Courage Compassion Clarity

Informing change in a time of crisis

Annual Report 2019/20 and 2020/21

Patient Ombudsman

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Land Acknowledgement

Patient Ombudsman acknowledges that, traditionally, Toronto, where our office is located, was a gathering place for many nations including the Anishinabeg, the Haudenosaunee and the Wendat peoples.

Patient Ombudsman acknowledges the area covered by Treaty 13, also known as the Toronto Purchase, and we pay respects to the Mississaugas of the Credit.

Patient Ombudsman also pays special recognition to the other lands or territory belonging to Indigenous people throughout Ontario and the traditional lands and territories where individuals who contact Patient Ombudsman may be contacting us from.

Ce rapport est également disponible en français.

Patient Ombudsman's message

As Ontario's Patient Ombudsman, it is my privilege to share this annual report with our stakeholders. It would be an understatement to say that the last two years have been challenging. The impact of the COVID-19 pandemic can be seen throughout this report, both in the information presented and the stories shared. But even with the pandemic and other challenges we faced, this nascent office remained focused on meeting an ever-growing demand for help navigating a health care system that is increasingly complex and continuously evolving.

Committed to Listening, Learning and Leading

The vision for Ontario's first health ombuds office was to be a trusted champion for fairness and to influence positive change in the health care system. Bringing that vision to life requires listening to the stories of patients and caregivers who rely on our system for their care and listening to the health care organizations and the dedicated professionals who work to provide the care. Only then can we fully understand the issues and arrive at recommendations that serve to bring about change so that others have more positive health care experiences.

To do this, our office is guided by a set of values that inform how we work. We respect the dignity, privacy and diversity of every person who comes to us and take the time to listen closely and carefully, acknowledging all experiences and perspectives. We communicate clearly in a professional, courteous way that respects all people, languages and abilities. We treat people fairly and look at every issue impartially, listening to all sides. We are empathetic and acknowledge that every experience is unique, while responding with openness and compassion. We strive to be trustworthy and accountable to the people we serve and to provide high-quality service that adapts and improves as we learn.

At its most fundamental, the work of an ombuds involves looking at what was decided, how it was decided and how people were treated before deciding if an organization acted fairly. Over the last five years, the Patient Ombudsman team has developed considerable expertise in assessing fairness, resulting in resolutions that are trusted and respected by all parties. Ideally fairness in decision-making and service delivery would be considered at the outset – when health sector organizations are designing policies and programs – so that the issues that typically give rise to complaints to our office don't occur. The 'fairness by design' concept is championed by many in Canada's ombuds community, and I wholeheartedly support this proactive approach to achieving fairness.

Hardship and Heartbreak

The COVID-19 pandemic has created no end of hardship – from the loss of loved ones and time with friends and family, to the loss of freedoms we took for granted. In our first of three special reports that look at the impact COVID-19 had on resident, patient and caregiver experiences, we aimed to quickly distill the insights from the complaints we received and reflect them back to the health care system to inform pandemic planning and decision-making. The office's ability to pivot and adjust to the challenges brought on by the pandemic is something the Patient Ombudsman team should be enormously proud of.

It was also during the pandemic that our office suffered the heartbreaking loss of our ombuds, Cathy Fooks, who passed away December 30, 2020. Cathy was a highly respected health care leader, mentor, and irrepressible champion of patients and caregivers who pushed for changes to improve the health care system for us all. We keep Cathy, her family, and her many friends and colleagues in our hearts and thoughts as we continue this important work.

Important Milestones

Overall, complaints to the office have been increasing since the office opened. As the largest health care sector, hospitals typically make up the bulk of complaints followed by long-term care and home and community care. By the end of April 2020, the office was receiving a disproportionate number of complaints about long-term care homes, pointing to the unfolding crisis in that sector. The office responded by issuing its first public call for complaints, initiating targeted outreach to key stakeholders as well as launching its first large-scale, system-level investigation of the impact of COVID-19 on the health care experience of long-term care home residents.

The initiation of a large-scale, system-level investigation was an important milestone for this office, and I look forward to sharing the results of that investigation in 2022. Through our broader investigative work and as you will see in the summary of our investigation on breakdowns in coordinated care, we have identified where gaps in oversight can make it challenging to comprehensively investigate a complainant's entire health care experience and deliver recommendations that speak to the full continuum of care. It should be a priority for all of us who are committed to improving the health care system to find ways to close these gaps, so patients and their loved ones are not caught in the middle.

The ability to report on the nature of complaints and the insights they provide is key to having impact as an ombuds. While the pandemic dominated much of the Patient Ombudsman's work during years 4 and 5, we continued to adjust our processes and invest in technology to increase our data collection and analysis capabilities so that we can report on the full breadth of health care experiences including the experiences of patients and caregivers who face challenges accessing health care due to racism, bigotry and intolerance.

Looking to the Future

When I took up my duties as Ontario's third Patient Ombudsman on March 29, 2021, I did so with the support of an exceptional team of professionals who, like me, are drawn to helping people navigate a health care system that, at times, seems anything but fair. Their hard work and dedication over these two years has allowed our office to not just survive but to also thrive.

I want to recognize the courage of the residents, patients, and caregivers who brought their concerns to us while also seeking compassion, understanding and support. I also want to recognize the thousands of professionals who work in Ontario's health care system; you have my gratitude and respect for the care you provide, sometimes under extremely challenging circumstances.

I welcome your thoughts, ideas, and insights from what you learn in this annual report.

Sincerely,

Craig Thompson
Patient Ombudsman

Remembering Cathy Fooks

Cathy Fooks was appointed as Ontario's second Patient Ombudsman on July 13, 2020 and led the office until her passing on December 30, 2020. Her integrity, kindness, humour and unparalleled dedication to excellence in health care and patient experience left a lasting legacy. Cathy continues to inspire the office's work and commitment to ensure that every experience counts.

Introduction

Patient Ombudsman opened its doors and phone lines on July 4, 2016 and began receiving complaints from patients (including long-term care home residents) and caregivers about their health care experiences. Over the last five years, we have worked hard to champion fairness in health care and listen to patients, caregivers and health sector organizations (HSOs).

The unique challenges posed by the COVID-19 pandemic and the tragic loss of our second Patient Ombudsman, Cathy Fooks, affected our ability to produce an annual report in our fourth year. Instead, this combined annual report covers both year 4 and 5 of operations while providing the opportunity to reflect on what has been accomplished in Patient Ombudsman's first five years.[1] We also look ahead at how we plan to continue adapting and improving our services to achieve better health care experiences for Ontario patients and their caregivers.

What we do

The Patient Ombudsman's authority is set out in the *Excellent Care for All Act, 2010*. Our role is to receive, respond to and help resolve complaints from current or former patients or their caregivers about their care or experiences with HSOs. The HSOs within our jurisdiction currently include public hospitals, long-term care homes and home and community care support services organizations.

The Patient Ombudsman can also undertake investigations into complaints or other matters within our jurisdiction related to patient care or experiences. We can then make recommendations to HSOs based on the findings of these investigations.

Patient Ombudsman believes that resolutions are best achieved at the point of care. As an impartial office of last resort, Patient Ombudsman can help when patients and caregivers have not been able to resolve their complaint directly through the internal complaints process with their HSO. Many of the patients and caregivers we hear from have ongoing care relationships with their HSOs. When we can, we seek to strengthen the trust and communication between patients, caregivers and health care providers.

With their consent, Patient Ombudsman works with complainants to understand their concerns, agree on the desired outcomes, gather information from health care providers and review records. Our primary focus is fairness. Sometimes our reviews indicate that HSOs have acted reasonably and made appropriate efforts to address the complainant's concerns. Other times, we will make suggestions to HSOs to address concerns and improve health care experiences for all.

Some matters are outside of Patient Ombudsman's jurisdiction. We cannot offer direct help if the complaint is about a regulated health care professional (e.g., a physician or nurse), a health care organization outside our jurisdiction (e.g., a retirement home) or if the complaint is part of another complaint proceeding (e.g., a court

[1] Patient Ombudsman's first three annual reports were based on its own unique operating year (July 1 to June 30), for this annual report, Patient Ombudsman has shifted its reporting to align with the Government of Ontario's fiscal year. The year 4 reporting covers the period from April 1, 2019, to March 31, 2020, and year 5 covers April 1, 2020 to March 31, 2021.

proceeding). When we can't provide direct help, we help patients and caregivers navigate and guide them to someone who can help.

Patient Ombudsman is required to receive complaints in writing, either through mail, email, fax or our online form. We can also take a complaint over the phone and transcribe it for those who need accommodation. Prior to the COVID-19 pandemic, Patient Ombudsman also welcomed patients and caregivers to come to our office in person to lodge a complaint.

Patient Ombudsman also operates a call centre to receive enquiries by phone.

Our Vision

To be a trusted champion for fairness and to influence positive change in Ontario's health care system.

Our Mission

We facilitate resolutions and investigate complaints involving HSOs, without taking sides, and make recommendations to improve experiences for all Ontarians.

Our Values

We are respectful.

We are considerate of the dignity, privacy and diversity of every person.

We are fair.

Everyone deserves to be treated fairly. That's why we look at every issue impartially, listening to all sides to achieve clarity and understanding.

We listen.

We take the time to listen closely and carefully, acknowledging all experiences and perspectives.

We communicate.

We communicate clearly and promptly so that every person knows what to expect. We do so in a professional, courteous way that respects all audiences, languages and abilities.

We are empathetic.

We acknowledge that every experience is unique and respond to every person with openness and compassion.

We are trustworthy.

We are accountable to the people we serve and strive to provide high-quality service that adapts and improves as we learn.

The Patient Ombudsman Team

Patient Ombudsman is made up of a team of 20 individuals with a diverse set of skills and backgrounds. The core frontline team includes seven Early Resolution Specialists and three Investigators who have backgrounds in health care delivery, human rights, health professional standards, patient relations, health equity, health administration and education. They are skilled communicators and facilitators with expertise in conflict resolution including mediation. Several are multilingual and provide service in both English and French. In 2020, Patient Ombudsman added an Early Resolution Indigenous Specialist to the team to build our capacity to provide sensitive, culturally competent services to Indigenous patients and caregivers, and support our outreach to Indigenous communities.

