Preparation Guide for the Professional Examination of the Ordre des infirmières et infirmiers du Québec

Nursing in Quebec Supplement
Preparation Guide for the Professional Examination
of the Ordre des infirmières et infirmiers du Québec

Supplement
Nursing in Quebec
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# Nursing in Quebec – The professional system

The *Professional Code* ........................................................................................................ 5
The *Nurses Act* .................................................................................................................. 8

# Nursing in Quebec – The professional framework

Foundations ...................................................................................................................... 10
Descriptive statements ..................................................................................................... 10
Essential criteria ............................................................................................................... 11

# Nursing in Quebec – The network

An overview of the public sector ....................................................................................... 12
Organization of the system ............................................................................................... 12
Nursing governance .......................................................................................................... 15
The employment sectors and clinical field of nurses ......................................................... 16
The nursing workforce ...................................................................................................... 16
Union membership .......................................................................................................... 17
Professional association membership .............................................................................. 17

# Nursing in Quebec – Serving the public

Mortality rates ................................................................................................................... 18
The main health problems in Quebec: some findings ....................................................... 19

# Nursing in Quebec – Collaborating with others

# Nursing in Quebec – The legal framework

Nurses’ civil liability ......................................................................................................... 24
Client rights ..................................................................................................................... 25
Some applications of the statutes and regulations governing the nursing profession .... 25
Appendix I – Excerpts from statutes and regulations

Nurses Act ................................................................. 32
Charter of Human Rights and Freedoms ........................................ 33
Civil Code of Québec .................................................. 33
An Act respecting health services and social services ............... 36
Organization and Management of Institutions Regulation ........ 41
An Act respecting Access to documents held by public bodies and
the Protection of personal information .............................. 43
Professional Code ..................................................... 43
Youth Protection Act .................................................. 45

Appendix II – Guiding principles applicable to control measures .... 49

References ........................................................................... 50
Being a nurse in Quebec means providing care and services for individuals and their families and friends in a health care system funded mainly by the public sector; it means practicing the profession with nurses recognized for their competence, allowing them to play a leading role in health care; it also means cooperating with professionals from all disciplines and with all categories of staff who keep health care institutions operating; lastly, it means belonging to a professional order that has more than 70,000 members, most of them women.

This supplement to the Preparation Guide for the Professional Examination of the Ordre des infirmières et infirmiers du Québec offers an overview of the professional, health social, and legal context of nursing practice in Quebec. The information presented will give you an idea of the context in which nurses practice and is intended mainly for nursing graduates from outside Quebec.

The nursing profession is governed by a general statute adopted in 1973, the Professional Code, and a specific statute, the Nurses Act. Some provisions of these acts were recently modified by the Act to amend the Professional Code and other legislative provisions as regards the health sector. One of the effects of this update was to renew the field of nursing practice defined in the Nurses Act.

The Professional Code

In Quebec, 45 professions are supervised by professional orders whose main mandate, as defined by law, is to ensure the protection of the public by supervising the practice of the profession by their members. The Professional Code, which governs the professional system, determines the mandate, duties and powers of five authorities: the government, the minister responsible for the application of professional legislation, the Office des professions du Québec (OPQ), the Québec Interprofessional Council and the professional orders. For nurses, this is the Ordre des infirmières et infirmiers du Québec (OIIQ). This enabling legislation also defines the OIIQ’s structure of authority by determining the responsibilities of the board of directors, which ensures the general administration of the Order’s affairs and sees to the application of the provisions of the Professional Code, the Nurses Act and their associated regulations. The board of directors consists of a president and 28 directors; 24 of whom are elected by the regional orders; the other four members of the board of directors are appointed by the OPQ. The executive committee and the annual general meeting of members are the other two decision-making authorities provided for in the Code for the professional order.

The powers invested in the OIIQ under the Professional Code include the authority to establish conditions for access to the profession and other mechanisms for regulating its practice. In order to regulate practice of the profession by its members, the OIIQ is required to establish a professional inspection committee, set up a disciplinary process that includes the formation of a disciplinary council and the appointment of a syndic, and draw up a code of ethics stipulating professional duties.
and obligations. In addition to implementing these statutory mechanisms provided for in the Code, the OIIQ organizes and holds other activities to promote its primary mission of protecting the public by supporting nurses’ commitment to meeting people’s health care needs. This support of nurses’ practice takes various forms, such as organizing continuing education activities and preparing practice guides.

Access to the nursing profession

To practice as a nurse in Quebec and use the title of “nurse,” you must hold a permit and be entered on the Roll of the Order.3

For nursing graduates from Quebec, the OIIQ issues the permit after they have obtained a diploma giving access to the permit, provided they meet certain regulatory conditions adopted by the OIIQ’s board of directors, including passing the OIIQ’s professional examination. In Quebec, unlike certain European countries, there is no State diploma allowing nurses to practice; candidates must pass the Order’s examination before they can be issued a permit. Nursing graduates from outside Quebec, for their part, must obtain recognition that their training is equivalent before they are allowed to sit the professional examination.

Under sections 32 and 46 of the Professional Code, in particular, an individual must apply to be entered on the Roll in order to practice. This Roll is the list of members in good standing of the OIIQ, in other words those members authorized to practice. This mandatory registration must be renewed annually and is subject to certain conditions, such as notifying the Order if you are the subject of a judicial or disciplinary decision, paying the annual dues and holding professional liability insurance.

The professional inspection committee

The role of the professional inspection committee is to supervise the practice of the profession by its members and, if necessary, to conduct specific inspections into the professional competence of any nurse. General supervision activities give nurses an opportunity to assess the quality of their practice and to obtain support in their efforts to improve their competence on an ongoing basis. These activities are carried out in cooperation with nurses in their workplace, i.e., health care institutions, private practice, etc. Specific inspections are held only in exceptional cases and target nurses with competency problems. The purpose of a specific inspection is to determine whether the nurse’s competence satisfies the essential criteria defined with a view to protecting the public and, if necessary, to recommend measures to allow her to update her knowledge and improve her competence. Depending on the results of the inspection, a period of refresher training or a refresher course may be imposed, and the nurse’s right to practice may be restricted or suspended for this period.

3. The statutes and regulations governing all the standards and procedures for access to the nursing profession can be consulted on the OIIQ Website (www.oiiq.org) in the “Être infirmière au Québec” section, under the heading “Lois et règlements”.

Preparation Guide for the Professional Examination of the Ordre des infirmières et infirmiers du Québec

Supplement: Nursing in Quebec – The professional system
The disciplinary council

Each professional order has a disciplinary council. It consists of a lawyer and two nurses. The council hears all complaints lodged against a nurse by the syndic, an assistant syndic or any other person, for offences under the Professional Code or the Nurses Act or associated regulations, including the Code of Ethics of Nurses. Following a hearing, at which the nurse is entitled to legal representation, the council may find her guilty as charged and impose one or more penalties, including temporary or permanent striking off the Order’s Roll, a fine, revocation of her permit, or restriction or suspension of the right to engage in professional activities.

The syndic

Upon being notified that a nurse has committed an offence under the provisions of the statutes or regulations governing the profession, the syndic or assistant syndic may investigate and require that it be provided with all information and documents relating to the inquiry. Depending on the conclusions of the inquiry, the syndic or assistant syndic may lodge a complaint with the disciplinary council. In some cases, the syndic or assistant syndic may inform the professional inspection committee if the problem relates to the nurse’s professional competence.

Of the 45 professions recognized by the Professional Code, 25 are covered by a specific act and are exclusive professions. The Nurses Act is an example of a specific act.
The Nurses Act

On January 30, 2003 the Act to amend the Professional Code and other legislative provisions as regards the health sector relative to nurses came into effect. The new section 36 of the Nurses Act defines the field of professional practice for nurses and the activities reserved to them. It stipulates that:

“The practice of nursing consists in assessing a person’s state of health, determining and carrying out of the nursing care and treatment plan, providing nursing and medical care and treatment in order to maintain or restore health and prevent illness, and providing palliative care.”

“The following activities in the practice of nursing are reserved to nurses:

(1) assessing the physical and mental condition of a symptomatic person;
(2) providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan;
(3) initiating diagnostic and therapeutic measures, according to a prescription;
(4) initiating diagnostic measures for the purposes of a screening operation under the Public Health Act (chapter S-2.2);
(5) performing invasive examinations and diagnostic tests, according to a prescription;
(6) providing and adjusting medical treatment, according to a prescription;
(7) determining the treatment plan for wounds and alterations of the skin and teguments and providing the required care and treatment;
(8) applying invasive techniques;
(9) participating in pregnancy care, deliveries and postpartum care;
(10) providing nursing follow-up for persons with complex health problems;
(11) administering and adjusting prescribed medications or other prescribed substances;
(12) performing vaccinations as part of a vaccination operation under the Public Health Act;
(13) mixing substances to complete the preparation of a medication, according to a prescription;
(14) making decisions as to the use of restraint measures.”

4. A guide for the application of the new legislation is available on the OIIQ Website (www.oiiq.org) in the “Être infirmière” section, under the heading “Lois et règlements”: Guide d’application de la nouvelle loi sur les infirmières et les infirmiers et de la loi modifiant le Code des professions et d’autres dispositions législatives dans le domaine de la santé.
Conditions regulating the practice of reserved activities include the application of the Public Health Act and prescriptions as defined in section 39.3 of the Professional Code. Thus, a nurse may perform vaccinations without an individual or collective prescription from a physician in accordance with the Quebec Immunization Protocol. She may also initiate diagnostic measures for the purposes of a screening operation under the Public Health Act, in particular screening campaigns for sexually transmitted and blood-borne infections provided for under a public health program (OIIQ, 2003, p. 12). Furthermore, medical prescriptions may be individual or collective and may specify medications, medical treatments, examinations and care (OIIQ, 2003, p. 9). Under the Regulation respecting the standards relating to prescriptions made by a physician, a collective prescription concerns a group of individuals or clinical situations stipulated in the prescription and allows nurses and other authorized professionals, under certain conditions, to administer a medication or provide treatment, for example, without waiting for an individual prescription.

