51.

SECTION 2—ETHICAL PRINCIPLES AND RULES OF PROFESSIONAL CONDUCT

6. ETHICAL PRINCIPLES

Ethics refer to the values (i.e. integrity, impartiality, respect, competence and loyalty) needed to safeguard the public interest. For administrators, it means respecting the right to rely on, among other things, one's judgment, honesty, responsibility, loyalty, equity, and dialogue when exercising choice and making decisions. Ethics are thus useful in uncertain situations, when there is absence of rules, when the rules are not clear, or when following the rules leads to undesirable consequences.

In addition to observing principles of ethics and professional conduct, members of the Board of Directors must:

- Exercise, within the scope of the powers conferred on them, the care, prudence, diligence and skill that a reasonable person would exercise in similar circumstances; they must also act with honesty, loyalty and in the interest of the establishment and of the population served.
- Fulfil their general duties and obligations holding to the requirements of good faith above all else.
- Display a constant concern for the respect of life, of human dignity, and the right of every person to receive health and social services, within applicable limits.
- Be sensitive to the needs of the population and ensure that fundamental human rights are taken into account.
- Endorse current priorities and objectives, notably accessibility, continuity, quality and safety of car and services, with the ultimate goal of improving the population's health and well-being
- Exercise their responsibilities while respecting recognized standards of accessibility, integration, quality, relevance, efficacy and efficiency, as well as available resources.
- Participate, actively and in a spirit of collaboration, in implementing the establishment's overall priorities.
- Contribute, through the performance of their duties, to fulfil the mission, to respecting the values set forth in this Code, by drawing on their aptitudes, knowledge, experience, and rigour.
- Ensure that rules concerning confidentiality and discretion are respected at all times.

7. RULES OF PROFESSIONAL CONDUCT

Rules of professional conduct are a set of legal rules of conduct whose violation can lead to sanctions. They can be found in various laws and regulations cited in Section 2. These duties and professional rules of conduct thus establish what is prescribed and what is prohibited.

In addition to observing principles of ethics and professional conduct, members of the Board of Directors must:

8.1 Availability and Competence

- Be available to fulfil their functions by regularly attending Board of Directors meetings, according to the terms specified in the *Règlement sur la régie interne du conseil d'administration de l'établissement*.
- Acquaint themselves with the issues and actively take part in deliberations and decisions.
- Promote mutual cooperation.
- Fulfil their functions by putting their knowledge, abilities, and experience to work for the benefit of their colleagues and of the population.

8.2 Respect and Loyalty

- Respect the provisions of applicable laws, regulations, standards, policies, and procedures, as well as the general duties and obligations related to their office in accordance with the standards of good faith.
- Maintain courteous behaviour and relationships based on respect, cooperation, professionalism and an absence of any form of discrimination. Respect the rules of procedure governing Board of Directors meetings, especially those concerning the allocation of speaking time, decision-making, and the diversity of views, which should be considered as necessary for sound decision-making, as well as any decision reached, regardless of dissent.
-
- Respect all Board of Directors decisions, regardless of dissent, by showing reserve when offering public comment regarding decisions taken.

8.3 Impartiality

- Declare themselves on proposals by exercising their right to vote in the most objective manner possible. To this end, they cannot make any commitment with respect to a third party, nor provide such a party with any guarantee regarding their vote or any decision.
- Place the interests of the establishment before any personal or professional interest.

8.4 Transparency

- Exercise their responsibilities transparently, notably by basing their recommendations on objective and sufficient information.
- Share with members of the Board of Directors any information that is useful or relevant in the decision-making process.

8.5 Discretion and Confidentiality

- Subject to the provisions of the law, show discretion concerning matters of which they gain knowledge in or during the performance of their duties.
- Display prudence and restraint in handling any information whose disclosure or use could harm the interests of the establishment, prejudice the private life of an individual, or confer any undue advantage upon a natural or legal person.
- Maintain the confidentiality of private deliberations among members of the Board of Directors, as well as the positions held, members' votes, and any other information that requires confidentiality, whether by virtue of law or pursuant to a decision by the Board of Directors.
- Refrain from using confidential information obtained in or during the performance of their duties for their own benefit, or that of any natural or legal person, or of any other interest group. This obligation does not have the effect of preventing a member who represents or is linked to a particular group from reporting back, except when information is confidential according to law or if the Board of Directors requires that confidentiality be respected.