The frontline team is supported by administrative and operational supports, legal counsel, specialists in privacy and records management, communications and engagement, policy and research, and a small executive management team. To ensure operational efficiency, Patient Ombudsman purchases back office supports from Ontario Health, including finance, human resources, realty and information technology.

Having a broad base of expertise and experience helps us to understand the context of complaints and the perspectives of patients, caregivers and health care providers. It also helps us propose meaningful solutions to complaints and make suggestions and recommendations that will have a real and positive impact.

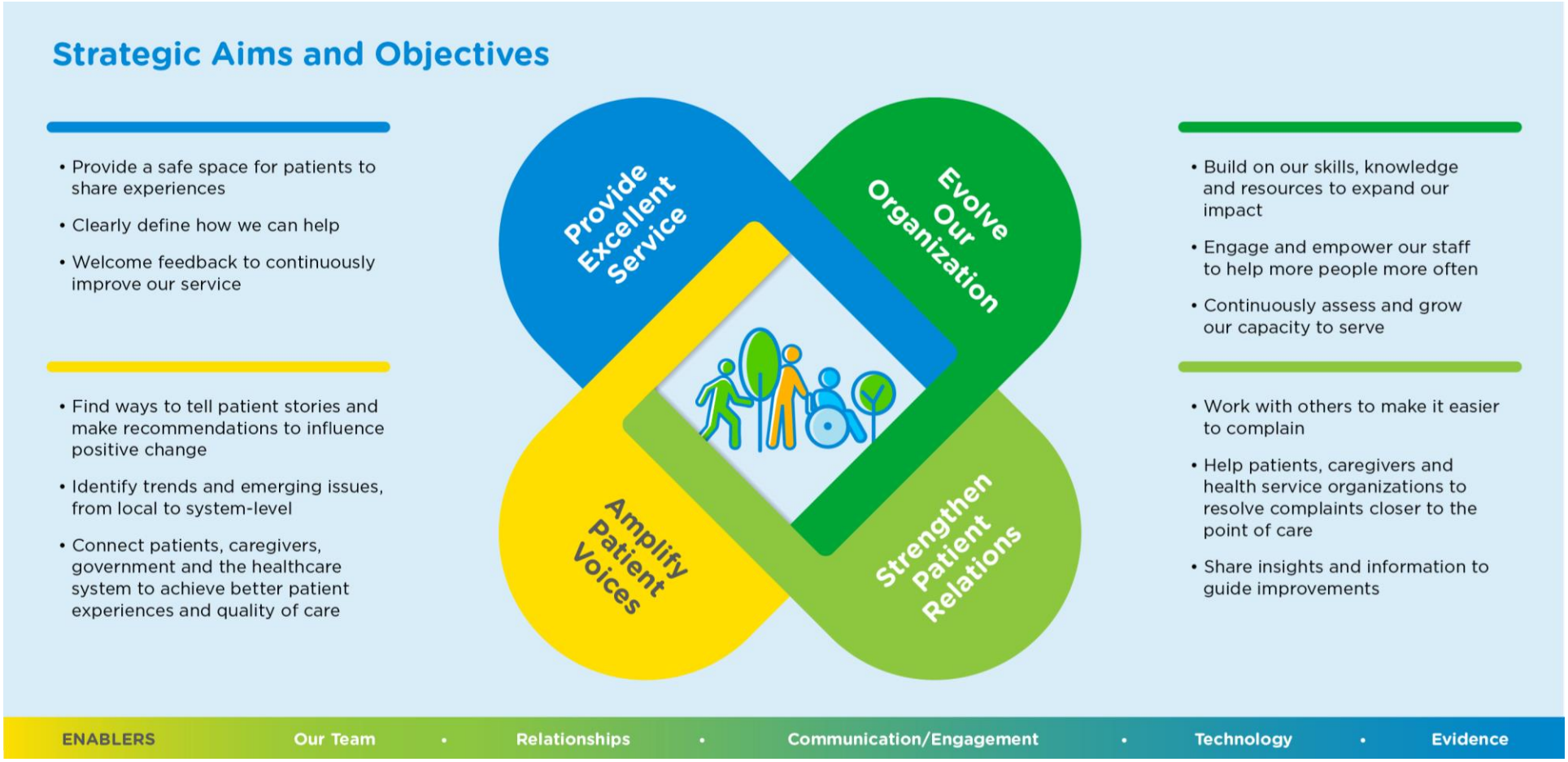
Feedback to Patient Ombudsman

My family greatly appreciates all the effort you put into helping us find answers. Thank you for your attempt even though we know that there will not be any clear-cut answers. The update you shared with us yesterday was a great step forward into understanding what happened at the hospital that night. We truly could not have gotten this far without your help.

Reflections on Patient Ombudsman's first five years

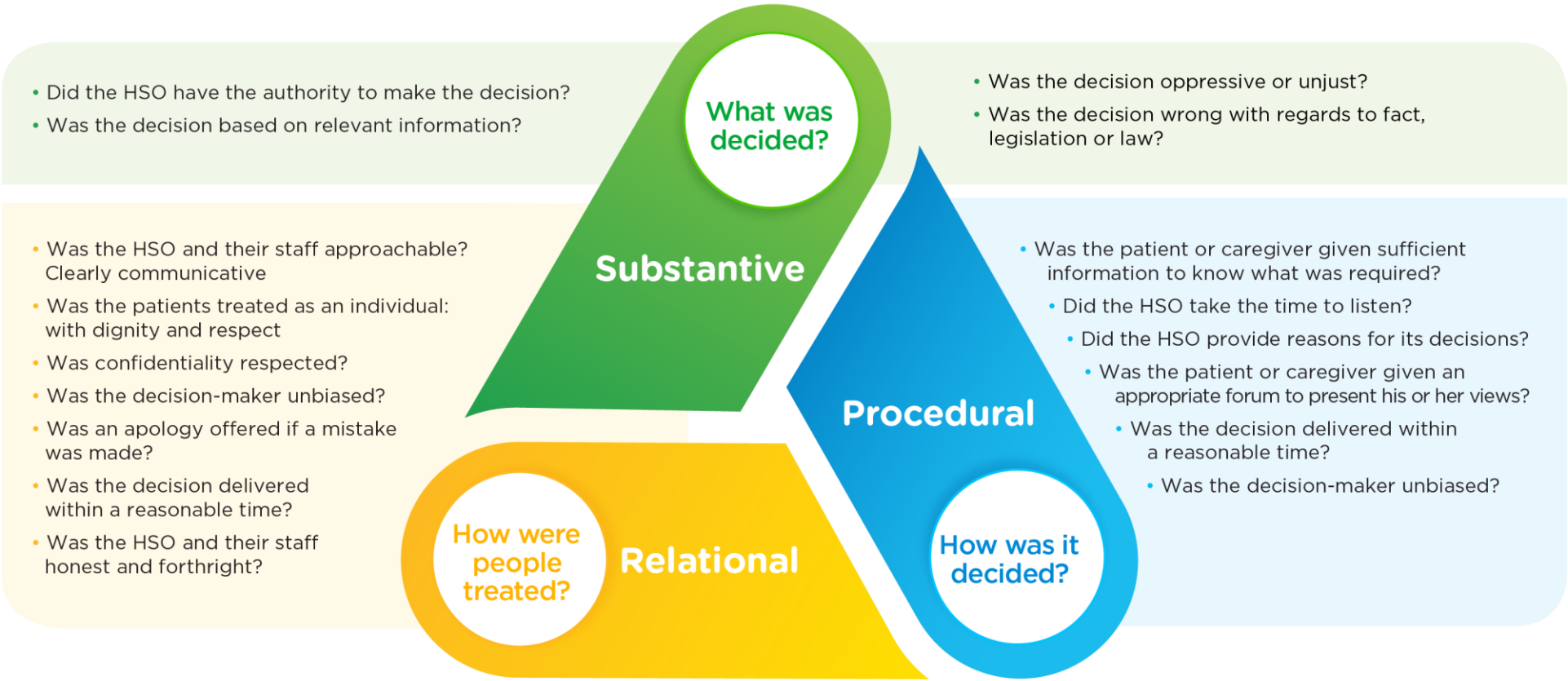
Over our first five years, Patient Ombudsman has evolved and developed our response to complaints to better meet the needs of Ontario patients and their caregivers. The foundation for our ongoing development was laid in our first three years with three significant accomplishments: the development of our first set of strategic aims and objectives; the adoption of the Fairness Triangle; and the development of our Service Charter.

Patient Ombudsman's **strategic aims and objectives**, developed in early 2018, will be reviewed and refreshed in 2022/23 to ensure a strong strategic focus going forward.



Our **Fairness Triangle** outlines a set of principles or considerations that Patient Ombudsman uses when analyzing a complaint and testing if a resolution is fair. Our Fairness Triangle is based on a tool developed by Ombudsman Saskatchewan and was developed in close consultation with our frontline complaints team as well as patients, caregivers, health care patient relations specialists and others to address our unique role in resolving and investigating complaints.

This tool has been helpful in providing transparency to HSOs about how Patient Ombudsman approaches complaints and what we are looking for in the responses of HSOs.



Our Service Charter provides greater transparency and clarity about what patients, caregivers and HSOs can expect from us, what we expect from them and how they can most effectively engage with us. We consulted with patient and caregiver advisory groups and patient relations representatives of HSOs to develop and implement the charter.

Building on these foundations, Patient Ombudsman continues to move forward by:

- Working with other oversight bodies to streamline referral processes to help patients and caregivers navigate complex system of complaints mechanisms.
- Developing our capacity to offer mediation/alternative dispute resolution services to resolve complaints and concerns.
- Learning from our initial focus complaint resolution and our insights into recurring, serious complaint issues to build our capacity to take on more, and more complex, investigations.
- Building more efficient and effective business processes for triage, case assessment, case progression and complex complaint resolution.
- Continuously improving our complaint management systems, updating our online and digital services, and enhancing our data analytics, including planning for the collection of race and socio-demographic data to help us identify and improve our service to marginalized and vulnerable populations.

Feedback to Patient Ombudsman

Thank you for this thorough report. I am satisfied with the Patient Ombudsman report/recommendations…I am pleased to see that there is clear articulation in your report of areas of opportunity…That is all I wanted - that the hospital takes responsibility of things that went wrong and look for opportunities for improvement…While it is unfortunate that it took your office to shine light into these areas, I am grateful for your effort.

