Patient Ombudsman
Ombudsman des patients

Investigation completed: January 2025

Investigation Summary

Delay of secondary disclosure report

This investigation summary allows Patient Ombudsman to publicly share the outcome of a formal investigation to raise awareness of important issues and specific circumstances negatively impacting health care experiences in Ontario. More importantly, the resulting recommendations are intended to be a catalyst for systemic change and improvement.

Patient Ombudsman has decided not to share identifying information so that the focus remains on the complaint, the issues, and the resulting recommendations. Only those individuals and organizations directly involved with the investigation were provided with the full investigation report. Patient Ombudsman continues to follow-up with the health sector organization on its efforts to implement these recommendations.

Complaint

A member of the complainant's family passed away at a hospital in the Toronto area in September 2020. The family requested and received a copy of the family member's electronic medical record in October 2020. On February 19, 2021, executive leaders at the hospital received a letter of complaint from the family that, according to the complainant, contained a "voluminous" number of concerns.

On September 28, 2021, members of the patient's family attended a secondary disclosure meeting with the chief of medicine, chief of pharmacy and the chief officer of patient experience (chief). The family told Patient Ombudsman that while the meeting left core issues unaddressed, the chief officer of patient experience committed to having these issues addressed and to delivering a report containing information discussed at the disclosure meeting.

Despite this commitment and the five emails the family sent to the chief officer of patient experience between October 2021 and January 2022, requesting the secondary disclosure report, the hospital did not provide the report. More than two years later, on March 12, 2024, the chief officer of patient experience reached out to the family by email with an apology for the delay and to seek clarity on next steps. The family responded that they would like a copy of the secondary disclosure report, which they still had not received. The next day the family filed a complaint with Patient Ombudsman.

In September 2024, the family sent another email to the chief officer of patient experience again requesting a copy of the secondary disclosure report. They were told by the chief officer of patient experience that they would receive a copy of the report by the hospital's self-imposed deadline of October 11, 2024. This deadline was extended by the chief officer of patient experience to October 25, 2024, and was still not met. A subsequent email from Patient Ombudsman also received no response. Patient Ombudsman followed process and initiated an investigation on November 5, 2024.

Patient Ombudsman's expectation is that hospitals communicate issues that affect patients and families as soon as reasonably possible. If there is an unavoidable delay, hospitals should communicate the reasons for the delay and identify when, approximately, the patient or family should expect the communication. Hospitals must take care to ensure any delay in providing a response does not create hardship for the person affected. None of this occurred in this case.

Investigation

Patient Ombudsman sought to obtain a copy of the secondary disclosure report, hospital policies and procedures related to disclosure of harmful events, and the internal and external communications from the chief officer of patient relations regarding this case from March 2024 to date.

Using the fairness framework, Patient Ombudsman reviewed the documents for insights into the timeliness of providing the secondary disclosure report including within the timeline cited in the disclosure policy, which is "within two weeks of [the] verbal secondary disclosure meeting."

Findings

Patient Ombudsman found the following:

Finding 1: The hospital staff did not adhere to the *Disclosure of Harmful Patient Safety Incidents* policy (10764314).

Finding 2: The delay in producing the report and sending it to the complainant was unreasonable and detracts from the credibility of the hospital's quality review process.

Finding 3: The delay in providing the secondary disclosure report to the family contributed to the family's emotional distress.

Conclusion

Patient Ombudsman concludes that the hospital's failure to provide the secondary disclosure report in a timely manner was unreasonable and unfair. The hospital did not meet the timeline set out in its disclosure policy. The family was subjected to ignored email requests, missed deadlines and prolonged grief. Patient Ombudsman believes that this would have continued had the family not filed a complaint with our office. Although Patient Ombudsman remains unclear as to why the hospital continued to promise a report that was not prepared until November 15, 2024, or after it was requested formally during this investigation, we found the substituted letter demonstrated that the hospital had begun implementation of the recommendations arising from its quality review. Patient Ombudsman acknowledges that the hospital extended apologies to this family for the long delay.

Recommendations

Review Policy and Process

1. Patient Ombudsman recommends that the hospital reviews its quality review and disclosure process to ensure that there are sufficient procedures and resources to support reasonable and timely communication with patients and families.

Education

2. Patient Ombudsman recommends that the disclosure policy be reviewed with staff prior to all secondary disclosure meetings so that staff are clear on the policy's expectations and their own responsibilities before, during and after the meeting.

Contingency Plan for Extended Absences

3. Patient Ombudsman recommends that the hospital implement a contingency coverage plan when a department leader is away on extended leave so that the leader's active responsibilities continue to be met.

Cette resource est également disponible en français.