8.6 Political Considerations

- Make their decisions independently of all partisan political considerations.

8.7 Public Relations

- Respect applicable rules within the establishment concerning information, communication, use of social media, and relationships with the media, among others, by not expressing themselves to the media or on social media if not authorized by the rules.

8.8 Public Office

- Notify the Board of Directors of their intention to run for election to an elective public office.
- Immediately resign from their functions if elected to a full-time public office. They must resign if the public office is part-time and is likely to interfere with their duty of confidentiality and/or place them in a conflict of interest.

8.9 Goods and Services of the Institution

- Use establishment goods, resources, and services in the manner established by the Board of Directors. They cannot commingle the establishment's goods and their own. They cannot use these goods for their own profit or to profit a third party, unless they are duly authorized to do so. The same applies to resources and services put at their disposal by the organization, in accordance with recognized modes of use, applicable to all.
- Not receive any remuneration other than that provided for by law for the performance of their duties. However, members are entitled to a reimbursement of expenses incurred in the performance of their duties, within the conditions and to the extent set by the government.

8.10 Benefits and Gifts

- Do not solicit, accept, or require, on behalf of themselves or of a third party, nor pay or commit to pay to a third party, directly or indirectly, a gift, a token of hospitality, or any other advantage or consideration that is likely to influence them in the performance of their duties or to create expectations to that effect. All gifts and tokens of hospitality must be returned to the giver.

8.11 Inappropriate Interventions

- Avoid intervening in the process of hiring personnel.
- Avoid any move to favour family or friends or any other natural or legal person.

SECTION 3—CONFLICT OF INTEREST

9. Members cannot perform their duties for their own interest or for that of a third party. They must prevent all conflicts of interest and any appearance of conflict of interest and avoid placing themselves in a situation that renders them unfit to perform their duties. A member is notably in a conflict of interest when the interests involved are such that he might prefer some of them at the expense of the establishment or obtain from them an advantage, whether direct or indirect, current or eventual, personal or in favour of a third party.

10. Within a reasonable time of starting their functions, members must organize their personal affairs so that they may not interfere with the performance of their duties, by avoiding incompatible interests. The same applies when an interest devolves to an administrator by succession or by gift. The same applies when an interest devolves to an administrator by succession or by gift. They must not exercise any form of influence on other members.

11. Members must abstain from participating in deliberations when their objectivity, judgment or independence might be compromised due to personal, family, social, professional or business relationships. Moreover, the following situations, in particular, can represent a conflict of interest:

a) having a direct or indirect interest in a deliberation by the Board of Directors;

b) having a direct or indirect interest in a contract or a project of the establishment;

c) obtaining or being about to obtain a personal advantage as a result of a decision of the Board of Directors;

d) being engaged in a lawsuit against the establishment;

e) letting oneself be influenced by external considerations, such as the possibility of an appointment, or employment prospects or offers.

12. Members must submit and declare in writing to the Board of Directors any pecuniary interests they have, other than minority shares held in a company that do not represent a controlling stake, in any legal person, partnership or commercial enterprise that have a service contract with the establishment, or are likely to enter into one, using the form *Member Declaration of Interest* (see Appendix III). Moreover, they must abstain from sitting on the Board of Directors or participating in any deliberation or decision-making when a question concerning this interest is being discussed.

13. Members with a direct or indirect interest in a legal person or with a natural person that results in a conflict between their personal interest, that of the Board of Directors or of the establishment governed must, on pain of forfeiture from office, disclose such interests in writing to the Board of Directors using the form *Declaration of conflict* of interest in Appendix V.

14. Members who are in a real, potential or apparent situation of conflict of interest with respect to an issue raised during a session must declare the situation at once, and it shall be recorded in the minutes. They must retire during deliberations and decision-making concerning the issue. They must recuse themselves from deliberations and decision-making concerning the issue.

15. A donation or a bequest made to a member who is neither the spouse nor a close family member of the donor or testator is void, in the case of a donation, or without effect, in the case of a bequest, if the act takes place while the donor or testator is being treated or receiving services from the establishment.

SECTION 4—APPLICATION

16. THE ADMINISTRATORS' CODE OF ETHICS AND PROFESSIONAL CONDUCT:

All members commit to acknowledging and fulfil their responsibilities and functions to the best of their knowledge and to respecting the present document as well as the applicable laws. Within sixty (60) days of the adoption of the present Administrators' Code of Ethics and Professional Conduct by the Board of Directors, each member must submit the completed *Member commitment and affirmation form* from Appendix I of the present document.