In addition to these 14 reserved activities, section 39.4 of the Professional Code lists disseminating information, promoting health and preventing illness, accidents and social problems among individuals and within families and communities.

Furthermore, section 36.1 of the Nurses Act allows nurses authorized under regulations to engage in some activities reserved to physicians in their field of specialization.

Finally, the provisions of the Professional Code authorize non-professionals, under certain circumstances or in certain settings, to engage in some activities reserved to professionals in order to better meet public needs. Appendix I presents excerpts from this enabling legislation.

While professional legislation helps define the practice of nursing within the existing professional system, other statutes also govern, albeit in a different manner, the day-to-day practice of nursing; they will be described in the last section of this document.
In Quebec, the document *Outlook on the Practice of Nursing* (OIIQ, 2007) sets forth professional standards for the practice of nursing. It includes three sections: foundations, descriptive statements and essential criteria for the practice of nursing.

**Foundations**

The foundations presented in the document refer to the beliefs and principles underlying the practice of nursing in Quebec whose core concepts – health, the person, nursing and the environment – interact with one another. In this dynamic, the goal of nursing practice is to “enable people (person, family, group or community) to take charge of their health, according to their capacities and the resources available in their environment, regardless of their stage of life and the phase of their illness. The goal of nursing practice is also to enable people to ensure their own well-being and maintain a good quality of life” (OIIQ, 2007, p. 11).

**Descriptive statements**

The descriptive statements specify the nature of practice and describe different aspects of the nurse’s role. Each category of statements includes:

1. a principle defined on the basis of the foundations;
2. anticipated client outcomes;
3. elements of practice, including the care provided to achieve these outcomes; and
4. organizational elements that can support nursing practice and help achieve the outcomes.

The descriptive statements are divided into seven categories: the nurse-client partnership, health promotion, disease prevention, the therapeutic process, functional rehabilitation, quality of life, and professional commitment.

In addition to defining the nature of nursing practice, the descriptive statements are useful for examining the effects of nursing care provided to a client in relation to the anticipated client outcomes, with a view to improving professional practice. To support the continuing improvement of the quality of practice, nurses can use the statements to enhance their individual and collective practice.

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5. This document is available in English on the OIIQ Website (www.oiiq.org) in the “Salle de presse et publications” section, under the heading “Répertoire des publications”.
Essential criteria

The essential criteria identified in the document are an application of the descriptive statements with respect to public protection. They are defined in relation to the three corresponding targets: the client, the nurse and the organization (OIIQ, 2007, p. 22). “The client is exempt from controllable pain” is an example of a statement concerning the client. The criterion “In the practice of her profession, the nurse identifies and analyses risk factors in clients and in the environment” concerns the nurse. Lastly, “The nurse, within the organization, takes measures to maintain client safety” is an essential criterion regarding the organization. One of the uses of the essential criteria is to guide the evaluation conducted as part of the professional inspection process.

In addition to being useful as a reference framework for professional inspections and the continuing improvement of nursing practice, the document *Outlook on the Practice of Nursing* underpins the reference framework for the professional examination.
According to OIIQ statistics, there were 70,181 nurses on the Roll in 2007-2008, of whom 66,191 (94.3%) were practicing nurses and 3,990 (5.7%) were not practicing or were retired. Most nurses were practicing in the public health and social services sector, and the remainder in the private sector, education and various public and parapublic organizations.

**An overview of the public sector**

The implementation of the existing health and social services system began in the 1970s with the adoption of various statutes, including the *Act respecting health services and social services*. The Act has been amended many times since then. The system consolidates the provision of health and social services within a single government department and an extensive network. Public services are planned and funded by the provincial government. In 2008-2009, the province budgeted $25.5 billion for this item, which represents 40.5% of the Quebec government’s program spending. Operations are managed by health and social services agencies and by the institutions providing services. Access to services is free and universal for all Quebecers, regardless of geographic origin or income. Scientific and technological developments and constantly rising costs have led to frequent restructuring. Today, the reduction in the number of beds and the length of hospital stays is noteworthy; care is no longer provided solely in hospitals, the use of ambulatory services has grown, home care is expanding, and more and more care is provided to the client in his living environment, often by the client’s family and informal caregivers. Lastly, despite constantly rising budgets, the growing needs expressed by the population are creating problems with access to services.

**Organization of the system**

Quebec’s health and social services system comprises three operational levels: the *Ministère de la Santé et des Services sociaux* (MSSS), the *agences de la santé et des services sociaux* (ASSS), and health care institutions, namely, the *centres de santé et de services sociaux* (CSSS) and hospital centres, including university centres. The relationships between the different parts of the structure of Quebec’s health and social services system are illustrated on p.13.

**The Ministère de la Santé et des Services sociaux (MSSS)**

The MSSS is responsible for planning and establishing overall priorities in the health and social services system by proposing interventions that influence the determinants of Quebecers’ health and well-being; for example, it determines orientations, defines policies, coordinates health programs and assesses results. It must also ensure that there is adequate funding to finance the priorities set.

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6. At the time this supplement was published, Quebec’s health and social services system was being reorganized to reflect a clinical approach based on two principles, i.e., integrating primary care services (general medical and social services), secondary care services (specialized medical and social services) and tertiary care services (highly specialized medical and social services) and assuming responsibility for the local population in terms of improving its health, access to services and determining what services will be provided.
A number of organizations report to the MSSS and carry out their own missions. For instance, the Régie de l’assurance maladie du Québec (RAMQ) is responsible for paying doctors, dentists and pharmacists and reimbursing the costs of drugs to claimants under the public drug insurance plan. The Institut national de santé publique (INSP) ensures that public health expertise and knowledge is shared throughout the system and uses different strategies to improve public health and well-being.

* Institutions or organizations that are not part of a CSSS
Source: www.msss.gouv.qc.ca/sujets/organisation/ssss_enbref
Health and social services agencies

Each agency in Quebec’s 18 health and social services regions is responsible for the provision of integrated health and social services by organizing one or more réseaux locaux de services (RLS) on its territory, managing resources on its territory and allocating budgets to its health and social services centres (CSSS). Each agency has different bodies to help it carry out its mission. In particular, it has a Commission médicale régionale (CMR) that advises the agency on matters such as the organization and distribution of medical services. It also has a Commission infirmière régionale (CIR) that advises on subjects such as the organization, distribution and integration of nursing care on the territory; nursing workforce planning; matters relating to accessibility and coordination of regional services involving nursing care; and innovative approaches to care and their impact on the population’s health and well-being.

Local services networks and health and social services centres

The 95 RLS consist of health and social services centres (CSSS), private medical clinics and offices, including family medicine groups (FMGs), and community organizations. The CSSS were created by merging centres locaux de services communautaires (CLSC), centres d’hébergement et de soins de longue durée (CHSLD) and centres hospitaliers de soins généraux et spécialisés (CHSGS) and offer general health services and some specialized services. In short, the CSSS are made up of a group of institutions and are responsible for providing clinical services adapted to local needs and for improving the health of the population they serve. To meet the needs of this population, the CSSS have service agreements with rehabilitation centres, university hospital centres, medical clinics, etc., as necessary.

A CSSS may have one or more of the following missions:

1. a HC (hospital centre) mission: offers, in the physical health or mental health sectors, diagnostic services, general and specialized medical care and nursing care for hospitalized patients and outpatients;

2. a CHSLD mission: offers services to persons experiencing a loss of functional or psychosocial autonomy. Services, which are offered on a temporary or permanent basis, may vary and include lodging, support, assistance and rehabilitation. Psychosocial, nursing, medical and pharmaceutical services are also provided. CHSLDs can operate day centres or day hospitals;

3. a CLSC mission: offers routine primary care in health and social services (preventive, therapeutic, rehabilitation and reintegration services) to the population of the territory it serves. Newborn health, in-home physiotherapy services, follow-up care and home care services are all part of the range of services provided. The Info-Santé CLSC service is one of the primary care services offered over the telephone by nurses; it is accessible 24 hours a day, 7 days a week, throughout Quebec (OIIQ, 1998, p. 5; OIIQ, 1999b, p. 8);
4. an RC (rehabilitation centre) mission: offers adjustment, rehabilitation and social reintegration services, as well as accompaniment and support services for family and friends; services are offered to persons who have a physical or mental impairment, behavioural, psychosocial or family difficulties, or who are suffering from alcoholism or other addictions; accompaniment and support services are also offered to their families and friends;

5. the CPEJ or CJ (*centre de protection de l’enfance et de la jeunesse* or *centre jeunesse*) mission: offers psychosocial services for young people under 18 years of age and their families, for example, child placement or family mediation; social emergency services are also offered as required by a child’s situation.

**Nursing governance**

The *Act respecting health services and social services* has recognized the position of Director of Nursing (DN) for over 30 years and the person must be a nurse. Her role, as defined in the legislation, includes supervising and monitoring the quality of nursing care. Consequently, the DN is responsible for the planning, distribution, coordination and assessment of nursing care. Reforms in the health and social services network and the professional system have also brought new challenges for nursing governance, such that the DN’s role is now more closely linked to the continuity and integration of care, the evidence-based review of clinical practices, maintaining and developing professional competence, introducing new means of interprofessional collaboration and integrating the next generation of nurses in a context of scarce resources (OIIQ, 2004, p. 31). Furthermore, the DN fulfils the different facets of her role in collaboration with other departments in the institution and with the participation of the Council of Nurses (CN).