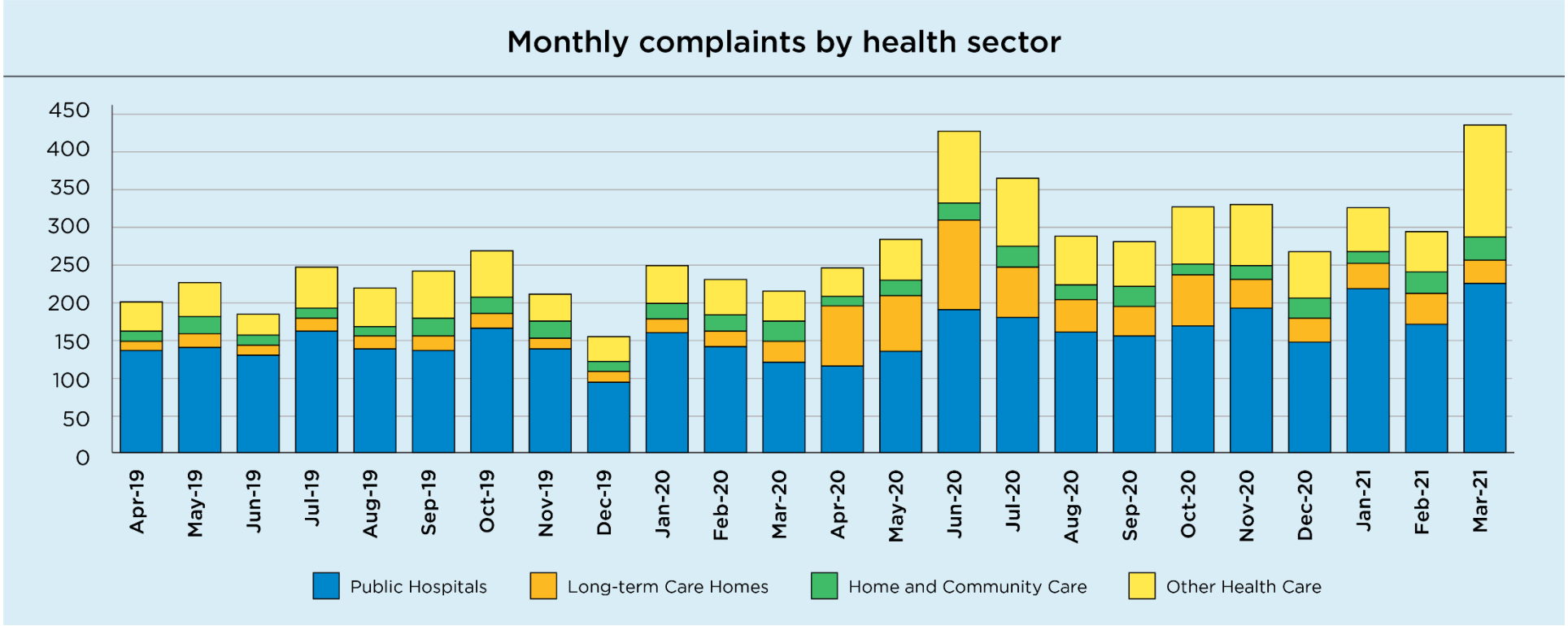
Pivoting in the face of a global pandemic

In January 2020, 10 months into Patient Ombudsman's year 4, the World Health Organization began raising awareness of a novel and highly infectious respiratory virus that had emerged in Wuhan, China. By the end of January, COVID-19 had been identified in 18 additional countries, including Canada. A global pandemic was declared on March 11, 2020.

In February 2020, Patient Ombudsman began business continuity planning to ensure that the office could maintain operations if the virus continued to spread. In addition to considering ways to keep our team safe and well-informed, Patient Ombudsman anticipated that we may be required to close the office and continue operations remotely from home. This meant ensuring we had a plan, and our team had the technology supports necessary to continue to receive complaints safely and securely by mail, email, fax and through our online web form. Given the significant impact a pandemic was likely to have on the health care experiences of patients and caregivers, Patient Ombudsman was also committed to keeping our call centre open and receiving complaints by phone. Patient Ombudsman staff began working from home in mid-March and the office was able to continue operating the call centre for complaints, in addition to maintaining other means of submitting complaints to our office.

At the end of March 2020, Patient Ombudsman began tracking a significant increase in complaints about the impact of COVID-19 on Ontario's long-term care homes. We reported weekly on complaints related to COVID-19 and shared our reports with health system leaders. The complaints highlighted serious concerns in long-term care homes, including inadequate infection prevention and control practices, lack of access to appropriate personal protective equipment, communication gaps and significant staff shortages that were affecting resident care.

Complaints about long-term care homes typically make up less than 10% of the complaints received by Patient Ombudsman. By the end of April 2020, 33% of complaints were about long-term care homes. To gain a better understanding of the complexity of these concerns, Patent Ombudsman issued its first public call for complaints on April 27, 2020. Throughout April, Patient Ombudsman also engaged in targeted outreach to the Ministry of Health, the Ministry of Long-term Care, and regional COVID-19 planning leads to share what we were hearing.



In April 2020, Patient Ombudsman also began to plan its first large-scale, system-level investigation of the impact of COVID-19 on the care and health care experience of long-term care home residents. The investigation was officially launched in June 2020, and the results will be released in 2022.

In October 2020, Patient Ombudsman released the first of three special reports on the impact of COVID-19 on the experiences of patients and caregivers. The first special report, *Honouring the voices and experiences of Long-Term Care Home residents, caregivers and staff during the first wave of COVID-19 in Ontario* focused on complaints received about long-term care homes between March and July 2020. Planning began for a second special report looking at complaints received about all three health care sectors under our jurisdiction during the second wave of the pandemic and a third report based on public surveys of resident, caregiver, and staff experience at long-term care homes.

Years 4 and 5 at a Glance

Year 4
2019/20

2,470 new complaints

From **2,215** unique patients orc aregivers

Involving **2,612** health care organizations or services

Describing **3,308** issues or concerns

1,790 complaints received by the call centre

Involving **1,859** health care organizations/services

680 formal written complaints

Involving **753** health care organizations/services

156 patients or caregivers who contacted the call centre also made a formal complaint

Year 5
2020/21

3,595 new complaints

From **3,324** unique patients orc aregivers

Involving **3,844** health care organizations or services

Describing **4,883** issues or concerns

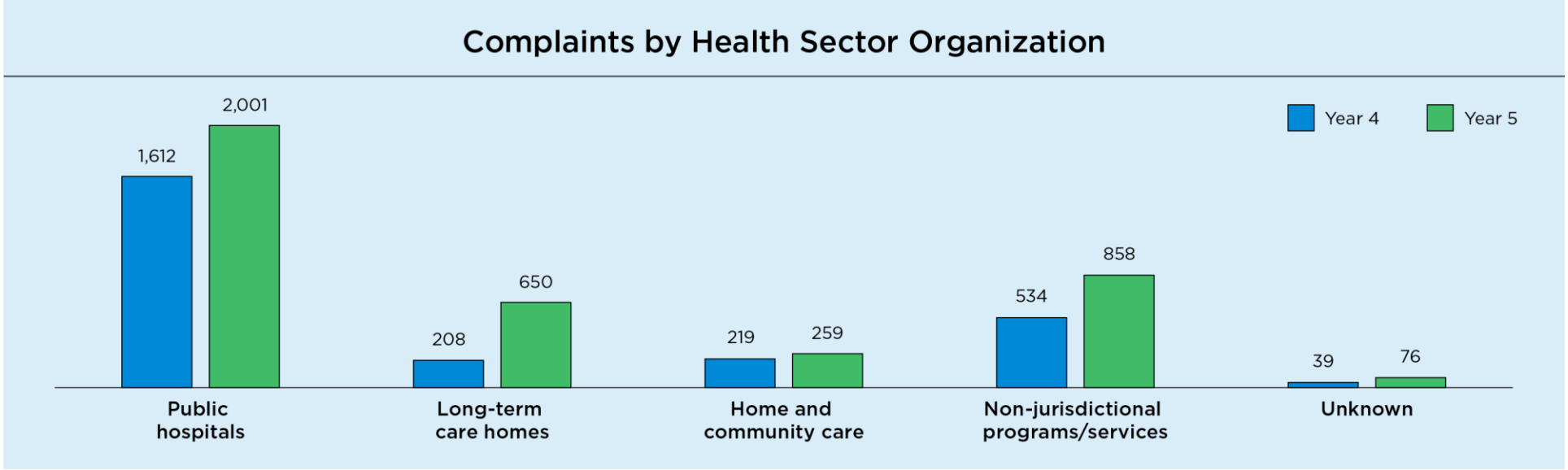
2,409 complaints received by the call centre

Involving **2,562** health care organizations/services

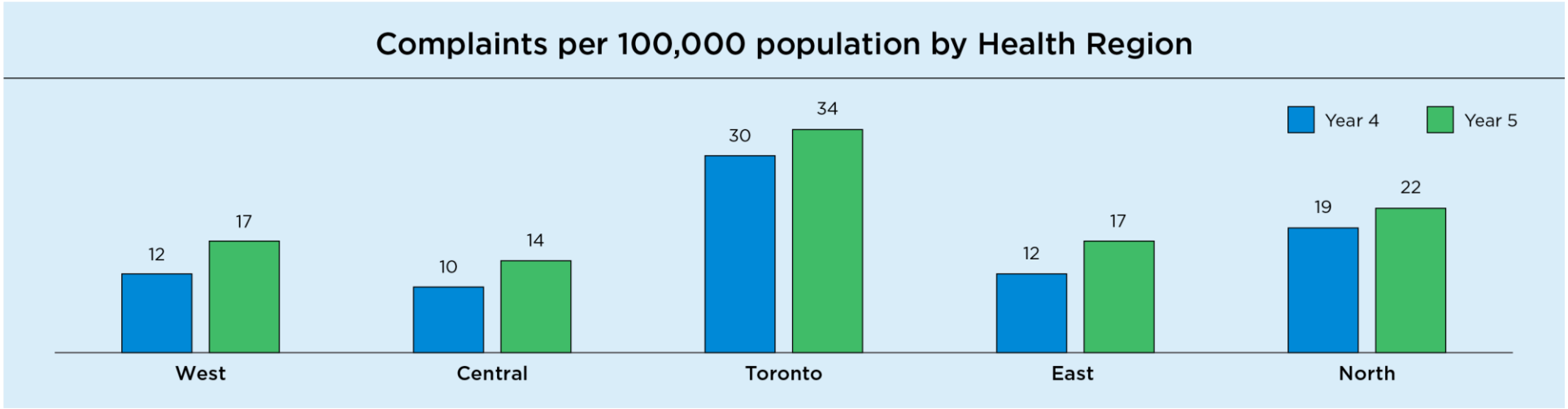
1,187 formal written complaints

Involving **1,282** health care organizations/services

203 patients or caregivers who contacted the call centre also made a formal complaint



As noted in previous years, Patient Ombudsman receives complaints from across the province. However, the office receives more complaints per 100,000 population about HSOs in the Toronto and North regions. The disproportionate number of complaints about Toronto region are largely related to complaints about hospitals and may reflect, in part, the concentration of academic teaching hospitals in Toronto that care for patients from across the province.