All new members must also do this within sixty (60) days of joining the Board. In case of doubt about the applicability or scope of the present Code, it is the member's responsibility to consult the Governance and Ethics Committee.

17. GOVERNANCE AND ETHICS COMMITTEE

In matters of ethics and professional conduct, the Governance and Ethics Committee's functions, among other things, are to:

f) develop an Administrators' Code of Ethics and Professional Conduct in compliance with article 3.1.4 of the *Act respecting the Ministère du Conseil exécutif*;

g) ensure the present Code is shared and promoted among the members of the Board of Directors;

h) inform members of the content and the implementing measures of the present Code;

i) advise the members on any question concerning application of the present Code;

j) handle declarations of conflict of interest and provide any members who so request an opinion on these declarations;

k) revise the present Code as required and submit any modifications for adoption by the Board of Directors;

l) periodically evaluate the application of the present Code and make recommendations to the Board of Directors as appropriate;

m) retain the services of external resources, if required, to review any issue that it receives from the Board of Directors;

n) conduct an analysis of any situations of breach of the law or of the present Code and report on it to the Board of Directors.

As it is the members of the Governance and Ethics Committee who set the rules of conduct, they should not be called on to interpret them, in a disciplinary context. Doing so could taint the disciplinary process by introducing a bias potentially unfavourable to the member in question. For this reason, it is proposed that an ad hoc review committee be set up to resolve the problem or to propose a rule, at the discretion of the Board of Directors.

18. *AD HOC* REVIEW COMMITTEE

18.1 The Governance and Ethics Committee sets up, as required, an ad hoc review committee composed of at least three (3) persons. One of these persons must have practical competencies in the domain of professional conduct and ethical reflection. The committee may be composed of members of the Board of Directors or of external resources with specific competencies, particularly in legal matters.

18.2 A member of the *ad hoc* review committee cannot serve on the committee if he is directly or indirectly involved in a matter that has been submitted to the committee.

18.3 The ad hoc review committee's functions are to:

a) conduct enquiries, at the request of the Governance and Ethics Committee, into any situation involving a presumed breach, by a member of the Board of Directors, of the rules of ethics and professional conduct set out in the present Code;

b) determine, following such an enquiry, whether a member of the Board of Directors has breached the present Code or not;

c) make recommendations to the Board of Directors on measures that should be imposed on an offending member.

18.4 The start date, the duration of the mandate, and the terms of reference of the ad hoc review committee are set by the Governance and Ethics Committee.

18.5 If the ad hoc review committee is unable to make its recommendations to the Governance and Ethics Committee before its members' terms of office of expire, the Governance and Ethics Committee may extend their terms of office for the time needed to fulfil the aforementioned requirement. The individual being investigated must be informed in writing.

19. DISCIPLINARY PROCESS

19.1 Any breach or dereliction of a duty or obligation under the Code constitutes a derogation and may result in a sanction.

19.2 When a person has substantial grounds to believe that a member may have breached the present document, the Governance and Ethics Committee will submit the matter to the ad hoc review committee by forwarding the *Reporting a situation of conflict of interest* form from Appendix VI completed by the person in question.

19.3 The ad hoc review committee determines, after analysis, whether an enquiry is warranted. If so, it notifies the member concerned of the alleged breach(es), referring to the relevant provisions of the Code. The notification advises the member that he may, within thirty (30) days, provide his observations in writing to the ad hoc review committee and, on request, be heard by the committee regarding the alleged breach(es). He must at all times respond diligently to any communication or request from the ad hoc review committee.

19.4 The member will be informed that the review concerning him will be conducted in a confidential manner, to protect the anonymity of the person making the allegation as much as possible. In case of a breach of confidentiality, the person who is the subject of the review must not communicate with the person who requested it. The persons responsible for conducting the enquiry must fill out the form Affirmation of discretion in the conduct of an enquiry in Appendix VII.

19.5 All members of the ad hoc review committee must act with respect for the principles of fundamental justice and with concern for confidentiality, discretion, objectivity and impartiality. They must be independent-minded and act with rigour and prudence.