The Act also mandates the CN representing the nurses in a health care institution to advise decision-making bodies on issues concerning quality of care. The Act stipulates that the CN fulfil its advisory role by electing an executive committee that submits recommendations to the health care institution’s executive director and board of directors on the following matters:

- general assessment of the quality of nursing practice;
- the rules of nursing care to guide clinical practice or the organization of nursing care;
- the proper distribution of nursing care in the centre;
- the scientific and technical organization of the centre;
- measures to assess and maintain nurses’ competence.
The employment sectors and clinical field of nurses

According to OIIQ statistics, on March 31, 2008, there were 65,586 nurses practicing in Quebec. Most of them (83.6%) work in the public health and social services sector: 46% in health and social services centres (CSSS), 28.3% in university or university-affiliated hospital centres and 9.2% in other public health care institutions. Another 7,170 (10.9%) are practicing in the private sector, 2,351 (3.6%) work in the education sector and 1,254 (1.9%) work in various other public and parapublic organizations.

It is also possible to practice nursing in other environments, including medical clinics, family medicine groups (FMGs) and nursing clinics where nurses offer services such as ambulatory, medical and surgical nursing care, gerontology/geriatrics care, home care, mental health care and foot care.

The two clinical fields that employ the largest number of nurses are gerontology/geriatrics and medical or surgical care. The other clinical fields are, in order of importance, emergency care, psychiatric/mental health care, intensive care, perinatal care, home support and care, perioperative care, ambulatory care and cardiology care. Note also that oncology care, end-of-life care, infection prevention and control and assessment of nursing care quality are also growth sectors. There has been a sustained increase in the number of nurses in specialized clinical fields. Lastly, the position of specialized nurse practitioner, requiring graduate studies, was recently introduced. Note that 42.3% of OIIQ members hold a university degree, while 57.7% have a diploma of collegial studies (DCS) or a hospital diploma.

Every year for the next 15 years, more than 2,000 nurses will become eligible for retirement. During this time, an equal or higher number of new nurses will have to enter the profession to ensure accessibility to care and services. This represents a considerable challenge for health care and services environments, which must ensure that experienced nurses can share their knowledge with those who are starting their career and take measures to keep nurses on the job.

The nursing workforce

In 2007-2008, the nursing workforce in the public health care system numbered 107,427 (MSSS, March 2009). Of this number, 50.4% were nurses who had completed college or university studies, 14.2% were nursing assistants with a high school diploma and 35.5% were orderlies with specific training.
Union membership

The primary mission of a union is to defend the economic and social interests of its members. It may also take on a social role; for example, in addition to defending nurses’ rights and negotiating improvements in their working conditions, the union works to improve the status of women. When a nurse works in a publicly funded institution, she must pay union dues which are deducted directly from her pay, although union membership itself is not mandatory. At present, the Fédération interprofessionnelle de la santé du Québec (FIQ) is the union with the largest number of nurses working in the system.

Professional association membership

Membership in a professional association is optional. In Quebec, there are approximately 30 professional associations, such as the Association des infirmières et infirmiers en diabétologie du Québec or the Corporation des infirmières et infirmiers de salle d’opération du Québec. These nursing associations work to establish connections between nurses in a given clinical field and to promote quality of care.
There are over 7,500,000 million people in Quebec, spread out over a vast territory. Nearly 80% of Quebec’s population lives in urban areas, almost half (48%) in the greater Montreal region where multiculturalism is more prevalent (Institut de la statistique du Québec – ISQ, 2006). The vast majority of Quebecers speak French. The Anglophone community represents 11% of Quebec’s population and Allophones, 10%.

In general, Quebecers are in favour of civil society and individual rights, and demonstrate considerable tolerance toward individual differences; this attitude is reflected in provincial legislation.

The health profile of Quebecers partly explains the services they use and determines government orientations in health matters. This section presents data on mortality rates and then exposes some important findings concerning the population’s general health and well-being.

**Mortality rates**

Quebecers, like people in most of the Western world, are living longer and longer. In 2007, 14.4% were 65 years of age or older and it is estimated that this proportion will reach 24% in 2026 (ISQ, 2008, pp. 20-21). Life expectancy at birth has improved to the point where it was 83 years for women and 78 years for men in 2004-2006 (ISQ, 2008, p. 37). Despite this finding of increased longevity, past the age of 65, people will live one-third of the rest of their lives with a moderate or severe disability (Institut national de santé publique du Québec – INSPQ, 2003). The main causes of disabilities and limitations are mental illness, respiratory problems, accidents, cardiovascular illnesses and stable osteoarticular problems.

The causes, in order of importance, of 84% of all deaths are:

1. malignant tumours, including lung cancer;
2. diseases of the circulatory system, mainly ischemic cardiopathies followed by cerebrovascular diseases;
3. diseases of the respiratory system, mainly chronic respiratory diseases and pneumonia;
4. accidental injuries;
5. diseases of the digestive system;
6. so-called “social” causes, such as AIDS, suicide, motor vehicle accidents, diabetes, alcoholism and cirrhosis (MSSS, 2001, pp. 149-151; MSSS, 2002b, p. 11).
The main health problems in Quebec: some findings

Below are some summary observations concerning the health and well-being of Quebec’s population. More explicit data are available in documents related to the *Programme national de santé publique 2003-2012* (MSSS, 2002b, 2008b) and in the document *Portrait de santé du Québec et de ses régions 2006* (INSPQ, 2006). Although the physical, social and economic environment plays a decisive role in health, these aspects are not addressed here.

With respect to maternal and infant health, the findings are as follows:

- infant and perinatal morality is declining;
- the number of elective abortions is increasing;
- the rate of teen pregnancies has been stable for some fifteen years;
- premature births are increasing, while the number of underweight babies is stable.

With respect to social health and mental health, the following observations were noted:

- conjugal abuse and crimes against the person are increasing;
- violence in the form of abuse or neglect of young people 18 years of age and under sees over 8,500 new cases taken into care every year;
- 5% of high school students have problems with drug and alcohol use;
- Quebec has one of the highest teenage suicide rates in the industrialized world. The suicide rate among young persons aged 10 to 19 is four times higher among males than among females; the proportion is similar among adults. About 3% of young people over 15 years of age have suicidal thoughts but have not acted on them;
- psychological stress affects more women than men.

With respect to accidental injuries, the data shows that:

- 4% of all deaths are related to accidental injuries;
- 50,000 annual hospitalizations are for accidental injuries and this number is constantly growing;
- falls resulting in hip fractures represent 40% of hospitalizations related to accidental injuries;
- mortality related to road accident has shown an important decrease.

With respect to infectious diseases:

- some diseases can be prevented by immunization, including measles, German measles, whooping cough, mumps, tetanus and *Haemophilus influenzae* type B infections;
- influenza (flu), for example, can affect from 300,000 to 500,000 Quebecers during a seasonal epidemic and produce complications leading to death for 1,000 to 1,500 people;
HIV/AIDS is more common among 25 to 49 year olds;
the hepatitis C virus, transmitted mainly through blood, affects about 40,000 people;
other infectious diseases are transmitted sexually, by different vectors, or result from resistance to antimicrobial agents, such as methicillin-resistant Staphylococcus aureus (MRSA).

The most commonly reported chronic health problems in Quebec are, in order of importance, non-food related allergies, back pain, high blood pressure, arthritis or rheumatism, migraines, asthma, thyroid problems, food allergies, heart disease and diabetes (INSPQ, 2006, p. 46).

Preventable chronic diseases are associated with a number of risk factors, such as smoking, excess weight, poor diet and a sedentary lifestyle:

- although there has been a decrease in the prevalence of smoking, over one-third of young people between 15 and 19 years of age and adults between 35 and 44 years of age smoke. Smoking is associated with cardiovascular and respiratory diseases and tumours;
- excess weight is due primarily to inactivity and a high-fat, high-sugar diet; the proportion of individuals with a body mass index (BMI) over 27 is rising; obesity is linked to diabetes and cardiovascular disease;
- lack of exercise is associated with excess weight, high blood pressure, cardiovascular disease, diabetes and osteoporosis.

A number of situations relating to the elderly are cause for concern:

- abuse and neglect of the elderly is an increasingly widespread phenomenon;
- the loss of autonomy associated with moderate or severe disability is estimated at 8% among adults between the ages of 65 and 74, and at 25% among those 75 years of age and older;
- the degree of functional autonomy gives rise to a number of risk factors which add to the repercussions of chronic illnesses;
- high medication use is also widespread among the elderly;
- cognitive disorders are increasing, for the number of elderly people is increasing (INSPQ, 2003).
However, positive findings reflecting the progress achieved in recent decades must also be mentioned. For instance, life expectancy has clearly been on the rise for the past 20 years, and Quebec is in line with the rest of the Western world in this regard. Fetal and infant mortality rates remain very low and deaths due to motor vehicle accidents continue to decrease; in addition, 9 out of 10 Quebecers say that they are in good, very good or excellent health, while 6 out of 10 consider themselves in very good or excellent health.

Quebec’s public health program uses these findings to determine health policy directions. The program’s objectives and activities relate to the following areas: the development of adaptation and social integration, lifestyles and chronic diseases, accidental injuries, infectious diseases, environmental health, occupational health and community development activities (INSPQ, 2006).
Changes in the configuration of the health care system have changed the distribution of users of services in health care settings. These days, care is no longer provided solely in hospitals; it may begin before and extend after hospitalization in a rehabilitation centre or in the client’s living environment. To make sure that the client, his family and friends benefit from continuing support and that their needs are met, it is important to take steps to ensure continuity of care. Collaboration is a key consideration in this respect and can take different forms.

Coordination of interventions by the multidisciplinary team and the nursing team is an integral part of nursing practice, given nurses’ close contact with clients, their families and informal caregivers and their role in accompanying them. This coordination function depends on the context of practice as well as the degree of integration of the multidisciplinary team and its functioning.