Most frequent concerns raised by patients and caregivers in Years 4 and 5

Public Hospitals 3,613 complaints about public hospitals Including **677** with issues related to COVID-19	**Top issues about Public Hospitals**		**Top Issues related to COVID-19**	
	Diagnosis/Treatment	**573**	Visitation	**242**
	Quality of care	**385**	Communication	**92**
	Discharge/Transfer	**381**	Discharge/Transfer	**79**
	Complaint process	**254**	Infection prevention and control	**79**
	Access or admission	**207**	Quality of care	**67**
	Sensitivity/Caring/Courtesy/Respect	**199**	Testing	**48**
Long-term Care Homes 858 complaints about long-term care homes Including **502** with issues related to COVID-19	**Top complaints about Long-term Care Homes**		**Top Issues related to COVID-19**	
	Quality of care	**90**	Visitation	**193**
	Alleged abuse/assault	**51**	Infection prevention and control	**139**
	Communication	**33**	Communication	**100**
	Personal security or safety	**31**	Staffing shortages	**89**
	Sensitivity/Caring/Courtesy/Respect	**31**	Quality of care	**74**
	Complaint process	**21**	Personal protective equipment	**50**
Home and Community Care 478 complaints about home and community care Including **96** with issues related to COVID-19	**Top complaints about Home and Community Care**		**Top Issues related to COVID-19**	
	Access* or admission	**77**	Access*	**28**
	Coordination/Continuity	**71**	Staff Shortages	**20**
	Staffing/Resources/Services	**60**	Discharge/transfer	**19**
	Communication	**31**	Infection prevention and control	**19**
	Quality of care	**26**	Communication	**8**
	Complaint process	**19**	Operational/Service/Policy	**8**

* Includes complaints about the level or amount of service

The most frequent complaints about public hospitals, long-term care homes and home and community care have remained stable over the past five years, with diagnosis/treatment as the top complaint about public hospitals, quality of care as the top complaint for long-term care homes and access or admission as the top complaint about home and community care. Complaints about access to home and community care are largely complaints from patients and caregivers who are seeking higher levels of service.

Between March 2020 and March 2021, Patient Ombudsman added additional complaint categories to identify concerns related to the COVID-19 pandemic. In hospitals and long-term care homes, concerns about restrictions on visitation were by far the most frequent complaints. Even after public health measures were relaxed and provincial policy guidance encouraged HSO to consider the important contribution loved ones make to patients' health and well-being, complaints have continued.

Patient Ombudsman saw only a modest increase in the number of complaints about home and community care, mostly related to service levels and staff shortages.

Patient Story

The complainant called Patient Ombudsman on the Friday before a long weekend with an urgent concern that a terminally ill family member was about to be discharged from hospital and the options for post-discharge care had not been discussed with the family. Patient Ombudsman made a courtesy call to the hospital's patient relations specialist to alert them to the family's concerns. The patient relations representative followed up immediately and as a result, the hospital agreed to postpone the discharge to allow an opportunity for collaborative discharge planning with the family.

How did Patient Ombudsman help?

It's challenging to capture data that fully reflects the work the frontline team engages in to resolve complaints and the results achieved. Resolutions often involve multiple conversations with complainants and HSOs to gather information, build agreement on realistic results, review health records and other documents, research solutions, facilitate information sharing and negotiate outcomes.

Some patients and caregivers simply want to be heard in the hope that by sharing their story, they can help others avoid similar experiences. Others are seeking outcomes that go beyond what Patient Ombudsman can achieve, including financial compensation or disciplining of health care providers.

During the COVID-19 pandemic, complaints are complicated by rapidly changing circumstances, evolving provincial and local public health guidance and the burden the pandemic places on the health care system, with staffing shortages and high levels of serious illness.

In many cases, Patient Ombudsman determined that the HSO had acted reasonably and had made appropriate efforts to address the patient's or caregiver's concerns. In other cases, HSOs recognized that patients and caregivers had not been treated fairly and they provided apologies, acknowledged the concerns, and made meaningful changes including policies changes, staff training, and acting on other suggestions from Patient Ombudsman.

Patient Story

The complainant's mother passed away in a long-term care home. Although the death was expected, the long-term care home did not inform the family when the resident's condition deteriorated. The family was able to be there for the hours before their mother's death only because they just happened to visit. The family asked that the home contact a clergy member for the resident, but the home did not follow-up and the family ultimately made the call themselves. The family told Patient Ombudsman they wanted to meet with the long-term care home and to have their experience acknowledged. The home did not agree to a meeting but acknowledged they had failed the family. The long-term care home made policy changes, expanded the staff authorized to contact clergy and provided training to all staff to ensure that other families would not have the same experience.

Year 4 Actions

19
Mandatory reports were made to the Ministry of Long-Term Care for reports of abuse, neglect or risk of harm

299
Courtesy calls were made to HSOs

1,719
Complainants received assistance with navigation, resulting in **2,402** referrals

923
referrals were to patient relations for complainants who had not yet completed the internal complaints process at the HSO

316
patients or caregivers were referred to online form or sent a complaint form

Reviewed records or researched information in
207 cases

Made suggestions to HSOs in
67 cases

Facilitated or participated in meetings or case conferences in
32 cases

Year 5 Actions

41
Mandatory reports were made to the Ministry of Long-Term Care for reports of abuse, neglect or risk of harm

358
Courtesy calls were made to HSOs

2,419
Complainants received assistance with navigation, resulting in **3,435** referrals

1,424
referrals were to patient relations for complainants who had not yet completed the internal complaints process at the HSO

216
patients or caregivers were referred to online form or sent a complaint form

Reviewed records or researched information in
257 cases

Made suggestions to HSOs in
33 cases

Facilitated or participated in meetings or case conferences in
59 cases,
including **2** formal mediations

Year 4 Outcomes to Complaint Enquiries

95%
of patients and caregiver who contacted the call centre received information, advice and referrals

Formal complaints were suggested in
243 cases

Information collected for the COVID-19 investigation in
2 cases

Patient Ombudsman was unable to connect with the complainant after the initial contact in
138 cases

Year 5 Outcomes to Complaint Enquiries

87%
of patients and caregiver who contacted the call centre received information, advice and referrals

Formal complaints were suggested in
207 cases

Information collected for the COVID-19 investigation in
151 cases

Patient Ombudsman was unable to connect with the complainant after the initial contact in
355 cases

Year 4 Outcomes to Formal Complaints

HSO met expectations in
144 cases

Acknowledgement by HSO
56 cases

HSO acted on PO suggestions in
45 cases

Apology provided in
30 cases

Staff education/training provided in
25 cases

Policy revised in
23 cases

Fees waived/adjusted in
12 cases

Information collected for COVID-19 investigation in
3 cases

Withdrawn by complainant in
62 cases

Year 5 Outcomes to Formal Complaints

HSO met expectations in
137 cases

Acknowledgement by HSO
47 cases

HSO acted on PO suggestions in
32 cases

Apology provided in
31 cases

Staff education/training provided in
26 cases

Policy revised in
13 cases

Fees waived/adjusted in
2 cases

Information collected for COVID-19 investigation in
114 cases

Withdrawn by complainant in
76 cases

Most common referrals

The complaints Patient Ombudsman receives are often complex and may include issues arising from experiences in multiple HSOs, or organizations both within and outside Patient Ombudsman's jurisdiction. Some issues may have been reviewed by patient relations specialists at the HSO, while others may not have been reviewed yet. Complaints often include issues related to clinical decisions or conduct that are more appropriately dealt with by a professional regulatory college. Regardless of the nature or complexity of the complaint, Patient Ombudsman looks at each issue and, when appropriate, refers patients and caregivers to other oversight bodies or services that may be able to help when we cannot.

In years 4 and 5, Patient Ombudsman made more than 2,300 referrals to patient relations specialists in HSOs for complaints or parts of complaints that were not yet ready for Patient Ombudsman's involvement. To assist patients and caregivers to connect with their HSO, Patient Ombudsman made more than 650 courtesy calls. With consent, Patient Ombudsman contacted HSO patient relations specialists to facilitate a warm hand-off and request that the HSO reach out to the patient or caregiver.

Frequent referrals	Year 4	Year 5
College of Physicians and Surgeons of Ontario	**550**	**630**
College of Nurses of Ontario	**148**	**181**
Ontario Ombudsman	**99**	**169**
Information and Privacy Commissioner	**86**	**78**
Ministry of Health/Service Ontario	**84**	**77**
Other Regulatory Colleges	**51**	**72**
Legal Services	**56**	**54**
Ministry of Long-Term Care Inspections Program/Action Line	**37**	**64**
Ontario Health/Local Health Integration Network	**14**	**81**
MPP Constituency Offices	**28**	**67**
Other Ministries	**22**	**54**
Health care/Services	**31**	**41**

Frequent referrals (continued)	Year 4	Year 5
Retirement Homes Regulatory Authority	**14**	**57**
Advocacy Centre for the Elderly	**38**	**22**
Health Services Appeal and Review Board	**28**	**30**

What services did people complain about that are outside of Patient Ombudsman's jurisdiction?