19.6 The ad hoc review committee must respect the rules of procedural fairness by providing the member concerned a reasonable opportunity to know the nature of the allegation, to become acquainted with the documents in the ad hoc review committee's file, to prepare and make his written or verbal submissions. If, upon request, the member is heard by the ad hoc review committee, he may be accompanied by a person of his choosing. However, this person cannot take part in the deliberations, nor in the decision of the Board of Directors.

19.7 Persons or authorities charged with examining or enquiring into alleged or actual conduct that may be contrary to standards of ethics or professional conduct, or charged with determining or imposing appropriate penalties, may not be prosecuted by reason of acts performed in good faith in the performance of their duties.

19.8 The ad hoc review committee forwards its report to the Governance and Ethics Committee, at the latest sixty (60) days following the start of its enquiry. This report is confidential and must contain:

o) A description of the facts surrounding the allegation;

p) A summary of the testimony and the documents consulted, including the point of view of the member concerned;

q) A reasoned conclusion on the merit of the allegation regarding a breach of the Code;

r) A reasoned recommendation on the measure to be imposed, if applicable.

19.9 On recommendation of the Governance and Ethics Committee, the Board of Directors shall meet, in camera, to decide on the measure to be imposed on the member in question. Before deciding to apply a measure, the Board must notify the member and offer him an opportunity to be heard.

19.10 The Board of Directors may temporarily relieve of his functions any member accused of a breach, to allow for an appropriate decision to be made in the case of an urgent situation requiring rapid intervention, or in an alleged case of serious misconduct. If the member in question is the president and executive director, the chairman of the Board of Directors must immediately notify the Minister of Health and Social Services.

19.11 Any measure taken by the Board of Directors must be communicated to the member concerned. Any measure imposed upon him, as well as the decision to relieve him of his functions, must be in writing and reasoned. Where there has been a breach, the chairperson of the Board of Directors will inform the president and executive director or the Minister, depending on the severity of the breach.

19.12 This measure may be, depending on the nature and severity of the breach, a call to order, a reprimand, a suspension of a maximum duration of three (3) months or a revocation of the member's mandate. If the measure is to revoke the mandate, the chairperson of the Board of Directors shall inform the Minister of Health and Social Services.

19.13 The secretary of the Board of Directors retains all files related to the application of the Administrators' Code of Ethics and Professional Conduct, in a confidential manner, for the entire duration prescribed by the establishment's retention schedule and in accordance with the Archives Act (CQLR, chapter A-21.1).

20. NOTION OF INDEPENDENCE

Members of the Board of Directors, whether independent, designated, or appointed, must disclose to the Board of Directors in writing, at the earliest opportunity, any situation likely to affect their status. They must submit to the Board of Directors the form Notification of a breach of independent status from Appendix II of the present Code, at the latest thirty (30) days following the advent of such a situation.

21. OBLIGATIONS AT THE END OF A TERM

With respect to the present document, members of the Board of Directors must, after their term ends:

- Respect the confidentiality of any information, debate, exchange or discussion that they witnessed in or during the performance of their duties.
- Behave in such a way as to not obtain any undue advantage, on their personal behalf or on behalf of another, from their former position as administrator.
- Not act on their personal behalf or on behalf of another, with respect to a procedure, negotiation, or any other situation in which they have participated and concerning which they have information not available to the public.
- Abstain from seeking employment with the establishment during their term and in the year following their term, unless they are already employed by the establishment. Potential cases for exception shall be submitted to the Board of Directors.

APPENDICES

APPENDIX I—MEMBER COMMITMENT AND AFFIRMATION

ELECTION OFFICE CONTACT DETAILS

I, _____ [printed name and surname], member of the Board of Directors of the _____, declare that I have read and understood the Administrators' Code of Ethics and Professional Conduct, adopted by the Board of Directors on _____, that I understand its meaning and scope, and declare that I am bound by each of its provisions as if it were a contractual engagement on my part with respect to the _____.

With that in mind, I solemnly affirm that I will fulfil all the duties of my position, and exercise its powers, faithfully, impartially, and honestly, to the best of my ability and knowledge.

I solemnly affirm that I will not accept any sum of money or any consideration for what I will have achieved in the performance of my duties, other than the remuneration and reimbursement of my expenses allocated in accordance with the law. I commit to not disclosing or allowing to be known, without being so authorized by law, any information or document of a confidential nature of which I gain knowledge in or during the performance of my duties.

In witness whereof, I _____, have read and understood the Administrators' Code of Ethics and Professional Conduct of the _____ and I commit to complying with it.