Collaboration emphasizes the sharing of information and coordination of activities by the multidisciplinary team to meet clients’ needs and ensure continuity of care. In psychiatric and geriatric settings, where the degree of cooperation and cohesion of the multidisciplinary team is often greater, multidisciplinary collaboration is likely to extend beyond the exchange of information, consultation and the coordination of activities. The team’s interventions are focused on achieving common objectives reflecting the needs and priorities of the client, his family and informal caregivers. The client, his family, informal caregivers and professionals from various disciplines share responsibility for developing the intervention plan by contributing their respective competencies and combining them in the client’s best interests. The interdisciplinary intervention plan ensures the continuity and coordination of interventions.

Collaboration with informal caregivers includes evaluating their capabilities as well as interventions to accompany them through the client’s health experience with a view to ensuring continuity of care; teaching is of key importance in this respect.

Collaboration within a nursing team consisting of nurses, nursing assistants and orderlies or home care workers serves to ensure that clients receive quality care on a continuous basis. Nurses use various means to ensure such continuity, including the therapeutic nursing plan (TNP) where she enters nursing directives to ensure the required clinical follow-up is provided. The nurse determines the TNP as well as a nursing care and treatment plan, if necessary, based on her clinical assessment and adjusts it according to the evolution of the client’s health and the treatment outcomes. She ensures that the plans are carried out by assigning tasks to team members after verifying that they have the legal authority, knowledge and skills required to perform the activities in question.

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7. The interdisciplinary intervention plan contains all the interventions planned by the interdisciplinary team, in cooperation with the client and his family, to meet the client’s needs for care, treatment and assistance during an episode of care, within and between establishments (OIIQ, 2007, p. 26).
Collaboration within a given institution and between institutions is another means of helping to ensure continuity of care. Reducing the length of hospitalization and arranging rapid transfers from the health care institution to the client’s home or living environment call for collaboration based mainly on sharing information and coordinating activities. The nurse on the nursing unit helps ensure continuity of care by providing the CLSC nurse with information on the health of a client who has just had an operation and requires care and services at home; or by communicating with the residence where the client lives to obtain basic information on his level of functional autonomy to determine the nursing care and treatment plan; or by interacting with the client’s case manager. Continuity of care may also consist in providing the liaison nurse with information on the client’s and his family’s needs, completing a form to transmit this information to the rehabilitation centre, or calling the diabetes clinic to exchange information on a recently admitted client who is being followed by the clinic.

8. Case management is an interdisciplinary method of providing care based on knowledge of the group’s needs and the achievement of results throughout the continuum of care, from prehospitalization to posthospitalization (OIQ, 1996).
The legal framework imposes obligations on nurses and influences their day-to-day practice. On the one hand, there are professional statutes and associated regulations; on the other hand, other statutes and regulations also apply to the profession, such as legislation relating to the organization of health and social services. These legal considerations, along with professional and ethical considerations, underlie nurses’ reasoning and clinical decision making. Clinical decisions regarding isolation and restraint measures and the reporting of individuals at risk of violence are just some examples of situations where these different considerations come into play in determining nurses’ professional liability.

Before looking at the applicable legislation in greater detail, we should first consider nurses’ civil liability and some of the client’s rights as a user of services.

**Nurses’ civil liability**

Nurses, like everyone else, must respect the rules of conduct that apply to them to ensure that they do not harm others (Civil Code of Québec, s. 1457). The Code of Ethics of Nurses stipulates, in fact, that nurses cannot elude their civil liability. As professionals, nurses are fully and entirely responsible for their decisions and actions (Dionne, 1993, p. 77). Nurses’ obligations with respect to their professional activities are generally an obligation of means that is analyzed from the standpoint of an objective reference standard, i.e., what a reasonably prudent, diligent and competent nurse would have done under the same circumstances. Accordingly, if the complication of a client’s condition is found to be a result of negligence on the part of the nurse who was monitoring the client, thereby establishing a link between the harm caused and the fault committed, then the nurse could be sued and could be legally liable. In this regard, ignorance of the law or of standards relating to the delivery of nursing care is no excuse. Thus it is crucial for nurses to ensure that they have the knowledge and skills necessary to make the clinical decisions required; otherwise they must ask for assistance, training or supervision. The same applies to any activities that a nurse assigns to other members of the nursing team or to non-professionals; in such cases she is responsible for verifying that the individual in question has the necessary competencies to perform these tasks. When a nurse assesses a client’s needs and gives family members or non-professional staff instructions on the care and treatment to be given, she must provide them with adequate training and ensure that they have understood and are capable of carrying out her instructions. Accordingly, she must forbid any person she considers unable to provide the necessary care from attempting to do so. The nurse must also provide clinical follow-up and periodically reassess the health of the client and the caregiver’s capability to provide the required care (OIIQ, 2003, p. 72).

Owing to nurses’ possible civil liability, the OIIQ’s board of directors adopted the *Regulation respecting professional liability insurance for nurses*, which obliges nurses to have professional liability insurance against any fault or negligence committed in the practice of their profession.
Client rights

Clients have certain legal rights that professionals must respect. These rights are defined, in particular, in the Civil Code of Québec, the Charter of Human Rights and Freedoms, the Act respecting health services and social services and in various associated regulations. For example, clients have the following legal rights:

- the right to access to their records;
- the right to non-disclosure of confidential information;
- the right to inviolability of his person.

Some applications of the statutes and regulations governing the nursing profession

This section refers to the different statutes governing the profession and various associated regulations.

Excerpts from the Charter of Human Rights and Freedoms, the Civil Code of Québec, the Act respecting health services and social services, the Act respecting Access to documents held by public bodies and the Protection of personal information, the Act respecting the protection of persons whose mental state presents a danger to themselves or to others, the Youth Protection Act and the Organization and Management of Institutions Regulation are presented in Appendix I.

The Code of Ethics of Nurses, which has force of law in Quebec, serves as a guide for nurses and imposes general and specific duties and obligations toward the public, clients and the profession, in order to protect the public and regulate unacceptable conduct within the profession. The new Code of Ethics of Nurses has been in force since January 2003. The provisions of the Code, divided into ten sections, stipulate proper professional conduct with respect to consent, the confidentiality of certain information, and professional conduct related to integrity.

The subjects addressed in the following pages are intended to serve as examples of how the above statutes and regulations shape nurses’ decision making. It should be noted, however, that a given situation may be covered by more than one section of the legislation. This is not an exhaustive list; the sections mentioned are intended merely to illustrate the legal context of the issues raised by the situations described.

9. The Code of Ethics of Nurses and the Chroniques Déonto published in Le Journal can be consulted on the OIIQ Website (www.oiiq.org) in the “Être infirmière” section, under the heading “Déontologie”.

Preparation Guide for the Professional Examination of the Ordre des infirmières et infirmiers du Québec
Supplement
Nursing in Quebec – The legal framework
Access to a user’s record and confidentiality

- Myriam, age 24, has been hospitalized for ulcerative colitis; can she consult her record and treatment plan? Her husband also wants to consult Myriam’s record. What information can he be given with respect to developments in Myriam’s health situation?

Users 14 years of age or over have right of access to their record. In some situations, however, this right may be denied; for instance, if the attending physician considers that communicating the record or any part thereof could be seriously prejudicial to the user’s health.

The law provides that the user’s record is confidential and no one may have access to it without the user’s consent. Myriam could refuse to allow her husband to be given the information in her record. Without Myriam’s consent, her husband cannot consult her record.

- Mrs. Lemieux has been hospitalized for a hemicolectomy and requires assistance to wash and get out of bed. Her record says that she is an alcoholic and comes from a centre for abused women. What type of information may the nurse give the team members responsible for Mrs. Lemieux’s hygiene care?

Only the information required to provide the necessary care may be given to the orderly assisting Mrs. Lemieux. In this case, there is no need for the orderly to know Mrs. Lemieux’s medical history or psychosocial situation to assist her with her hygiene care.

It may be necessary to give health care team members information from the client’s record if there is a danger for the client or other people. For instance, if a person is admitted for a suicide emergency, the information required to protect him should be given to the health care team responsible for monitoring his condition.

Documentation of care

- Mr. Adrian Rioux has been hospitalized for 15 days on the active geriatrics unit; his condition is stable and he is being followed by the multidisciplinary team. What data should be entered in the nurse’s notes in Mr. Rioux’s record?

The client’s record includes the nurse’s progress notes and the TNP, for which there is a documentation standard. Documenting care is a professional responsibility that helps ensure the safety and quality of care by making it possible to monitor the evolution of the client’s health situation and intervene in an appropriate and timely manner. Thus, all relevant and accurate information, specific facts and up-to-date data must be documented in the record and organized for easy access to information so as to support clinical decisions (OIIQ, 2002, pp. 7-9).
The purpose of documenting care is to communicate information to the health care team and other members of the multidisciplinary team, thereby contributing to continuity of care, as well as to ensure continuity during shift changes, breaks or when a client is transferred to another institution.

Note that from a legal point of view, and in the event of a lawsuit, the information entered in the client’s record may be very important evidence.

For nurses in private practice, a regulation stipulates the terms and conditions applying to record keeping. The Règlement sur les effets, les cabinets de consultation et autres bureaux des membres de l’Ordre des infirmières et infirmiers du Québec is available on the Order’s Website (French only).

**Consent to care**

- Mr. Thibault has just learned that he has prostate cancer and must undergo a prostate resection. He has signed his consent form for the operation. A few hours later, after a few telephone conversations with friends, he begins to question his decision. He is worried about the after-effects. He says “I didn’t think it would turn my whole life upside down. I’d like to wait and think about other possibilities.” What is the nurse’s responsibility if a client refuses care or treatment?

The law provides that every person is inviolable and is entitled to the integrity of his person. Consequently, no one may interfere with his person without his free and enlightened consent.