Patient Ombudsman continues to receive a significant number of complaints about health care organizations and services that are beyond its mandate. As noted above, in many cases Patient Ombudsman can assist patients and caregivers by directing them to professional regulatory colleges or other oversight bodies that can assist them. For a number of these complaints, however, there is no independent oversight organization that can help. For many, the only option is to escalate their complaints through the leadership of the organizations providing their care. Understandably, many patients and caregivers are reluctant to pursue these complaints out of concern that complaining will affect their care.

As in prior years, complaints about primary care, and in particular access to primary care, are by far the most frequent non-jurisdictional complaints that Patient Ombudsman received. A number of people reported that they had been registered on Health Care Connect for several years but had not been able to find a family doctor wiling to accept them as a patient.

The COVID-19 pandemic was a significant factor in many of the non-jurisdictional complaints received by Patient Ombudsman in year 5. This includes complaints about access to primary and other physician care, visitation restrictions in retirement homes, and challenges accessing COVID-19 testing, test results and vaccinations.

Most frequent non-jurisdictional complaints	Year 4	Year 5
Primary care	**136**	**207**
Specialist care	**43**	**94**
Retirement homes	**20**	**72**
Ontario Health/Local Health Integration Network (LHIN)-funded Community Services	**37**	**50**
Services/programs provided by other ministries	**36**	**51**
Medical care – Unspecified	**41**	**37**

Most frequent non-jurisdictional complaints (continued)	Year 4	Year 5
Public Health	**5**	**67**
Other health care professionals	**24**	**27**
Private hospitals/independent health facilities	**25**	**22**
Laboratory/diagnostic services	**14**	**32**

In addition to complaints about these services, Patient Ombudsman also received complaints about programs operated directly by the Ministry of Health (e.g., OHIP) and the Ministry of Long-Term Care (e.g., Long-Term Care Home Quality Inspection Program). If patients and caregivers were unable to resolve their concerns directly with the ministries, Patient Ombudsman provided referrals to the Ontario Ombudsman.

Patient Story

A patient contacted Patient Ombudsman to complain about inconsistent personal support services and missed visits by their home care service provider. Prior to a hospitalization they had received consistent services through a single service provider agency. As a result of the hospitalization, their regular workers had been reassigned, multiple agencies were now involved in providing care and not all of the hours approved in the care plan were being provided. The patient wanted the original plan and provider to be put back in place. After a conference call with all parties, the Home and Community Care Support Services Agency arranged for all services to be provided through a single service provider agency to improve continuity and communication. The complaint was satisfied with the outcome.

Spotlight Issues Years 4 and 5

Patient Ombudsman monitors the complaints we receive to identify emerging issues. By shining a light on these issues, Patient Ombudsman hopes to encourage HSOs to review their policies and practices and seek opportunities to improve patient and caregiver experiences. This year, the spotlight issues also share how Patient Ombudsman is adapting to improve our responses to complaints. Five spotlight issues are examined in the annual report for years 4 and 5.

The first spotlight issue presents a summary of the findings of an 'own motion' investigation that was completed in early 2021. The investigation examined the case of a vulnerable patient who was cared for by multiple HSOs, as well as an assisted living agency. Despite the involvement of multiple providers, the lack of cross-sector communication and coordination resulted in a very poor outcome for the patient. The other spotlight issues examine:

- Sexual assaults in hospitals
- Culturally competent care and complaint resolution for indigenous patients and caregivers
- Use of force by hospital security staff, and
- Continuing challenges with visitation.

Spotlight issue 1 - Investigation into breakdowns in coordinated care for a vulnerable patient

Patient Ombudsman was contacted by a hospital physician regarding a patient whose condition led the physician to believe they had experienced severe neglect. The patient was admitted to the hospital's intensive care unit in grave condition with respiratory, cardiac and neurological symptoms in addition to multiple serious pressure wounds. The physician believed that the pressure wounds must have developed over weeks or months.

Because the patient was actively receiving care from several health providers, Patient Ombudsman was concerned about how the patient could have arrived at such a state. The patient was living in supportive housing where they received daily assistance with personal care and was receiving home care professional services. They had also had several recent hospital admissions and emergency department visits. Patient Ombudsman initiated an own motion investigation to determine how this occurred and whether any deficiencies at a system level affected the patient's care.

The records reviewed and interviews conducted by Patient Ombudsman describe a vulnerable patient with a number of chronic conditions who was isolated from their family, and resistant to care and social support. They had been living in supportive housing for a couple of years, but their condition had declined markedly in the months prior to a complaint to Patient Ombudsman. As their condition deteriorated, the patient had four separate hospitalizations in just over two months and began to receive increasing levels of

home care services from the LHIN (now known as Home and Community Care Support Services (HCCSS)) above the services they were receiving from their supportive housing provider. There was also an incomplete long-term care home application.

Patient Ombudsman found a number of factors led to the patient's poor outcome:

- Unclear communication including internally within provider organizations, among providers, and between providers and the patient's substitute decision maker (SDM). In this instance, the SDM had a distant relationship with the patient that resulted in communication delays.
- Lack of clear accountability for coordinating and providing the patient's care and failure to problem solve proactively and collaboratively.
- Delay in receiving a completed long-term care home application and failure to contact the Ontario Public Guardian and Trustee (OPGT) when the delay left the patient at significant risk.
- Poor or no escalation of concerns about suitability of level of care offered through the supportive housing provider to relevant parties that could act.
- Lack of contingency planning for a vulnerable individual.
- Compounding social determinants of health, including food insecurity, income and income distribution, social exclusion, and lack of a social safety network.

Recommendations:

Patient Ombudsman made several recommendations to both the hospital and HCCSS. Patient Ombudsman also made some suggestions to the supportive housing provider that are optional because they are not within our jurisdiction. These included:

1. To protect vulnerable patients during transitions, the hospital should:
    a. Ensure SDMs are involved and notified when vulnerable patients are being discharged, no matter what setting the person is returning to.
    b. Work with other providers early on in discharge planning processes.
    c. Work to ensure that vulnerable patients are flagged to HCCSS for appropriate post-discharge follow-up.
    d. Notify HCCSS Care Coordinators when it seems like a patient is receiving HCCSS services or seeking placement in long-term care from the community.
    e. Make all inquiries needed to ensure that discharge destinations are safe.
    f. Confirm that receiving staff will be present when patients are discharged to other health care providers.
    g. Involve HCCSS in cases of admissions for geriatric "failure to thrive."
    h. Work to ensure that long-term care home planning and placement processes can begin in hospital, where appropriate.
2. To ensure patients are in receiving appropriate care and supports in the community, HCCSS should:
    a. Clarify roles and responsibilities, understand how issues can be escalated between providers and determine who is responsible for planning future care arrangements. In particular, determine when HCCSS will become the lead agency for care; manage wound care while understanding maximums in place for supportive housing providers; and ensure all parties are informed in the long-term care home placement process.
    b. Organize early care conferences among providers where there appears to be challenges in providing care and ensuring SDMs understand the risks involved.
    c. Provide additional guidance and education to staff regarding contacting the OPGT when the patient is in a crisis situation and clarifying its policies and processes on SDM availability.
    d. Do its best to ensure SDMs understand risks and timeframes for decision-making.
    e. Ensure other providers are aware of challenges in crisis placement in long-term care.
    f. Contact the OPGT within a reasonable time when there are challenges communicating with an SDM during a crisis placement into long-term care. A general timeframe of seven days would be appropriate where there is a crisis designation.

Patient Ombudsman made a number of optional suggestions to the supportive housing provider that were largely reciprocal to the suggestions made to HCCSS given the need for both providers to collaborate and engage on these issues.

Spotlight Issue 2 - Sexual Assaults in Hospitals

In years 4 and 5, Patient Ombudsman received 29 complaints reporting sexual assaults by other patients or staff in public hospitals. Most of the complaints occurred on mental health units or involved patients with a history of mental health or addictions problems, developmental disabilities, or other vulnerabilities.

Many people continue to believe that sexual assault necessarily involves violence or force, or that acquiescing to a sexual act always implies consent. This can affect the way people interact with those who report sexual assault, the kinds of questions they ask, and their responses to the answers.

This is further complicated in mental health settings, where reports are more likely to be perceived as lacking credibility or be attributed to symptoms of a patient's psychiatric condition. Depending on how the incident is discussed with patients who are reporting assault, the patient may feel interrogated or sense that the person they are reporting the incident to does not believe them.

Sexual assaults are avoidable and HSOs should take every reasonable precaution to provide safe and secure environments for their patients, staff, and visitors. All reports of sexual assault should be taken seriously and undergo an appropriate investigation. Mental health status is not a reason to approach a report of sexual assault differently than for any other patient.

When receiving a report, it is important to recognize that it's not up to a staff member or physician to believe or disbelieve a report of sexual assault or threat, but to follow a respectful and sensitive approach to receiving the information, an objective process for investigating what transpired, and to assess the safety of the care setting.

In addition to complaints about sexual assaults in hospital, Patient Ombudsman also received 18 complaints from patients who had experienced sexual assaults prior to their hospital admission and reported that insensitive care in hospitals had left them feeling retraumatized. Health care providers may not be aware of a patient's history of trauma and how past trauma can affect their experience of care, for example, when undergoing a sensitive procedure such as an anal swab, vaginal examination, or catheterization.

Adopting trauma-informed approaches to care can reduce the risk of causing further harm to patients who have experienced sexual trauma. It is particularly important to imbed trauma-informed principles and approaches in policies and practices that guide HSOs' responses to reports of sexual assault, including how complaints are managed.

Trauma and violence-informed approaches are not about 'treating' trauma…Instead, the focus is to minimize the potential for harm and retraumatization, and to enhance safety, control and resilience for all clients involved with systems or programs. These approaches benefit everyone, whether or not they've experienced trauma in their lives or their personal history is known to service providers.

Public Health Agency of Canada, 2018

How Patient Ombudsman is responding

Patient Ombudsman identified a cluster of complaints involving reports of sexual assault and insensitive care for patients with past sexual trauma. Patient Ombudsman also identified serious concerns with hospitals' responses to a number of these complaints, including

- Failure to conduct investigations following reports of sexual assault or insensitive care.
- Lack of policies and procedures to ensure appropriate follow-up on reports of sexual assault.
- Minimizing or ignoring complaints based on patients' mental health status.
- Lack of engagement with patients and limited transparency about the hospital's response.
- Insensitive communication, including blaming patients or thanking them for their feedback.
- Threatened or actual retaliation against patients who reported sexual assaults or complained to a health professions regulatory college.