Signature	**Date (YYYY/MM/DD)**	**Location**
Name of the Commissioner of Oaths	**Signature**	

APPENDIX II—NOTIFICATION OF A BREACH OF INDEPENDENT STATUS

SIGNED NOTIFICATION

I, the undersigned, _____ [printed name and surname], hereby declare that I believe I am in a situation likely to affect my status as an independent member within the Board of Directors of the _____ due to the following acts:

_____

_____

_____

_____

_____

Signature	Date (YYYY/MM/DD)	Location

APPENDIX III—MEMBER DECLARATION OF INTEREST

I, _____ [printed name and surname], member of the Board of Directors of the _____, declare the following:

1. Pecuniary Interests

☐ I do not have any pecuniary interests in a legal person, partnership or commercial enterprise.

☐ I have pecuniary interests, other than minority shares held in a company that do not represent a controlling stake, in the legal persons, partnerships, or commercial enterprises identified below [name the legal persons, companies or enterprises concerned]:

_____

_____

_____

2. Administrator Role

☐ I am not acting as the director of a corporation, organization, business, for-profit or non-profit organization, other than my mandate as a member of _____.

☐ I am acting as the director of a corporation, organization, and business, for-profit or non-profit organization, identified below, aside from my mandate as a member of _____. *[Name the legal persons, companies, enterprises, or organizations concerned]:*

_____

_____

_____

3. Employment

I am employed as follows:

Occupation	Employer

I declare that I am under obligation to update this declaration as soon as my situation warrants, and I commit to adopting a conduct that complies with the Administrators' Code of Ethics and Professional Conduct of the _____.

In witness whereof, I have read and understood the Administrators' Code of Ethics and Professional Conduct of the _____ and commit to complying with it.

Signature	**Date (YYYY/MM/DD)**	**Location**

APPENDIX IV—DECLARATION OF INTERESTS FOR THE EXECUTIVE DIRECTOR

I, _____ [printed name and surname], President and Executive Director and ex-officio member of the _____, declare the following:

1. Pecuniary Interests

☐ I do not have any pecuniary interests in a legal person, partnership or commercial enterprise.

☐ I have pecuniary interests, other than minority shares held in a company that do not represent a controlling stake, in the legal persons, partnerships, or commercial enterprises identified below [name the legal persons, companies or enterprises concerned]:

_____

_____

_____

2. Administrator Role

☐ I am not acting as the director of a corporation, organization, business, for-profit or non-profit organization, other than my mandate as a member of _____.

☐ I am acting as the director of a corporation, organization, and business, for-profit or non-profit organization, identified below, aside from my mandate as a member of _____. *[Name the legal persons, companies, enterprises, or organizations concerned]:*

_____

_____

_____

3. Employment

"The president and executive director and the assistant president and executive director of an integrated health and social services centre or an unamalgamated institution must devote themselves exclusively to the work of the institution and the duties of their office.

However, with the Minister's consent, they may engage in other professional activities, whether remunerated or not. They may also carry out any mandate the Minister entrusts to them." (art. 37, CQLR, chapter O-7.2).

In witness whereof, I have read and understood the Administrators' Code of Ethics and Professional Conduct of the _____ and commit to complying with it.

Signature	**Date (YYYY/MM/DD)**	**Location**

APPENDIX V—DECLARATION OF CONFLICT OF INTEREST

I, the undersigned, _____ [printed name and surname], member of the Board of Directors of the _____, believe that I am in a situation of conflict of interest, given the following facts:

_____

_____

_____

_____

_____

Signature	**Date (YYYY/MM/DD)**	**Location**

APPENDIX VI—REPORTING A SITUATION OF CONFLICT OF INTEREST

I, the undersigned, _____ *[printed name and surname]*, consider that the following member: _____, is in an apparent, real, or potential situation of conflict of interest give the following acts:

_____

_____

_____

_____

_____

I ask that the Board of Directors forward this report to the Governance and Ethics Committee for analysis and a recommendation, and I understand that certain information provided in this form constitutes personal information protected by the Act respecting Access to documents held by public bodies and the Protection of personal information (CQLR, chapter A-2.1).

I consent to this information being used for the sole purpose of determining whether or not there exists a situation of apparent, real or potential conflict of interest.