Consent is informed if the person receives comprehensive and complete information about both the illness and the nature of possible treatments and their effects. The person must have considered the information before making a decision and must have alternatives. A decision is free when it is made without undue coercion or pressure. It is not free if it is made under pressure in the form of a moral or physical constraint or even violence (see “Les obligations déontologiques de l’infirmière et le consentement aux soins,” Le Journal, vol. 2, no. 3, p. 6, OIQ, 2005). When a person signs a form consenting to care, he is entitled to ask the health care team questions about the nature of the treatment. The nurse attending Mr. Thibault and assisting him in understanding his health situation must ensure that the information he possesses is accurate and allows him to make a free and informed decision; otherwise, she must take steps, such as consulting his doctor, to obtain further information. Mr. Thibault may need to review the risks with his doctor so as to better assimilate the information or he may wish to postpone his decision and take more time to assess the consequences. If the person is incapable of giving free and informed consent, the law makes explicit provisions, discussed below, on capacity to give consent.
• Alexandre, age 15, underwent an open reduction of a fractured humerus after he was shoved violently during a riot. He refused to allow you to inform his parents before the surgery. The next morning, the doctor notified Alexandre’s parents. They were surprised that they had not been consulted when their son was admitted to sign the consent form for the operation.

Under the provisions of the law, a minor 14 years or older may give his consent alone to care under certain conditions. Alexandre may sign the consent form for the operation, but if he remains at the hospital for more than 12 hours, his parents must be informed that he is there.

When clients are hospitalized, they sign a general consent form and a specific consent form for any specific intervention. Ensuring that a person gives free and informed consent also means making sure that they are capable of making such decisions.

**Capacity to give consent and mandate in case of incapacity**

• Mrs. Labonté has been transferred from the residential and long-term care centre (CHSLD) to the surgical unit; she has Alzheimer’s-type dementia and has fractured a hip. The information transmitted about Mrs. Labonté includes the court-approved mandate of incapacity, which designates a mandatory, her nephew, Paul Gagnon. Can Mr. Gagnon give his consent for the surgery? What information can he be given about his aunt’s health?

Capacity to give consent is a highly relevant question in situations where the person is unable to make an informed decision. This may be a temporary or permanent situation.

With regard to protective supervision provided for by law, Quebec legislation prescribes different forms for minors and for persons of full age: advisorship to a person of full age, private tutorship, private curatorship, representation of a person of full age by the Public Curator, representation of a person of full age by a mandatory (mandate of incapacity) and tutorship for a minor. 

Individuals who may be subject to tutorship or curatorship include those with degenerative diseases, such as Alzheimer’s-type dementia; mentally impaired persons; mentally disturbed persons; and persons with various organic syndromes or a cranial injury.

The law also grants all capable individuals the right to designate representatives of their choice to take care of them and their property should they become incapable of doing so. The mandate is issued as an original notarial deed or before witnesses, and can be executed only if the person becomes incapable and the mandate is approved by the court, at the request of the mandatory designated in the mandate. The mandate ceases once the person becomes capable again and his capability is recognized by the court.

In the example at hand, the mandatory, Paul Gagnon, is Mrs. Labonté’s representative and can make decisions on behalf of his aunt. The information will be given to him. Under the mandate designating him, he will exercise his aunt’s rights, including access to her record as provided for by law.

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Consent and confinement in an institution

- Jérôme, age 18, has been brought to the hospital by the police. He is admitted with a diagnosis of paranoid schizophrenia and the doctor issues a preventive confinement order. On the unit, he is agitated and threatens the staff. He wants to leave the institution.

When there is reason to keep a client in an institution without his consent, the law provides specific rules. The provisions of the Civil Code of Québec, which are complemented by the Act respecting the protection of persons whose mental state presents a danger to themselves or to others, are intended to regulate the confinement of a person owing to his mental state. The rules are designed to ensure respect for the rights of people confined in an institution against their will, while protecting these people and those around them. The protective measures provided apply only if the person is considered dangerous enough to justify them.

In this case, Jérôme was seen by a doctor, who considered that the young man’s mental state presented a serious and immediate danger to himself or others, and placed him in preventive confinement, against his will, so that he is not allowed to leave the institution. Preventive confinement, which lasts 72 hours at most, does not prevent Jérôme’s family and friends from visiting, oblige him to accept treatment or undergo a psychiatric assessment against his will. Once the 72 hours are up, Jérôme can leave the hospital, unless a court has ordered that the confinement be extended in order to have him undergo a psychiatric assessment.

If the court decides to extend a person’s confinement to have him undergo a psychiatric assessment, preventive confinement then becomes temporary confinement (garde provisoire) and the person is not allowed to leave the hospital. Different procedures apply in this case regarding the psychiatric assessments that must be done and the resulting decisions (Civil Code of Québec, ss. 26 to 31).

Isolation and restraint measures

- Mrs. Laverdure’s violent behaviour represents an imminent danger for other clients. She intimidates clients and there is a risk that she will become violent. Measures have already been taken to prevent the violence from escalating, but in vain.
- Mr. Benoit has undergone surgery and presents with delirium of infectious origin; he is agitated, confused and at a high risk of falls. He has no family or friends available to stay with him at the hospital; his family wants to prevent a fall at all costs and approves the use of restraints.

The use of restraints and isolation as control measures is a sensitive issue, since it overrides certain human rights. The decision to use these measures must balance the need for them against the risk of possible abuse. Like other issues relating to health care delivery, both ethical and legal considerations come into play. In an institution within the meaning of the Act respecting health services and social services, section 118.1 of the Act stipulates that the use of such measures must be minimal and resorted
to only exceptionally, and must be appropriate having regard to the person’s physical and mental state. These measures are intended only to prevent individuals from inflicting harm upon themselves or others. The use of any such measures must be noted in detail in the client’s record. Finally, the institution must adopt a procedure for the application of such measures and make it known to users. Guiding principles applicable to control measures are listed in Appendix II. Accordingly, the institution’s procedure for the application of such measures must be consulted.

Given the imminent risk of Mrs. Laverdure becoming violent and the failure of the alternative measures taken to prevent the violence from escalating, it would be justifiable to administer the appropriate medication PRN, but also to isolate her until the medication has taken effect. This is an unplanned intervention, meaning that the situation must be analyzed after the fact.

As for Mr. Benoit, the use of restraints calls for a thorough assessment of his health situation and the prior use of alternative measures, close supervision and constant reassessment of their appropriateness, if applicable. If restraints prove necessary, they must be used for as short a time as possible, so as not to unjustly interfere with the client’s freedom or compromise his safety. Since June 1, 2003, the decision to use restraint measures is one of the activities reserved to nurses and no longer requires nurses to obtain a medical prescription. However, this reserved activity is part of a systematic approach aimed at reducing the use of restraints by first applying effective and efficient replacement options that are respectful of the individual and his autonomy, environment and friends and family (OIIQ, 2003, p. 39).

**Emergencies**

- Mr. Bruneau’s physical condition indicates that he is at risk of imminent shock. There is no medical prescription for an intravenous infusion. Is it possible to insert a catheter in a peripheral vein and set up an infusion in order to intervene quickly if necessary?

This is a true emergency, since there is a risk of Mr. Bruneau’s veins collapsing, which would make it difficult to insert a catheter if it is not done immediately; this could compromise later treatments and thereby endanger Mr. Bruneau’s life or integrity. Section 2 of the *Charter of Human Rights and Freedoms* and the first paragraph of section 13 of the *Civil Code of Québec* provide that protecting a person’s life and physical integrity requires that assistance be given and the required care provided when his life is in danger. A nurse is therefore authorized to perform an act that is not reserved to her, in an emergency, if she has the necessary knowledge to do so and no professional authorized by law is able to intervene immediately (OIIQ, 2003, p. 14).

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11. Until the *Act to amend the Professional Code and other legislative provisions as regards the health sector* came into effect, the decision to use isolation measures required a medical prescription.
Risk of neglect or violence

- What is the nurse’s obligation if she believes that a child’s security and development are endangered because its family has failed to provide appropriate care or because she suspects maltreatment?

If a nurse has reasonable grounds to believe that a child under 18 years of age is a victim of sexual abuse or physical maltreatment through neglect, it is her duty to report this situation to the director of youth protection in accordance with section 39 of the *Youth Protection Act*. In such cases, the Act provides that professional secrecy does not apply and that anyone who makes such a report in good faith cannot be prosecuted. Such situations call for prudence and the nurse may seek support from the multidisciplinary team.

**Controlled Drugs and Substances Act**

- Mr. Jean Arpin needs relief from pain that he rates at moderate to severe. The medical prescription is for an opiate PO. Why is the medication not kept in his personal locker?
  - What requirements apply to the handling of narcotics in a health care institution?

In a health care institution, certain drugs and other substances are subject to strict rules governing their storage, distribution and administration. Local procedures are instituted to fulfil legal obligations. Opiates, for instance, must be kept under lock and key; medications other than controlled substances, such as sedatives and anxiolytics, may be kept in the narcotics cabinet. Depending on institutional policy, there is usually a designated nurse on the unit who has access to narcotics. Their use is regulated by strict standards, including regular inventory and the requirement that a witness be present if only a portion of the dose of a controlled substance is administered; the witness must sign to guarantee that the unused portion has been disposed of.

The above examples are intended to show how statutes and regulations can shape nursing practice. Day-to-day reality is often more complex and requires nurses to examine many factors when making decisions, variables that the above examples could not cover. Consequently, nurses must always take professional and legal considerations into account in their decisions.
36. The practice of nursing consists in assessing a person’s state of health, determining and carrying out the nursing care and treatment plan, providing nursing and medical care and treatment in order to maintain or restore health and prevent illness, and providing palliative care.

The following activities in the practice of nursing are reserved to nurses:

1. Assessing the physical and mental condition of a symptomatic person;
2. Providing clinical monitoring of the condition of persons whose state of health is problematic, including monitoring and adjusting the therapeutic nursing plan;
3. Initiating diagnostic and therapeutic measures, according to a prescription;
4. Initiating diagnostic measures for the purposes of a screening operation under the Public Health Act (chapter S-2.2);
5. Performing invasive examinations and diagnostic tests, according to a prescription;
6. Providing and adjusting medical treatment, according to a prescription;
7. Determining the treatment plan for wounds and alterations of the skin and teguments and providing the required care and treatment;
8. Applying invasive techniques;
9. Participating in pregnancy care, deliveries and postpartum care;
10. Providing nursing follow-up for persons with complex health problems;
11. Administering and adjusting prescribed medications or other prescribed substances;
12. Performing vaccinations as part of a vaccination operation under the Public Health Act;
13. Mixing substances to complete the preparation of a medication, according to a prescription; and
14. Making decisions as to the use of restraint measures.