In response, Patient Ombudsman dedicated one of its three investigators to review and attempt to resolve all complaints related to sexual assaults in HSOs. The goal was to ensure that complaints were addressed in a consistent, sensitive way and identify system-level opportunities to improve the response to complaints about sexual assaults.

When exploring a complaint involving sexual assault or insensitive care of a patient with past sexual trauma, the Patient Ombudsman investigator will typically begin with the Patient Relations representative and then engage any other staff, as appropriate. The investigator will explore the HSO's awareness of trauma-informed care (TIC) approaches and whether the principles of TIC are reflected in their policies and procedures, particularly policies and procedures for addressing reports about sexual assaults.

If requested, Patient Ombudsman will share resources on TIC and may suggest that the HSO consider staff and physician education on TIC. Online learning tools are available to enhance understanding of TIC policies and procedures and to ensure that TIC approaches are adopted by staff members or physicians who may hear reports of sexual assaults.

Key principles of TIC and examples of how they can be used in responding to reports of sexual assaults or insensitive care for patients with past trauma:

Safety – provide safe space for a patient to report what occurred.

Trustworthiness - listen without judgement, probe without interrogating.

Choice – engage the patient in decisions about conducting a forensic exam following sexual assault, police involvement, support person involvement in the review process. Offer supportive care and/or resources.

Collaboration – seek understanding of what transpired and how with input from patient and share information with patient transparently about what happened.

Empowerment – acknowledge the patient's courage, their contribution to create a sexually safe environment, and potential and strength to heal.

Case study 1

Patient Ombudsman received a complaint reporting a patient was sexually assaulted by another patient in the mental health unit of an acute care hospital. The complainant was concerned that the hospital did not offer a physical assessment, did not undertake a thorough investigation, and would not allow a family member to visit the patient despite the patient requesting this support.

The hospital's initial assessment was that the incident was consensual. After contact from Patient Ombudsman's investigator, the hospital requested an opportunity to take further steps to review what had occurred. The hospital confirmed that it did not have a policy on sexual safety or sexual assault reports. The investigator suggested that the hospital develop a policy and procedure and proposed that the complainant and patient be invited to provide input. The hospital agreed and followed up on the suggestions.

After the hospital completed its investigation, the complainant contacted Patient Ombudsman again. The complainant had received a generic letter from the hospital confirming the closure of the file and thanking them for their "feedback." The patient reported they had not received any information about what the hospital learned through its review.

Patient Ombudsman followed up with the hospital and reviewed the information on the hospital's investigation, the hospital's closure letter to the patient, and the hospital's new policy.

Patient Ombudsman provided the hospital with suggestions to improve its new policy, including adding principles of TIC, seeking input from a patient/family representative, and consulting with experts in sexual assault.

The hospital agreed to act on the suggestions and confirmed that a member of their leadership team would send a candid and more sensitive apology to the patient.

In addition to sharing the results of the review, the Patient Ombudsman investigator provided the patient with information about community resources for sexual assault victims.

Case study 2

A former patient contacted Patient Ombudsman about their experience as a patient in the mental health unit of a community hospital. The patient described a series of progressively worsening incidents of harassment involving sexual behaviour from another patient. They reported the other patient's behaviour to the nursing staff and their fear of being sexually assaulted, but nothing was done to prevent the other patient from approaching.

With the patient's consent, the Patient Ombudsman investigator contacted the hospital and reviewed the details of the complaint. The hospital confirmed that it had a policy and procedure concerning the handling of complaints about sexual assaults. They were unfamiliar with TIC approaches and were amenable to receiving information, which was shared by the Patient Ombudsman investigator. The investigator also inquired into the hospital's procedures for ensuring safety in the mental health setting. The hospital confirmed that there were processes in place and recognized the need to explore if they had been followed in response to this patient's experience.

At the investigator's request, the hospital representatives confirmed that they would ensure that video surveillance for dates of the patient's admission would be reviewed and retained. They also agreed to immediately undertake an inquiry with the mental health unit to ensure that patient safety standards were being adhered to. A video conference with the patient was arranged to support a sensitive hand-off from Patient Ombudsman back to hospital Patient Relations representative to complete the resolution process.

Resources:

BC Provincial Mental Health and Substance Use Planning Council, *Trauma Informed Practice Guide*,, May 2013.

Public Health Agency of Canada, *Trauma and violence-informed approaches to policy and practice*, February 2018.

Barnes, B., Addressing Sexual Violence in Psychiatric Facilities, Psychiatric Services 71:9, September 2020.

Lawn, T. and McDonald, E., Developing a policy to deal with sexual assault on psychiatric in-patient wards, Psychiatric Bulletin, 33, 108-111, 2009.

Care Quality Commission, London, Sexual Safety on Mental Health Wards, 2018.

Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, Lau DT, Shalowitz J, Shaw T, Walton M, eds. The Patient Safety Education Program – Canada Curriculum Module 13: Patient Safety & Mental Health, PSEP-Canada in collaboration with the Ontario Hospital Association, 2013.

Spotlight Issue 3 - Culturally competent care and complaint resolution for Indigenous patients and caregivers

Case study: At-risk Indigenous youth

Patient Ombudsman received a call from a youth advocate about an Indigenous youth who was a patient in a hospital mental health unit. The advocate was concerned about the hospital's lack of recognition or supports for Indigenous youth.

The hospital was planning to discharge the youth to a hotel as part of their efforts to prepare for COVID-19. The youth advocate was concerned that the youth was at extreme risk based on their history of past trauma, lack of social supports, and overall coping skills. The advocate noted that another Indigenous youth had recently been discharged to the community and committed suicide within 48 hours of discharge.

The advocate did not have consent from the patient to enable Patient Ombudsman to discuss the specific circumstances with the hospital, however, the Early Resolution Specialist offered to contact the hospital to have a high-level discussion about their approach to addressing the needs of Indigenous youth and how they ensure safe discharges.

The Early Resolution Specialist spoke with the hospital director responsible for quality and risk management and discussed general concerns Patient Ombudsman had received about support for Indigenous patients, the value of traditional cultural supports, such as the involvement of community elders in the circle of care, and safe discharges of patients with mental health problems and a history of past trauma. The hospital director confirmed that the hospital had Indigenous Navigators on staff and committed to meeting with staff to discuss the issues raised by Patient Ombudsman.

In years 4 and 5, Patient Ombudsman received 27 complaints from 25 complainants reporting discrimination or a lack of culturally sensitive care for Indigenous patients in hospitals, long-term care homes, and home and community care. The complaints were wide ranging. They included reports that health care providers were unwilling to listen to patients and family members, use of racial epithets, and refusal to include traditional healing in the patient's care. Some complainants reported insensitivity, delays or denial of care based on erroneous assumptions that patients were inebriated or seeking drugs. In most cases, the complainants were not aware of the HSOs' internal complaints processes or their ability to engage with Indigenous navigators.

In 2019, Patient Ombudsman recognized that our own organization needed to focus on thoughtful and meaningful approaches to working with complainants who identify as Indigenous as they engage with our complaint resolution service. We identified the need to build our own capacity to work with Indigenous patients and caregivers with sensitivity and cultural competence, and to further understand the experiences of Indigenous people in their interactions with Ontario's health care system.

In January 2020, Patient Ombudsman launched an Indigenous Strategy and began the important work of connecting, listening, and learning from key stakeholders in Indigenous health. A working group was established and began engaging in outreach to Indigenous health

care leaders and key stakeholders to help guide our work and identify gaps and opportunities to improve our practices.

Patient Ombudsman prioritized hiring an Early Resolution Indigenous Specialist to support complaint resolutions for Indigenous patients and caregivers, to assist in our community outreach, and to continue building cultural competence across Patient Ombudsman. Alethea Kewayosh, Ontario Health's Director of the Indigenous Cancer Care Unit kindly volunteered to participate on the recruitment panel and has been an invaluable resource to Patient Ombudsman.

While the recruitment process was underway, a member of the existing Early Resolution Specialist team with experience and training in Indigenous health care volunteered to take on dedicated responsibility for complaints from Indigenous patients and caregivers.

The COVID-19 pandemic interrupted Patient Ombudsman's ability to fully implement the Indigenous Strategy. In addition to significantly increasing the volume of complaints to Patient Ombudsman, COVID-19 restrictions and the transition to working from home created challenges with outreach efforts. However, in January 2020, we welcomed our first Early Resolution Indigenous Specialist.

This commitment remains a priority for Patient Ombudsman, and the working group has identified a number of priorities for further action including:

- Continuing education to build cultural competence across Patient Ombudsman.
- Ongoing outreach efforts to inform our practices and raise awareness of our services.
- Reviewing and revising our intake and complaint resolution processes to ensure Patient Ombudsman is a safe space for Indigenous patients and caregivers to raise their concerns.
- Enhancing our website to provide specific information and resources for Indigenous patients and caregivers.
- Improving our data collection to guide further improvements.

Spotlight Issue 4 – Use of force by hospital security staff

The high frequency of physical and verbal assaults on health care providers is widely documented. Many hospitals now hire security guards or engage private security companies to assist with managing aggressive or violent patients and visitors.

Finding a balance between providing a safe environment for patients and health care workers while ensuring access to care for vulnerable patients who may be prone to aggressive language or behaviour is not a simple matter. The consequences of getting it wrong are serious, given that force may be used in addressing perceived or actual threats.

Failure to train security officers in the use of safe and effective physical control techniques to address combative patients…exposes the health care facility to greater legal risk as well as greater danger to the patient, other patients, visitors and staff.

Brubaker, 2015

In years 4 and 5, Patient Ombudsman received 58 complaints that reported aggressive interventions by hospital security staff, including 33 reports of assaults or physical injury. Most of the incidents occurred on mental health units or involved patients with mental health or addictions issues in the emergency department. There was a significant escalation of these types of complaints in 2020/21— more than 70% of complaints about security interventions were received between April 2020 and March 2021. Frustration with delays and public health restrictions, and general anxiety related to the COVID-19 pandemic may have contributed to an increase in incidents involving hospital security.