Signature	**Date (YYYY/MM/DD)**	**Location**

APPENDIX VII—AFFIRMATION OF DISCRETION IN THE CONDUCT OF AN ENQUIRY

I, the undersigned, _____ [printed name and surname], solemnly declare that I will not reveal or make known, unless authorized by law, any confidential information coming to my knowledge in the exercise of my duties.

Signature	**Date (YYYY/MM/DD)**	**Location**

APPENDIX 2: MALTREATMENT IN A FEW STATISTICS— YOUTH PROTECTION DIRECTORATE

SIGNALEMENTS PROCESSED DURING THE YEAR

		2017-2018							2018-2019							2019-2020							
		0-5	6-12	13-15	16-17	Unknown	Total	%	0-5	6-12	13-15	16-17	Unknown	Total	%	0-5	6-12	13-15	16-17	Unknown	Total	%	% aug.
Signalements not retained	Girl	188	273	190	152	5	808	49.6%	233	332	245	184	5	999	48.0%	262	380	292	204	6	1 144	48.0%	
	Boy	194	368	147	96	4	809	49.7%	250	490	212	122	2	1 076	51.7%	292	503	277	161	6	1 239	51.9%	
	Unknown	5	5	0	1	0	11	0.7%	4	1	0	0	0	5	0.3%	1	1	1	0	0	3	0.1%	
	Total	**387**	**646**	**337**	**249**	**9**	**1 628**	**45.1%**	**487**	**823**	**457**	**306**	**7**	**2 080**	**51.7%**	**555**	**884**	**570**	**365**	**12**	**2 386**	**58.9%**	**14.7%**
Signalements retained	Girl	348	387	157	99	1	992	50.1%	319	354	201	101	3	978	50.3%	251	341	158	59	4	813	48.9%	
	Boy	347	448	120	61	9	985	49.8%	370	422	112	54	8	966	49.7%	319	350	125	52	4	850	51.1%	
	Unknown	2	0	0	0	0	2	0.1%	1	0	0	0	0	1	0.1%	0	0	0	0	0	0	0.0%	
	Total	**697**	**835**	**277**	**160**	**10**	**1 979**	**54.9%**	**690**	**776**	**313**	**155**	**11**	**1 945**	**48.3%**	**570**	**691**	**283**	**111**	**8**	**1 663**	**41.1%**	**-14.5%**
Signalements processed	Girl	536	660	347	251	6	1 800	49.9%	552	686	446	285	8	1 977	49.1%	513	721	450	263	10	1 957	48.3%	
	Boy	541	816	267	157	13	1 794	49.7%	620	912	324	176	10	2 042	50.7%	611	853	402	213	10	2 089	51.6%	
	Unknown	7	5	0	1	0	13	0.4%	5	1	0	0	0	6	0.1%	1	1	1	0	0	3	0.1%	
	Total	**1 084**	**1 481**	**614**	**409**	**19**	**3 607**	**100.0%**	**1 177**	**1 599**	**770**	**461**	**18**	**4 025**	**100.0%**	**1 125**	**1 575**	**853**	**476**	**20**	**4 049**	**100.0%**	**0.6%**