36.1. Nurses may, if they are so authorized by regulations under subparagraph b of the first paragraph of section 19 of the Medical Act (chapter M-9) and under paragraph f of section 14 of this Act, engage in one or more of the following activities referred to in the second paragraph of section 31 of the Medical Act:

1. Prescribing diagnostic examinations;
2. Using diagnostic techniques that are invasive or entail risks of injury;
3. Prescribing medications and other substances;
(4) prescribing medical treatment; and
(5) using techniques or applying medical treatments that are invasive or entail risks of injury.

**Charter of Human Rights and Freedoms**

R.S.Q., c. C-12

Excerpts

5. Every person has a right to respect for his private life.
9. Every person has a right to non-disclosure of confidential information.

No person bound to professional secrecy by law and no priest or other minister of religion may, even in judicial proceedings, disclose confidential information revealed to him by reason of his position or profession, unless he is authorized to do so by the person who confided such information to him or by an express provision of law.

The tribunal must, *ex officio*, ensure that professional secrecy is respected.

**Civil Code of Québec**

S.Q. 1991, c. 64

Excerpts

11. No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

14. Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.

A minor 14 years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over 12 hours, the person having parental authority or tutor shall be informed of that fact.

17. A minor 14 years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects.
18. Where the person is under 14 years of age or is incapable of giving his consent, consent to care not required by his state of health is given by the person having parental authority or the mandatary, tutor or curator; the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave and permanent effects.

26. No person may be confined in a health or social services institution for a psychiatric assessment or following a psychiatric assessment concluding that confinement is necessary without his consent or without authorization by law or the court.

Consent may be given by the person having parental authority or, in the case of a person of full age unable to express his wishes, by his mandatary, tutor or curator. Such consent may be given by the representative only if the person concerned does not object.

27. Where the court has serious reasons to believe that a person is a danger to himself or to others owing to his mental state, it may, on the application of a physician or an interested person and notwithstanding the absence of consent, order that he be confined temporarily in a health or social services institution for a psychiatric assessment. The court may also, where appropriate, authorize any other medical examination that is necessary in the circumstances. The application, if refused, may not be submitted again except where different facts are alleged.

If the danger is grave and immediate, the person may be placed under preventive confinement, without the authorization of the court, as provided for in the Act respecting the protection of persons whose mental state presents a danger to themselves or to others.

28. Where the court orders that a person be placed under confinement for a psychiatric assessment, an examination must be carried out within 24 hours after the person is taken in charge by the institution or, if the person was already under preventive confinement, within 24 hours of the court order.

If the physician who carries out the examination concludes that confinement in an institution is necessary, a second psychiatric examination must be carried out by another physician within 96 hours after the person is taken in charge by the institution or, if the person was already under preventive confinement, within 48 hours of the court order.

If a physician reaches the conclusion that confinement is not necessary, the person must be released. If both physicians reach the conclusion that confinement is necessary, the person may be kept under confinement without his consent or the authorization of the court for no longer than 48 hours.
29. A psychiatric examination report must deal in particular with the necessity of confining the person in an institution if he is a danger to himself or to others owing to his mental state, with the ability of the person who has undergone the examination to care for himself or to administer his property and, where applicable, with the advisability of instituting protective supervision of the person of full age.

The report must be filed with the court within seven days of the court order. It may not be disclosed, except to the parties, without the authorization of the court.

30. Confinement in an institution following a psychiatric assessment may only be authorized by the court if both psychiatric reports conclude that confinement is necessary.

Even if that is the case, the court may not authorize confinement unless the court itself has serious reasons to believe that the person is dangerous and that the person’s confinement is necessary, whatever evidence may be otherwise presented to the court and even in the absence of any contrary medical opinion.

30.1. A judgment authorizing confinement must also set the duration of confinement.

However, the person under confinement must be released as soon as confinement is no longer justified, even if the set period of confinement has not elapsed.

Any confinement required beyond the duration set by the judgment must be authorized by the court, in accordance with the provisions of article 30.

31. Every person confined in and receiving care in a health or social services establishment shall be informed by the establishment of the program of care established for him and of any important change in the program or in his living conditions.

If the person is under 14 years of age or is incapable of giving his consent, the information is given to the person who is authorized to give consent to care on his behalf.

35. Every person has a right to the respect of his reputation and privacy.

No one may invade the privacy of a person without the consent of the person unless authorized by law.

37. Every person who establishes a file on another person shall have a serious and legitimate reason for doing so. He may gather only information which is relevant to the stated objective of the file, and may not, without the consent of the person concerned or authorization by law, communicate such information to third persons or use it for purposes that are inconsistent with the purposes for which the file was established. In addition, he may not, when establishing or using the file, otherwise invade the privacy or damage the reputation of the person concerned.
41. Where the law does not provide the conditions and modalities of exercise of the right of examination or rectification of a file, the court, upon application, determines them.

Similarly, if it becomes difficult to exercise those rights, the court, upon application, settles the difficulty.

**An Act respecting health services and social services**

*R.S.Q., c. S-4.2*

**Excerpts**

9. No person may be made to undergo care of any nature, whether for examination, specimen taking, treatment or any other intervention, except with his consent.

Consent to care or the authorization to provide care shall be given or refused by the user or, as the case may be, his representative or the court, in the circumstances and manner provided for in articles 10 and following of the Civil Code.

12. The right of any person which are recognized under this Act may be exercised by a representative

The following persons are presumed to be representatives, according to the circumstances and subject to the priorities provided for in the Civil Code:

1. the holder of parental authority of a user who is a minor or the user’s tutor;
2. the curator, tutor, spouse or close relative of a user of full age under legal incapacity;
3. an authorized person mandated by the incapable user of full age before his incapacity;
4. a person proving that he has a special interest in the user of full age under legal incapacity.

17. Every user 14 years of age or over has right of access to his record. However, the institution may deny him access to it temporarily if, on the advice of his attending physician or the physician designated by the executive director of the institution, communication of the record or any part thereof would likely be seriously prejudicial to the user’s health. In that case, the institution, on the recommendation of the physician, shall determine the time at which the record or the part thereof to which access has been denied can be communicated to the user, and notify him thereof.

18. No user is entitled to be informed of the existence or be given communication of information concerning him furnished by a third person which is contained in his record, where knowledge of the existence or the communication thereof would make it possible to identify the third person, unless that person has agreed in writing to the disclosure of the information and of its source to the user.
The first paragraph does not apply where the information was furnished by a health or social services professional or by an employee of an institution in the performance of his duties. For the purposes of this paragraph, trainees, including medical residents, shall be regarded as health or social services professionals.

19. The record of a user is confidential and no person may have access to it except with the consent of the user or the person qualified to give consent on his behalf. Information contained in a user’s record may, however, be communicated without the user's consent

(1) on the order of a court or a coroner in the exercise of the functions of office;

(2) at the request of the local service quality and complaints commissioner under section 36, of a medical examiner under the third paragraph of section 47, of a review committee referred to in section 51 or one of its members under the second paragraph of section 55, of a regional service quality and complaints commissioner under section 69, of a council of physicians, dentists and pharmacists or of an expert from outside the institution that the council calls on under the second paragraph of section 214;

(3) at the request of a person designated by an agency to carry out an inspection under the second paragraph of section 413.2 or at the request of an agency or of a person designated by an agency to conduct an inquiry under the second paragraph of section 414;

(4) to the Minister under section 433 for the exercise of the Minister’s functions under section 431;

(5) to a person authorized to make an inspection under the second paragraph of section 489 or section 489.1;

(6) to a person designated by the Government under the second paragraph of section 500 to investigate a matter referred to in the first paragraph of that section;

(7) in the cases and for the purposes set out in sections 19.0.1, 19.0.2, 19.0.3, 19.2 and 27.1, in the second paragraph of sections 78.1 and 107.1, in the fifth paragraph of section 108, in the second paragraph of section 185.1, in section 204.1, in the fourth paragraph of section 349.3, in sections 520.3.0.1 and 520.3.1 and in the first paragraph of section 520.3.2;
(8) at the request of a revisory committee referred to in section 41 of the Health Insurance Act (chapter A-29) under section 77, or of a person or committee referred to in section 192 of the Professional Code (chapter C-26), if necessary to carry out their duties;

(9) for the purposes of the Public Health Act (chapter S-2.2);

(10) in the cases and for the purposes set out in sections 8 and 9 of the Act to protect persons with regard to activities involving firearms (chapter P-38.0001);

19.0.1. Information contained in the record of a user may be communicated, in order to prevent an act of violence, including a suicide, where there is reasonable cause to believe that there is an imminent danger of death or serious bodily injury to the user, another person or an identifiable group of persons.

The information may in such case be communicated to any person exposed to the danger or that person’s representative, and to any person who can come to that person’s aid. The information may only be communicated by a person or a person belonging to a class of persons authorized by the director of professional services or, failing such a director, by the executive director of the institution.

The persons so authorized may only communicate such information as is necessary to achieve the purposes for which the information is communicated.

The executive director of the institution must, by a directive, determine the terms and conditions according to which the information may be communicated. Every person authorized to communicate the information is required to comply with the directive.