Patient Ombudsman is required to give HSOs an opportunity to resolve complaints before we become involved. For the majority of the complaints Patient Ombudsman receives about hospital security, the hospitals had not yet completed their own review. In some cases, Patient Ombudsman was unable to contact or engage the complainant in the resolution process. The resolution process is underway in the remaining cases.

In Ontario, the *Private Security and Investigative Services Act, 2005* and related regulations set out the requirements for security guard and security company licensing, training and testing. The Ministry of the Solicitor General has established a syllabus outlining training requirements. Security guards must complete a minimum of 40 hours of basic training when Emergency Level First Aid Certification is included and no less than 33.5 hours when Emergency Level First Aid Certification not included. A review of websites suggests that some of the larger security companies provide additional training for security guards that work in health care settings.

Beyond the basic training syllabus, there are no standardized education requirements for de-escalation techniques, use of force and effective communication with mental health patients and other vulnerable populations.

Patient Ombudsman believes the integration of security guards and use of force is an area that requires additional attention by the health care community. At a minimum, Patient Ombudsman suggests that HSOs:

- Have a use of force policy that is sensitive to the patient populations and cultures served.
- Ensure all security personnel receive de-escalation training and recognize that use of force is a last resort.
- Ensure policies, procedures and training for security encompasses unconscious bias and supports the needs of diverse persons using the hospital.
- Document and review all incidents that involve the use of force against patients and visitors to ensure that policies and procedures were followed and identify opportunities for improvement.
- Optimize the use of technology in reviewing use of force incidents, for example, CCTV or implementing body-worn cameras.

Patient Story

The complainant was transported to hospital following a suicide attempt. After several hours, the patient was escorted out of the emergency department by a security guard. When the care team alerted security that the patient was in fact admitted for a 72-hour period of observation and assessment, several more security guards approached and grabbed the patient's arms, leaving bruises that the patient documented. The patient indicated that the guards were causing pain, so the patient kicked outward. The patient reported being pushed violently into the concrete, and then picked up and carried back into the hospital. The patient reported that a CT scan was required to rule out head trauma and they still had bruises, swelling and dizziness several days later. Patient Ombudsman suspended its review since another proceeding was underway.

Patient Story

Patient Ombudsman received a complaint reporting that a youth was assaulted by a security guard on a hospital mental health unit. The patient reported that a security guard sat on their neck. When the patient struggled in response to the pain of being restrained, they were then punched in the face with a closed fist. The Patient Relations representative was aware of the incident and planned to review the video and report back, but the youth's family had not received any follow-up.

With consent, Patient Ombudsman contacted the hospital to determine the status of the review and a timeline for their response. Following Patient Ombudsman's contact, the patient relations representative contacted the family. The complainant was invited to contact Patient Ombudsman after the hospital completed its review if there were unresolved concerns.

Resources:

Brubaker TW. Use of force in the health care setting. J Healthcare Protection Management. 2015;31(1):73-80.

George, Constance E. What Might a Good Compassionate Force Protocol Look Like? AMA J Ethics, 2021, 23(4), E326-334.

Ministry of the Solicitor General, Private Security and Investigative Services Training Syllabus for Security Guards: https://www.ontario.ca/document/training-syllabus-security-guards

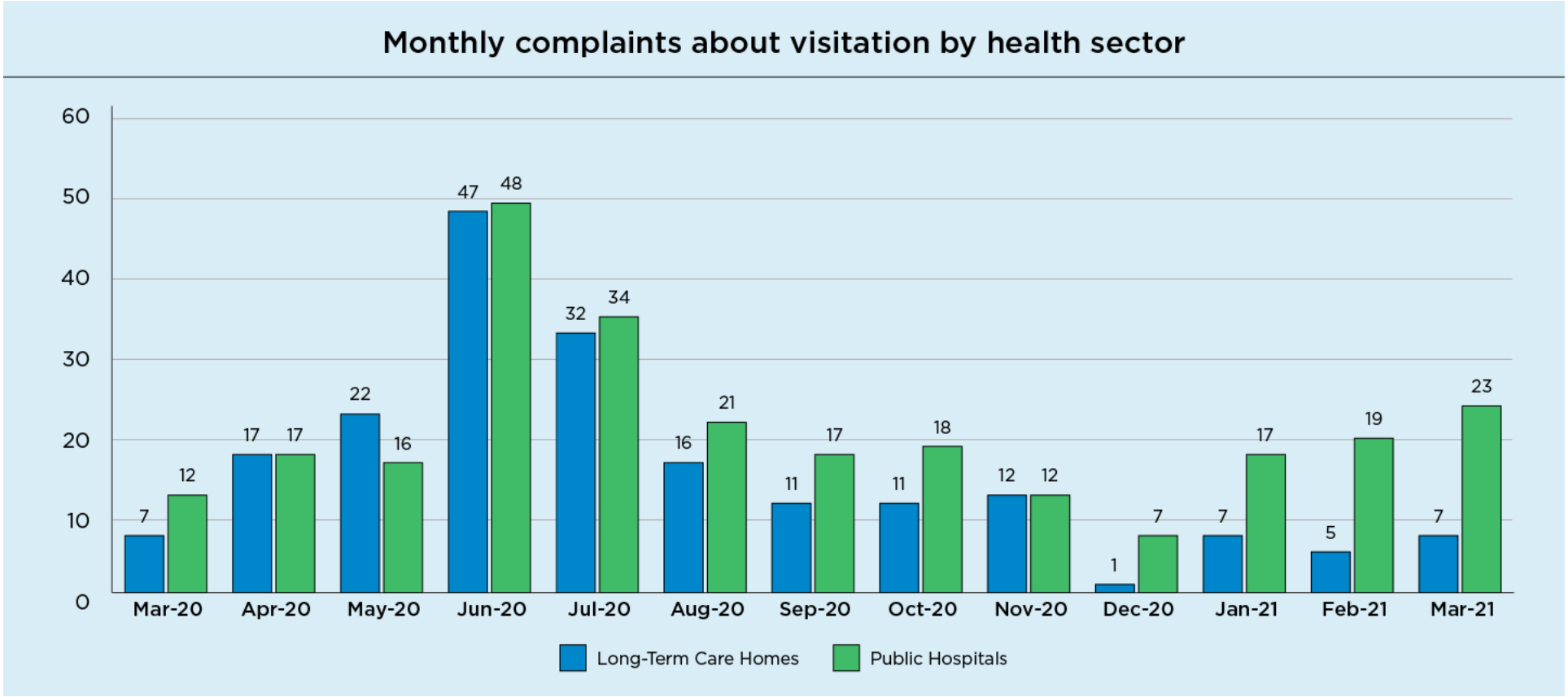
Schoenfisch, Ashley L. and Pompeii, Lisa A. Security Personnel Practices and Policies in U.S. Hospitals Findings from a National Survey. Workplace Health & Safety, November 2016, 64 (11), 531-542.

Toronto Star, Two security guards charged with manslaughter in the death of a woman at Toronto General Hospital, December 8, 2020.

Spotlight Issue #5 - Continuing Challenges with Visitation

In years 4 and 5, Patient Ombudsman received more than 500 complaints about restrictions on visitation including 269 complaints about public hospitals, 206 about long-term care homes, and 31 about other residential care settings that are outside of Patient Ombudsman's jurisdiction. Ninety-six percent of the complaints occurred between March 2020 and March 2021 and involved visitation restrictions arising from the COVID-19 pandemic.

As shown in the chart below, complaints about visitation restrictions in long-term care homes peaked in the summer of 2020 and have continued, but with less frequency since December 2020. In the latter part of year 5, complaints about visitation in long-term care homes most often involved confusion about changes to policy guidance over time, miscommunication and reports about homes that implemented visitor policies that were more restrictive than suggested by the provincial guidance.



Patient Ombudsman has highlighted the effects of visitation restrictions on long-term care home residents in its three special reports on COVID-19.[2,3,4] The complaints received by Patient Ombudsman over the course of the pandemic and the results of Patient Ombudsman's public survey describe the impacts of isolation, lack of stimulation and absence of support from family caregivers on the health and well-being of many long-term care home residents.

The Government of Ontario has recognized the importance of visitation and provided specific guidance to long-term care homes, including the requirement for homes to have policies on visitation that reflect government directives and guiding principles:[5]

Guiding principles:

Safety – any approach to visiting must balance the health and safety needs of residents, staff and visitors and ensure risks are mitigated

Emotional well-being – welcoming visitors is intended to support the mental and emotional well-being of residents by reducing any potential negative impacts related to social isolation

Equitable access – all residents must be given equitable access to receive visitors, consistent with their preferences and within reasonable restrictions that safeguard residents

Flexibility – the physical or infrastructure characteristics of the home, its workforce or human resources availability, whether the home is in an outbreak and the current status of the home with respect to personal protective equipment (PPE) are all variables to consider when setting home-specific policies

Equality – residents have the right to choose their visitors. In addition, residents or their substitute decision-makers have the right to designate caregivers

[2] *Honouring the voices and experiences of Long-Term Care Home residents, caregivers and staff during the first wave of COVID-19 in Ontario: Special Report*, Patient Ombudsman, October 2020.

[3] *Honouring Voices and Experiences Reflections from waves 2 and 3 of the pandemic: Special Report 2*, Patient Ombudsman, August 2021.

[4] *Honouring Voices and Experiences – Long-term care home survey: Special Report 3*, Patient Ombudsman, December 2021.

[5] *COVID-19 guidance document for long-term care homes in Ontario*, Government of Ontario, published May 4, 2021, most recent update December 14, 2021.

Public hospitals have received less specific provincial guidance on visitation. In June 2020, the Ministry of Health's guidance for acute care[6] was amended to recognize the importance of visitors to patients' well-being. The guidance urged hospitals to be adaptive and flexible and balance the need to mitigate risks with "the mental, physical and spiritual needs of patients for their quality of life." Complaints to Patient Ombudsman about visitation in hospitals have remained relatively high into 2021.

It's not unusual for public hospitals to have visitor policies that vary by unit or site based on the judgment and decisions of individual unit managers. This can be confusing and frustrating for visitors who may have limited access to information about the reasons for varying policies and rules.

Patient Story

Patient Ombudsman received a complaint from the grandchild of a patient receiving palliative care at a community hospital. The grandchild understood that they had been added to the list of visitors, but when they arrived at the hospital for the visit, they were advised by the hospital screener that they were not on the visitor list and could not enter.