SIGNALEMENTS RETAINED BY PRESENTING PROBLEM

		2017-2018							2018-2019							2019-2020						
Presenting Problem		0-5	6-12	13-15	16-17	Unknown	Total	%	0-5	6-12	13-15	16-17	Unknown	Total	%	0-5	6-12	13-15	16-17	Unknown	Total	%
Abandonment	Girl	1					1	20.0%		1	1	3		5	62.5%	1		1	2		4	40.0%
	Boy	1	2	1			4	2.2%			3			3	1.5%	3		2	1		6	3.9%
	Unknown																					
Total Abandonment		**2**	**2**	**1**			**5**	**0.3%**		**1**	**4**	**3**		**8**	**0.4%**	**4**		**3**	**3**		**10**	**0.6%**
Physical Abuse	Girl	34	93	42	16		185	44.5%	30	94	50	24	1	199	48.4%	13	94	33	12		152	47.5%
	Boy	43	149	21	14	3	230	55.3%	52	127	24	8	1	212	51.6%	37	102	23	6		168	52.5%
	Unknown	1					1	0.2%														
Total Physical Abuse		**78**	**242**	**63**	**30**	**3**	**416**	**21.0%**	**82**	**221**	**74**	**32**	**2**	**411**	**21.1%**	**50**	**196**	**56**	**18**		**320**	**19.2%**
Risk of Serious Physical Abuse	Girl	21	16	5	4		46	50.5%	33	20	5	1		59	54.6%	10	15	8			33	55.9%
	Boy	23	17	2	2	1	45	49.5%	26	20	1	2		49	45.4%	13	8	3	2		26	44.1%
	Unknown																					
Total Risk of Serious Physical Abuse		**44**	**33**	**7**	**6**	**1**	**91**	**4.6%**	**59**	**40**	**6**	**3**		**108**	**5.6%**	**23**	**23**	**11**	**2**		**59**	**3.5%**
Sexual Abuse	Girl	9	25	17	12		63	74.1%	11	15	10	8		44	83.0%	6	20	21	6		53	76.8%
	Boy	6	9	4	3		22	25.9%	4	3		2		9	17.0%	3	10	3			16	23.2%
	Unknown																					
Total Sexual Abuse		**15**	**34**	**21**	**15**		**85**	**4.3%**	**15**	**18**	**10**	**10**		**53**	**2.7%**	**9**	**30**	**24**	**6**		**69**	**4.2%**
Risk of Serious Sexual Abuse	Girl	13	13	8	6		40	54.8%	7	10	3	1		21	46.7%	16	18	6	2	2	44	58.7%
	Boy	13	14	5	1		33	45.2%	11	11		1	1	24	53.3%	12	15	2		2	31	41.3%
	Unknown																					
Total Risk of Serious Sexual Abuse		**26**	**27**	**13**	**7**		**73**	**3.7%**	**18**	**21**	**3**	**2**	**1**	**45**	**2.3%**	**28**	**33**	**8**	**2**	**4**	**75**	**4.5%**
Psychological Abuse	Girl	147	127	32	19		325	54.0%	128	121	41	21	1	312	48.1%	106	99	26	11		242	47.7%
	Boy	136	110	25	4	2	277	46.0%	167	134	23	10	2	336	51.8%	127	104	25	9		265	52.3%
	Unknown								1					1	0.2%							
Total Psychological Abuse		**283**	**237**	**57**	**23**	**2**	**602**	**30.4%**	**296**	**255**	**64**	**31**	**3**	**649**	**33.4%**	**233**	**203**	**51**	**20**		**507**	**30.5%**
Negligence	Girl	42	45	11	7		105	42.3%	43	40	26	10	1	120	47.1%	40	43	28	5		116	46.0%
	Boy	48	77	14	3	1	143	57.7%	43	72	14	5	1	135	52.9%	51	58	17	9	1	136	54.0%
	Unknown																					
Total Negligence		**90**	**122**	**25**	**10**	**1**	**248**	**12.5%**	**86**	**112**	**40**	**15**	**2**	**255**	**13.1%**	**91**	**101**	**45**	**14**	**1**	**252**	**15.2%**
Serious Risk of Neglect	Girl	81	61	11	9	1	163	51.7%	67	47	19	6		139	55.4%	59	45	15	5	2	126	49.6%
	Boy	77	58	10	4	2	151	47.9%	67	36	5	1	3	112	44.6%	73	39	13	2	1	128	50.4%
	Unknown	1					1	0.3%														
Total Serious Risk of Neglect		**159**	**119**	**21**	**13**	**3**	**315**	**15.9%**	**134**	**83**	**24**	**7**	**3**	**251**	**12.9%**	**132**	**84**	**28**	**7**	**3**	**254**	**15.3%**
Serious Behavioural Issues	Girl		7	31	26		64	44.4%		6	46	27		79	47.9%		7	20	16		43	36.8%
	Boy		12	38	30		80	55.6%		19	42	25		86	52.1%		14	37	23		74	63.2%
	Unknown																					
Total Serious Behavioural Issues			**19**	**69**	**56**		**144**	**7.3%**		**25**	**88**	**52**		**165**	**8.5%**		**21**	**57**	**39**		**117**	**7.0%**
Total	Girl	348	387	157	99	1	992	50.1%	319	354	201	101	3	978	50.3%	251	341	158	59	4	813	48.9%
	Boy	347	448	120	61	9	985	49.8%	370	422	112	54	8	966	49.7%	319	350	125	52	4	850	51.1%
	Unknown	2					2	0.1%	1					1	0.1%							
TOTAL		**697**	**835**	**277**	**160**	**10**	**1 979**	**100.0%**	**690**	**776**	**313**	**155**	**11**	**1 945**	**100.0%**	**570**	**691**	**283**	**111**	**8**	**1 663**	**100.0%**