19.0.2. In order to ensure that the information contained in its local files or index is accurate, up-to-date and complete, or, if necessary, to verify a person’s eligibility under the health insurance plan established by the Health Insurance Act (chapter A-29) or the hospital insurance plan established by the Hospital Insurance Act (chapter A-28), an institution may send the following information contained in a user’s record to the Régie de l’assurance maladie du Québec: the name, date of birth, sex, address, language code, health insurance number, telephone number, unique identification number, date of death and social insurance number of each user or insured person of the institution, and the names of the mother and father or, if applicable, the legal representative of each user or insured person. The social insurance number may not be transmitted except for the purpose of verifying its validity or facilitating the transfer of the other information.
The Régie must destroy the local files or index containing the information that is communicated to it under this section for cross-matching with its register of insured persons.

19.0.3. An institution that transfers a user to another institution must send the other institution a summary of the information necessary to take the user in charge within 72 hours after the transfer.

19.1. Consent to a request for access to a user’s record for study, teaching or research purposes must be in writing; in addition, it must be free and enlightened and given for specific purposes. Otherwise, it is without effect.

The consent is valid only for the time required for the attainment of the purposes for which it was granted or, in the case of a research project approved by an ethics committee, for the period determined, where that is the case, by the ethics committee.

19.2. The director of professional services of an institution or, if there is no such director, the executive director may authorize a professional to examine the record of a user for study, teaching or research purposes.

Before granting such authorization, the director must, however, ascertain that the criteria determined under section 125 of the Act respecting Access to documents held by public bodies and the Protection of personal information (chapter A-2.1) are satisfied. If the director is of the opinion that the professional’s project is not in compliance with generally accepted standards of ethics or scientific integrity, the director must refuse to grant the authorization.

The authorization must be granted for a limited period and may be subject to conditions. It may be revoked at any time if the director has reason to believe that the authorized professional is violating the confidentiality of the information obtained or is not complying with the conditions imposed or with generally accepted standards of ethics and scientific integrity.

20. A user under 14 years of age is not entitled, at the time of an application for information or rectification, to be informed of the existence or to be given communication of information of a medical or social nature concerning him that is contained in his record, except through his advocate within the framework of a judicial proceeding.

Nothing in the first paragraph shall restrict normal communication between a user and a health or social services professional or an employee of an institution. For the purposes of the first paragraph, trainees, including medical residents, shall be regarded as health or social services professionals.
21. The holder of parental authority is entitled to have access to the record of a user who is a minor. However, an institution shall refuse to give the holder of parental authority access to the record of a user who is a minor where

(1) the user is under 14 years of age, an intervention within the meaning of section 2.3 of the Youth Protection Act (chapter P-34.1) has been made in his regard or a decision respecting him has been made under the said Act, and the institution, after consulting the director of youth protection, determines that communication of the record of the user to the holder of parental authority will or could be prejudicial to the health of the user;

(2) the user is 14 years of age or over and, after being consulted by the institution, refuses to allow his record to be communicated to the holder of parental authority and the institution determines that communication of the record of the user to the holder of parental authority will or could be prejudicial to the health of the user.

22. The tutor, curator, mandatary or the person who may give his consent to care for a user is entitled to have access to the information contained in the record of the user to the extent that such communication is necessary for the exercise of that power.

Any person who attests under oath that he intends to apply for the institution or review of protective supervision for a user or the homologation of a mandate given by the user for the eventuality of his inability, is entitled to have access to the information contained in the medical and psychosocial assessment of the user, if the assessment determines that the user is unable to care for himself and administer his property. Only one applicant has a right of access to such information.

23. The heirs, legatees by particular title and legal representatives of a deceased user are entitled to be given communication of information contained in his record to the extent that such communication is necessary for the exercise of their rights in such capacity. The same applies to the person entitled to the payment of a benefit under an insurance policy on the life of the user or under a pension plan of the user.

The spouse, ascendants or direct descendants of a deceased user are entitled to be given communication of information relating to the cause of death of the user, unless the deceased user entered in writing in his record his refusal to grant such right of access.

The holder of parental authority is entitled to be given communication of the information contained in the record of a user under 14 years of age even if the user is deceased. However, that right of access does not extend to information of a psychosocial nature.

Notwithstanding the second paragraph, persons related by blood to a deceased user may be given communication of information contained in his record to the extent that such communication is necessary to verify the existence of a genetic or hereditary disease.
118.1. Force, isolation, mechanical means or chemicals may not be used to place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must be appropriate having regard to the person's physical and mental state.

Any measure referred to in the first paragraph applied in respect of a person must be noted in detail in the person's record. In particular, a description of the means used, the time during which they were used and a description of the behaviour which gave rise to the application or continued application of the measure must be recorded.

Every institution must adopt a procedure for the application of such measures that is consistent with ministerial orientations, make the procedure known to the users of the institution and evaluate the application of such measures annually.

**Organization and Management of Institutions Regulation**

**R.S.Q., c. S-5, r.3.01**

**Excerpts**

**50.** Every institution shall keep an individual record for each beneficiary who obtains services from it, except in cases covered by sections 45 and 51.

The information required from the beneficiary under section 23 shall be kept in the record.

Nothing in this Regulation shall be interpreted as excluding the use of data processing or any other technique for setting up and keeping files on beneficiaries in an institutions.

**51.** Where an institution provides services to a registered beneficiary, that institution is not required to open a record, but it shall enter the name of the beneficiary and the nature of the services provided in a register kept for that purpose.

An institution providing school health services is not required to open a record for persons receiving no other services.

Services supplied to a worker under the Act respecting Occupational Health and Safety (R.S.Q., c. S-2.1), do not require the opening of a record within the meaning of this Regulation.
53. The record kept by a hospital centre shall include:

(1) report of outpatient services;
(2) medical observation, physical examination, provisional diagnosis and dental examination;
(3) prescriptions;
(3.1) a record of the preparation and administering stages of medication;
(4) progress notes by physicians, dentists, pharmacists and members of the clinical staff;
(5) report on the need for close treatment and on the capacity of the person to manage his property made under the Mental Beneficiaries Protection Act (R.S.Q., c. P-41) and reviews thereof;
(6) requests for and reports on consultation;
(7) requests for and reports on treatment;
(8) summary of interviews with professionals;
(9) items used in arriving at a diagnosis or in prescribing a treatment, such as photographs, ultrasonic pictures, X-rays as well as parts of electrocardiograms and electroencephalograms and other relevant documents;
(10) reports of diagnostic examinations;
(11) the document required by section 52.1;
(12) the document attesting that the beneficiary’s consent was obtained for the care or services provided by the hospital centre;
(13) anaesthetic procedure;
(14) pre-operation diagnosis, nature of proposed surgery, operating procedure indicating the nature of the surgery, findings, operating techniques used and description of the parts removed;
(15) anatomical-pathological report and cytological report;
(16) reports of nosocomial infection;
(17) requests for transfer;
(18) reports on accidents to beneficiaries in any institution;
(19) the summary sheet, comprising the principal diagnosis, the order diagnoses and problems, complications, medical, surgical or obstetrical treatment, special examinations and the attestation of the attending physician confirming authenticity;
(20) a note of the beneficiary’s leaving;
(21) notice of discharge by the attending physician or dentist and a note that the beneficiary has left;
(22) beneficiary’s consent for the institution to take photographs, films or recordings of him;
(23) copy of the death certificate;
(24) report of autopsy.
An Act respecting Access to documents held by public bodies and the Protection of personal information

R.S.Q., c. A-2.1

Excerpts

53. Personal information is confidential, except in the following cases:

(1) the person to whom the information relates consents to its disclosure; in the case of a minor, consent may also be given by the person having parental authority;

(2) where it relates to information obtained by a public body in the performance of an adjudicative function; the information remains confidential, however, if the body obtained it when holding a sitting in camera or if the information is contemplated by an order not to disclose, publish or distribute.

54. In any document, information concerning a natural person which allows the person to be identified is personal information.

62. Every person qualified to receive personal information within a public body has access to personal information without the consent of the person concerned where such information is necessary for the discharge of his duties.

Moreover, the person must belong to one of the categories of persons referred to in subparagraph 4 of the second paragraph of section 76 or in subparagraph 5 of the first paragraph of section 81.

Professional Code

R.S.Q., c. C-26

Excerpts

39.3. For the purposes of section 37.1 of this Code and the second paragraph of section 36 of the Nurses Act (chapter I-8), the word “prescription” means a direction given to a professional by a physician, a dentist or another professional authorized by law, specifying the medications, treatments, examinations or other forms of care to be provided to a person or a group of persons, the circumstances in which they may be provided and the possible contraindications. A prescription may be individual or collective. [ ... ]

39.4. The field of practice of the members of an order includes disseminating information, promoting health and preventing illness, accidents and social problems among individuals and within families and communities to the extent that such activities are related to their professional activities.
39.6. Notwithstanding any inconsistent provision, a parent, a childcare provider or an informal caregiver may engage in professional activities reserved to members of an order.

For the purposes of this section, an informal caregiver is a close relation who provides care and regular support, without remuneration, to another person.

39.7. The invasive care involved in assistance with activities of daily living that is required on a sustained basis for the maintenance of health does not constitute a professional activity reserved to members of an order where it is provided by a person as part of the activities of an intermediate or family-type resource referred to in the Act respecting health services and social services (chapter S-4.2) or as part of a home care program provided by an institution operating a local community service centre.

39.8. Notwithstanding any inconsistent provision, a person working for an intermediate or family-type resource referred to in section 39.7 or under a home care program provided by an institution operating a local community service centre, or a person working in a school or another temporary alternative environment for children, may administer prescribed ready-to-administer medications by oral, topical, transdermal, ophthalmic, otic or rectal route or by inhalation, and administer insulin by subcutaneous route.

39.9. The Office may, by regulation, determine places, cases and circumstances in which a person may engage in the activities described in sections 39.7 and 39.8 as well as the applicable conditions and procedures.

When drafting such a regulation, the Office must have due regard for the availability of professionals in those places, cases and circumstances and for the supervision provided by a centre operated by an institution.

Before making a regulation under the first paragraph, the Office must consult with the Minister of Health and Social Services and the professional orders concerned.