Patient Ombudsman followed up with the hospital and learned that the patient had been transferred to a different unit with different rules. In the new unit, only the patient's children, not the grandchildren, were permitted to visit. The changes in unit and visitation rules were not communicated to the family, and the screener was unaware of the policy differences across units.

[6] *COVID-19 Guidance: Acute care, Version 6*, Ministry of Health, June 15, 2020.

Patient Story

The complainant contacted Patient Ombudsman to complain about excessive visitation restrictions on their mother's unit in the hospital. The visitation schedule had been amended to reduce visit opportunities to a single visitor twice per week with limited time slots for the entire unit. Other units that cared for patients with similar needs continued to permit visits daily. In addition, the restrictions were not applied consistently, and some families were granted exceptions. The complainant had been unsuccessful in getting an explanation for the unit's visitation policies.

Patient Ombudsman reached out to leadership at the hospital to discuss the importance of having consistent policies that are based on evidence and proportional to the risks. Patient Ombudsman also discussed the need for procedural fairness and clear, timely communication with family members and other care partners.

Patient Ombudsman continues to recommend that all HSOs should adopt the least restrictive limits on visitation based on risks and evidence, and that policies should be clearly communicated to those affected and provide for exceptions on compassionate grounds.

While there may be valid reasons for different units in hospitals to have different policies based on the risks to patients, the availability of staff resources or other factors, it serves no one if the policies appear to be arbitrary or cannot be explained to patients and caregivers. The decisions of unit managers should be based on a consistent framework with guiding principles that ensure fairness and transparency and recognize the importance of a least restrictive approach.

Resource:

Essential Care Partner and Visitor Presence Policies and Resources, Ontario Hospital Association, September 2021.

Operations and Finance in Years 4 and 5

Growth in complaints to Patient Ombudsman

Patient Ombudsman saw an unprecedented 46% increase in the number complaints received between years 4 and 5. While Patient Ombudsman saw growth in complaints about all types of HSOs, the most dramatic change was observed in complaints about long-term care homes. The number of complaints in year 5 was over triple the number of complaints received in year 4.

Prior to year 5, Patient Ombudsman experienced annual growth ranging from 5% to 16%.[7] The impact of the COVID-19 pandemic on patients' and caregivers' experiences was a significant factor driving growth in year 5, however, Patient Ombudsman also experienced growth in complaints that did not include issues related to the pandemic. It's likely that increasing public awareness of Patient Ombudsman contributed to the growth.

	Year 1	Year 2	Year 3	Year 4	Year 5
Total complaints	1,984	2,301	2,419	2,470	3,595
% growth		16%	5%	2%	46%
# HSOs included in complaints	1,984	2,301	2,419	2,612	3,844
% growth		16%	5%	8%	47%

Between March 2020 and March 2021, 40% of complaints involved concerns related to COVID-19. The volume of complaints ultimately required Patient Ombudsman to establish a triage process to ensure urgent complaints were addressed in a timely manner and less urgent complaints were assigned to a backlog. Patient Ombudsman made efforts to maintain communication with complainants to ensure they were aware of the status of their complaints. By realigning internal resources to bolster the frontline team, Patient Ombudsman was able to add an additional Early Resolution Specialist on a contract basis to help manage the surge in cases.

[7] In years 1 to 3, the Patient Ombudsman complaint management system required a separate case file for each HSO. In July 2019, an update to the complaint management system enabled complaints about multiple HSO to be managed in one case file. Therefore, the most meaningful way to look at annual growth over the Patient Ombudsman's first five years is based on the number of HSOs included in complaints.

In addition to the ongoing investigation of the impact of COVID-19 on the care and health care experiences of long-term care home residents, Patient Ombudsman completed a significant own-motion investigation involving multiple HSOs. A summary of this investigation is included in the Spotlight issues in this report.

Two other investigations were initiated in years 4 and 5 but were delayed due to challenges posed by the pandemic.

Outreach and engagement

Outreach to patients, caregivers and health system stakeholders is an important part of Patient Ombudsman's role. As a relatively new office, there is still work to do to raise awareness of our services and how we can help. Sharing our insights into patient experiences also provides valuable information to drive improvements in the delivery of health care. In June 2019, we began a province-wide effort to meet with hospitals and LHIN (now known as Home and Community Care Support Services) staff and Patient and Family Advisory Councils. By the spring of 2020, we had visited 12[8] of 14 health regions across the province. While the COVID-19 pandemic interrupted our ability to meet in person, we continue to meet virtually with stakeholders whenever possible. Patient Ombudsman met with and presented to numerous stakeholders in years 4 and 5, including:

- AdvantAge Ontario
- Alliance for Health Communities
- Alzheimer Society Caregiver Support Groups throughout Toronto
- Canadian Association for Retired Persons (CARP)
- Canadian Mental Health Association Ontario Conference
- Cancer Care Ontario Person Centred Care Leads
- Family Councils Ontario
- Family Directive Alternative
- Federation of Health Regulatory Colleges of Ontario
- Henley Place Family Council
- Joint Indigenous Cancer Committee
- Ontario AIDS Network
- Ontario Association of Residents Councils
- Ontario Business Managers Association (public hospitals)
- Ontario Caregiver Organization
- Ontario Hospital Association Patient Experience Community of Practice
- Ontario Long-Term Care Homes Association
- Ontario Patient Relations Association
- Ontario Renal Network Patient and Family Advisory Council
- Rainbow Health Ontario
- Rencontre du Conseil consultatif des services de santé en français
- Senator Yvonne Boyer (Indigenous healthcare)
- Toronto Community Housing Disability Support Housing Unit Managers
- Windsor Essex Community Health Centre

[8] Central, Central West, Champlain, Erie St. Clair, Hamilton Niagara Haldimand Brant, Mississauga Halton, North East, North Simcoe Muskoka, South East, South West, Toronto and Waterloo Wellington

Adapting to changes in governance and accountability

On December 2, 2019, the governance of Health Quality Ontario was transferred to the new Ontario Health agency. As a result, Ontario Health assumed responsibility for providing back office and operational support to Patient Ombudsman, including the administration of Patient Ombudsman's finances.

A charter was developed in 2018 to guide the relationship between Health Quality Ontario and Patient Ombudsman. In addition to outlining the responsibilities and accountabilities of each party, the charter was designed to ensure Patient Ombudsman's operational independence in carrying out its mandate. When Ontario Health assumed responsibility for supporting Patient Ombudsman, the existing charter was grandfathered over until a new charter could be developed. That work is underway and will be completed in 2021/22.

Financial performance

In our first three years, separate audited financial statements were produced for Patient Ombudsman, in addition to Health Quality Ontario's overall financial statements. In years 4 and 5, consolidated audited financial statements were produced for all agencies that transitioned to Ontario Health, and a separate audit was not produced for Patient Ombudsman. Patient Ombudsman's budget and actual expenditures are recorded as a line item in a schedule to Ontario Health's 2020/21 financial statements but are not detailed in the 2019/20 audit. For this annual report, Patient Ombudsman's budget and actual expenditures for 2019/20 are presented based on management reporting.

Statement of Operations for the period[9] (in thousands of dollars)	**Budget**	**Actual**
April 1, 2019 to March 31, 2020[10]	3,296	2,577
April 1, 2020 to March 31, 2021[11]	3,335	3,016

In both years 4 and 5, Patient Ombudsman operated with a surplus, partly a result of the vacancy in the position of the Patient Ombudsman.

[9] Note: Budget and actual figures do not include amortization.

[10] Health Quality Ontario 2019/20 Financial Settlement Report

[11] Ontario Health Financial Statements March 31, 2021.

Developing and supporting the Patient Ombudsman team

Restraints on public sector spending limited Patient Ombudsman's ability to offer opportunities for individual staff development and education in years 4 and 5. To ensure staff continued to have opportunities to learn and grow, a series of all staff in-service education sessions were held in years 4 and 5 that focused on:

- Building staff resilience.
- Increasing competency in helping patients and caregivers with mental health challenges, including crisis management. As a result of this training session, a streamlined referral process to distress centres was implemented.
- Mediation skills.
- Quality improvement.
- Health equity and cultural competency, including sessions focused on the health care experiences of Black, Indigenous and LGBTQ2S+ patients and caregivers.
- Long-term care homes quality inspections.

Employee engagement surveys were conducted in years 4 and 5 to inform ongoing education and staff development.

In July 2019, Patient Ombudsman launched a significant upgrade to our complaints management system and online complaints form. Specific training was also provided to support this initiative.

Working remotely presented new challenges and opportunities in helping the Patient Ombudsman team stay connected, particularly during a time of unprecedented growth and a significant change in the serious, and often deeply emotional experiences patients and caregivers shared with us. The team stepped up to help one another, offering virtual laughter yoga, meditation training sessions, Friday afternoon French lessons, and weekly virtual coffee breaks.

Patient Story

Following surgery, the patient was transferred to the hospital's rehabilitation unit. The first available rehabilitation bed was in a semi-private room. Shortly after the transfer, the patient was given a form to sign to agree to the semi-private co-payment. The patient had not requested a semi-private room and did not feel well enough to understand the implications of the form when it was presented. The form was never signed. The patient contacted Patient Ombudsman when they received an invoice for nearly $8,000 related to the semi-private co-payment. Patient Ombudsman raised concerns with the hospital about the clarity of the form, the timing of the communication with the patient and the fact that the patient had not requested a semi-private room. The hospital waived the charge and agreed to review their process for managing responsibility for payment.

Summary

The COVID-19 pandemic has placed stresses on the health care system unlike anything seen before, and the impact on patient, resident and caregiver experiences has been profound. By proactively planning and being quick to adjust, Patient Ombudsman has been able to maintain services throughout the crisis and assist more patient and caregivers than ever before. We're grateful to the patient and caregivers who shared their stories with us and the HSOs that worked with us to address their concerns.

In the coming months, Patient Ombudsman will be releasing the final report of its first major system-level investigation examining the impact of COVID-19 on the care and health care experiences of long-term care residents, as well as completing the investigations suspended as a result of the pressure of the pandemic.

Patient Ombudsman will be refreshing its strategic directions to guide the work of the office, resuming outreach to marginalized patient populations and renewing efforts to develop and improve our services.