ORIGIN OF SIGNALEMENTS

	2017-2018				2018-2019				2019-2020			
Signalements	**Not retained**	**Retained**	**Total**	**%**	**Not retained**	**Retained**	**Total**	**%**	**Not retained**	**Retained**	**Total**	**%**
Family Environment												
Parent	149	90	239	6.2%	180	74	254	5.8%	164	71	235	5.1%
Sibling	44	59	103	2.7%	39	46	85	1.9%	25	49	74	1.6%
Child itself	2	6	8	0.2%	6	3	9	0.2%	7	4	11	0.2%
Parent's partner	5	1	6	0.2%	7	2	9	0.2%	2	2	4	0.1%
Total Family Environment	**200**	**156**	**356**	**9.2%**	**232**	**125**	**357**	**8.1%**	**198**	**126**	**324**	**7.0%**
Employees of different organizations												
Employee of a CJ	139	239	378	9.7%	37	68	105	2.4%	0	0	0	0.0%
Employee of a CSSS	112	139	251	6.5%	44	40	84	1.9%	0	0	0	0.0%
Employee of a hospital or a physician	150	172	322	8.3%	163	170	333	7.6%	137	122	259	5.6%
Employee of a residential / foster care	11	7	18	0.5%	8	10	18	0.4%	9	4	13	0.3%
Employee of an organization	120	137	257	6.6%	262	231	493	11.2%	312	320	632	13.7%
Foster Family	1	3	4	0.1%	0	0	0	0.0%	5	2	7	0.2%
Other Professions	17	9	26	0.7%	36	8	44	1.0%	22	8	30	0.7%
Unknown												
Employee of a CI	0	0	0	0.0%	160	193	353	8.0%	278	259	537	11.7%
Total Employees of different organizations	**550**	**706**	**1 256**	**32.4%**	**710**	**720**	**1 430**	**32.6%**	**763**	**715**	**1 478**	**32.1%**
School Environment	**307**	**480**	**787**	**20.3%**	**482**	**436**	**918**	**20.9%**	**559**	**396**	**955**	**20.9%**
Law Enforcement	**532**	**709**	**1 241**	**32.0%**	**699**	**745**	**1 444**	**32.9%**	**989**	**660**	**1 649**	**35.8%**
Community												
Neighbours	130	75	205	5.3%	115	82	197	4.5%	93	65	158	3.4%
Others	23	12	35	0.9%	25	15	40	0.9%	35	9	44	0.9%
Total Community	**153**	**87**	**240**	**6.2%**	**140**	**97**	**237**	**5.4%**	**128**	**74**	**202**	**4.4%**
Total	**1 742**	**2 138**	**3 880**	**100.0%**	**2 263**	**2 123**	**4 386**	**100.0%**	**2 637**	**1 971**	**4 608**	**100.0%**

CHILDREN SUBJECT OF A *SIGNALEMENT*

	2017-2018						2018-2019							2019-2020						
	0-5	**6-12**	**13-15**	**16-17**	**Unknown**	**Total**	**0-5**	**6-12**	**13-15**	**16-17**	**Unknown**	**Total**	**% aug.**	**0-5**	**6-12**	**13-15**	**16-17**	**Unknown**	**Total**	**% aug.**
Children subject of at least one *Signalement*	852	1 147	470	304	17	2 790	946	1 238	564	349	16	3 113	11.6%	910	1 266	642	371	19	3 208	3.1%
Children subject of at least one retained *Signalement*	591	696	235	131	9	1 662	563	614	248	121	10	1 556	-6.4%	469	582	225	89	8	1 373	-11.8%

NUMBER OF ADOLESCENT OFFENDERS ASSESSED AND REFERRED BY THE PROVINCIAL DIRECTOR

	2018-2019						2019-2020					
	12-13	**14-15**	**16-17**	**18+**	**Total**	**%**	**12-13**	**14-15**	**16-17**	**18+**	**Total**	**%**
Girls	2	10	9	11	32	24%	0	1	10	3	14	13%
Boys	7	25	47	25	104	76%	5	33	38	22	98	88%
Total	**9**	**35**	**56**	**36**	**136**	**100%**	**5**	**34**	**48**	**25**	**112**	**100%**

Annual Management Report 2019–2020

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal

160 Stillview Ave.

Pointe-Claire, QC

H9R 2Y2

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal

Québec