39.10. Any person acting on behalf of Héma-Québec may take blood specimens by means of pre-installed tubing.

60.4. Every professional must preserve the secrecy of all confidential information that becomes known to him in the practice of his profession.

He may be released from his obligation of professional secrecy only with the authorization of his client or where so ordered by law.

The professional may, in addition, communicate information that is protected by professional secrecy, in order to prevent an act of violence, including a suicide, where he has reasonable cause to believe that there is an imminent danger of death or serious bodily injury to a person or
an identifiable group of persons. However, the professional may only communicate the information to a person exposed to the danger or that person’s representative, and to the persons who can come to that person’s aid. The professional may only communicate such information as is necessary to achieve the purposes for which the information is communicated.

60.5. Every professional must respect the right of his client to examine documents concerning him in any record established in his respect, and to obtain a copy of such documents.

However, where authorized by law, a professional may refuse to allow access to the information contained in such a record.

60.6. Every professional must respect the right of his client to cause to be corrected any information that is inaccurate, incomplete or ambiguous with regard to the purpose for which it was collected, contained in a document concerning him in any record established in his respect.

He must also respect the right of his client to cause to be deleted any information that is outdated or not justified by the object of the record, or to prepare written comments and file them in the record.

Youth Protection Act

R.S.Q., c. P-34.1

Excerpts

38. For the purposes of this Act, the security or development of a child is considered to be in danger if the child is abandoned, neglected, subjected to psychological ill-treatment or sexual or physical abuse, or if the child has serious behavioural disturbances.

In this Act,

(a) “abandonment” refers to a situation in which a child's parents are deceased or fail to provide for the child's care, maintenance or education and those responsibilities are not assumed by another person in accordance with the child's needs;

(b) “neglect” refers to

(1) a situation in which the child's parents or the person having custody of the child do not meet the child's basic needs,

(i) failing to meet the child's basic physical needs with respect to food, clothing, hygiene or lodging, taking into account their resources;

(ii) failing to give the child the care required for the child's physical or mental health, or not allowing the child to receive such care; or
(iii) failing to provide the child with the appropriate supervision or support, or failing to take the necessary steps to provide the child with schooling; or

(2) a situation in which there is a serious risk that a child's parents or the person having custody of the child are not providing for the child’s basic needs in the manner referred to in subparagraph 1;

(c) “psychological ill-treatment” refers to a situation in which a child is seriously or repeatedly subjected to behaviour on the part of the child’s parents or another person that could cause harm to the child, and the child’s parents fail to take the necessary steps to put an end to the situation. Such behaviour includes in particular indifference, denigration, emotional rejection, isolation, threats, exploitation, particularly if the child is forced to do work disproportionate to the child’s capacity, and exposure to conjugal or domestic violence;

(d) “sexual abuse” refers to

(1) a situation in which the child is subjected to gestures of a sexual nature by the child’s parents or another person, with or without physical contact, and the child’s parents fail to take the necessary steps to put an end to the situation; or

(2) a situation in which the child runs a serious risk of being subjected to gestures of a sexual nature by the child’s parents or another person, with or without physical contact, and the child’s parents fail to take the necessary steps to put an end to the situation;

(e) “physical abuse” refers to

(1) a situation in which the child is the victim of bodily injury or is subjected to unreasonable methods of upbringing by his parents or another person, and the child’s parents fail to take the necessary steps to put an end to the situation; or

(2) a situation in which the child runs a serious risk of becoming the victim of bodily injury or being subjected to unreasonable methods of upbringing by his parents or another person, and the child’s parents fail to take the necessary steps to put an end to the situation;

(f) “serious behavioural disturbance” refers to a situation in which a child behaves in such a way as to repeatedly or seriously undermine the child's or others' physical or psychological integrity, and the child’s parents fail to take the necessary steps to put an end to the situation or, if the child is 14 or over, the child objects to such steps.
38.1. The security or development of a child may be considered to be in danger where

(a) he leaves his own home, a foster family, a facility maintained by an institution operating a rehabilitation centre or a hospital centre without authorization while his situation is not under the responsibility of the director of youth protection;

(b) he is of school age and does not attend school, or is frequently absent without reason;

(c) his parents do not carry out their obligations to provide him with care, maintenance and education or do not exercise stable supervision over him, while he has been entrusted to the care of an institution or foster family for one year.

38.2. A decision to determine whether a report must be accepted for evaluation or whether the security or development of a child is in danger must take the following factors into consideration:

(a) the nature, gravity, persistence and frequency of the facts reported;

(b) the child's age and personal characteristics;

(c) the capacity and the will of the parents to put an end to the situation in which the security or development of the child is in danger;

(d) the community resources available to help the child and the child's parents.

39. Every professional who, by the very nature of his profession, provides care or any other form of assistance to children and who, in the practice of his profession, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of section 38 or 38.1, must bring the situation to the attention of the director without delay. The same obligation is incumbent upon any employee of an institution, any teacher, any person working in a childcare establishment or any policeman who, in the performance of his duties, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of the said provisions.

Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is considered to be in danger within the meaning of subparagraphs d and e of the second paragraph of section 38 must bring the situation to the attention of the director without delay.

Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of subparagraph a, b, c or f of the second paragraph of section 38 or within the meaning of section 38.1 may bring the situation to the attention of the director.
The first and second paragraphs apply even to those persons who are bound by professional secrecy, except to an advocate who, in the practice of his profession, receives information concerning a situation described in section 38 or 38.1.
FIRST PRINCIPLE
Chemicals, restraints and isolation may be used as control measures only to ensure safety when there is an imminent risk.

SECOND PRINCIPLE
Chemicals, restraints and isolation may be used as control measures only as a last resort.

THIRD PRINCIPLE
When chemicals, restraints or isolation are used as control measures, the measure applied must be the one that is the least restrictive for the person involved.

FOURTH PRINCIPLE
Control measures must be applied with respect and with attention to the person’s dignity, safety and comfort, and must be closely supervised.

FIFTH PRINCIPLE
The use of chemicals, restraints and isolation as control measures must be regulated by procedures in each institution and monitored to ensure compliance with protocols.

SIXTH PRINCIPLE
The use of chemicals, restraints and isolation as control measures must be assessed and monitored by the board of directors of each institution.

REFERENCES

Act respecting Access to documents held by public bodies and the Protection of personal information, R.S.Q., c. A-2.1.
Act respecting health services and social services, R.S.Q., c. S-4.2.
Act respecting the protection of personal information in the private sector, R.S.Q., c. P-39.1.
Act respecting the protection of persons whose mental state presents a danger to themselves or to others, R.S.Q., c. P-38.001.
Act to amend the Professional Code and other legislative provisions as regards the health sector, S.Q. 2002, c. 33.
Civil Code of Québec, S.Q. 1991, c. 64.
Institut de la statistique du Québec (2006). La situation démographique au Québec: bilan 2006, Quebec City, ISQ.
Institut de la statistique du Québec (2008). La bilan démographique du Québec: édition 2008, Quebec City, ISQ.
Institut national de santé publique du Québec (2003). Un portrait de la santé des Québécois de 65 ans et plus, Quebec City, INSPQ.
Institut national de santé publique du Québec (2006). Portrait de santé du Québec et de ses régions 2006: les analyses, Quebec City, INSPQ.
Ministère de la Santé et des Services sociaux (2001). The Québec Health and Social Services System: A Statistical Profile, Quebec City, MSSS.
Ministère de la Santé et des Services sociaux (2002a). Orientations ministérielles relatives à l’utilisation exceptionnelle des mesures de contrôle: contention, isolement et substances chimiques, Quebec City, MSSS.
Ministère de la Santé et des Services sociaux (2007). Plan d’organisation administrative du ministère de la Santé et des Services sociaux, Quebec City, MSSS.
Ministère de la Santé et des Services sociaux (2008a). En bref: le système de santé et de services sociaux au Québec, Quebec City, MSSS.

Ministère de la Santé et des Services sociaux (March 2009). *Nombre d'infirmières en poste dans le réseau d'établissements sociosanitaires du Québec, selon la région sociosanitaire et la catégorie d'infirmière, en 2007-2008* [table], [www.msss.gouv.qc.ca/statistiques/stats_sss/index.php?id=152,214,0,0,1,0]


Ordre des infirmières et infirmiers du Québec (2002). *Énoncé de principes sur la documentation des soins infirmiers*, Westmount, OIIQ.


Ordre des infirmières et infirmiers du Québec (2004). *La gouverne des soins infirmiers dans le cadre d'une organisation de services intégrés: une contribution essentielle à la réussite du projet clinique*, Westmount, OIIQ.


REFERENCES (cont.)

Ordre des infirmières et infirmiers du Québec and Ordre des infirmières et infirmiers auxiliaires du Québec (2005). *Orientations pour une utilisation judicieuse de la Règle de soins infirmiers*, Westmount, OIIQ.

*Organization and Management of Institutions Regulation*, S.Q., c.S-5, r. 3.01.
*Règlement sur les effets, les cabinets de consultation et autres bureaux des membres de l’Ordre des infirmières et infirmiers du Québec*, S.Q., c.I-8, r. 7.01.
*Règlement sur les normes relatives aux ordonnances faites par un médecin*, R.Q., c. M-9, r. 11.2.
*Regulation respecting professional liability insurance for nurses*, S.Q., c. I-8, r. 3.
*Youth Protection Act*, R.S.Q., c. P-34.1.

Websites

Institut de la statistique du Québec: www.stat.gouv.qc.ca

Institut national de santé publique du Québec: www.inspq.qc.ca

Ministère de la Santé et des Services sociaux (portrait of the network): www.msss.gouv.qc.ca/sujets/organisation/ssss_enbref

Ordre des infirmières et infirmiers du Québec: www.oiiq.org


Statutes and regulations applicable to the profession of nursing in Quebec: www.oiiq.org/infirmieres/lois_reglements.asp