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Northwest Regional Human Rights Authority
Report of Findings
Case #24-080-9019
Northwestern Medicine Kishwaukee Hospital

Introduction

The Human Rights Authority (HRA) opened an investigation into potential rights violations in the treatment of a patient at the Northwest Medicine Kishwaukee Hospital in DeKalb, IL. **The complaints are that the patient's right to receive proper care per discharge plan, the right to be free from abuse and neglect was ignored and a medical records request was denied.** After conducting the site visit interview, it was determined that the substantiated findings would violate protections under the Health Insurance Portability and Accountability Act (HIPAA) regulations (45 CFR 163.524) and the Illinois Administrative Code (77 Ill Admin Code 250).

Northwestern Medicine Kishwaukee Hospital in DeKalb, Illinois is part of the healthcare system that has four hospital locations within the northern part of the state since December 2015. The Kishwaukee location is a 98-bed, short-term, and acute-care facility. The services provided at the hospital includes endocrinology, labor and delivery, occupational medicine, emergency medicine, diagnostic treatment, orthopedics treatment and women's health services. The HRA reviewed the patient's medical records, with authorization, and met and discussed relevant policies with representatives from the emergency department, hospital administrators and hospital legal counsel, via a virtual site visit.

Complaint Summary

According to the complaint, after arriving in the emergency department, the patient did not receive adequate and humane treatment or services from the nursing personnel. Per the complaint, when the patient requested water , it was alleged that staff threw two water bottles at their legs. Before the patient left, there was a request made for medical records and the patient was reportedly told the records were unavailable.

Record Review

The patient drove to the Emergency Department at 4:19pm due to complaints of dizziness, confusion and numbness. The triage process started shortly after arrival, and various tests were conducted, while a room was being prepared. An hour later, the patient was settled into a private emergency room to await services and treatment. Per the medical records, it was reported that at 6:30pm, the ED nurse on duty would reach out to the on-call social worker, once the patient was medically cleared. At 7:42pm, it was determined that the patient was in need of a urinalysis, was provided water and after receipt of the water, it was noted that the patient was watching television and resting in the room.

Around 8:19pm, the ED Nurse returned to the room, shared that the labs had been drawn and checked to see if the patient was ready to provide a urinalysis. Per the medical records, the patient stated, "You haven't done anything for me since I've been here, this is ridiculous." It was relayed to the patient that by collecting a urine sample, this will give the provider additional answers towards the reason for admission. From the records, the patient told the attending nurse, "I am not giving you a urine", the nurse relayed a willingness to talk with the provider and make any adjustments once the patient was sitting down again. The patient stated, "I am not sitting in the bed, I am leaving, take this out before I throw it at you". The IV was removed from the patient and per the nursing notes, the attending nurse explained leaving **Against Medical Advice (AMA)** to the patient. The patient responded, per the nursing notes "I don't need no form or no urine, I am going to a different hospital". After making this statement, the attending nurse walked the patient to the front door of the ED and while the patient's car was warming up, the attending nurse informed security of her pending departure. The nursing notes documented that the patient was listed as discharged at 8:20pm.

Hospital Policy

The HRA reviewed the current policy and procedure **"Your Rights and Responsibilities as Our Patient"** and reviewed two separate parts of the policy; under **"emotional suppor**t," it states the patient can "express concerns, be heard and get an appropriate response without worry that doing so will cause retaliation". Per the medical records, the patient refused to provide a urine sample and requested that the attending nurse, remove the IV and the nurse removed it. Under the **information, education and communication** portion, the policy states, **"**As our patient, you have the right to: get a copy of your medical record. Your nurse can help you or you can contact the Medical Records Department after you leave the hospital". Per the medical records and site interview, the attending nurse reiterated that the patient did not ask for a copy of their records and left before being completely serviced.

Interviews

Advanced Practiced Registered Nurse (APRN)

The HRA inquired if the nurse recalled patient, and it was stated "no," and they did not review the notes, except in the presence of the attorney. For the HRA to get a better understanding of the ED intake admission process, the HRA asked if the Advanced Practiced Registered Nurse (APRN) could explain the process. The APRN stated the process is as follows:

"a. The patient is called back to the triage area, where the patient history, reasons for hospital visit is discussed and documented,
b. A medical exam is completed,
c. The patient returns to the waiting area, until an ED room is available,
d. The patient will be called back to an ED room where labs are drawn, a urine test is completed to rule out any other issues, especially a urinary tract infection (UTI). "

ED Nurse

The ED Nurse stated not having any recollection of this patient but reviewed the medical records for this visit. During the interview, the ED Nurse stated completing the triage admission process and reported out believing that the patient was cooperative during the tests. Per the medical records, it was noted that this ED Nurse would call the hospital social worker to the room after completing all labs and test. The HRA team inquired if this action occurred or not and during the interview, the ED Nurse did not recall if the social worker had been called to assess the patient, but explained, the patient's labs were not completed.

Risk Manager

The Risk Manager joined the site visit, due to the patient making an outcry at a follow-up medical appointment which triggered a complaint that opened an internal investigation. The HRA inquired if the Risk Manager could provide insight on how complaints and grievances are processed:

"a. Complaints go through the patient relations department and are documented through the event tracking system,
b. When complaints/grievances are filed, they are forwarded to the Risk Manager for follow-through,
c. A report is always sent/notified to the Illinois Department of Public Health for an external investigation,
d. Interviews are conducted with the hospital leader, the provider who took the report and employees involved in the 'alleged complaint',

e. At the conclusion of the investigation, the patient relations department will inform the patient of the outcome/conclusion."

The HRA inquired if the Risk Management could recall the initial complaint or grievance. The Risk Manager met with the provider and their assistant who took the complaint from the patient, which centered around their recent experience in the ED, in which they stated suffering emotional stress, having water bottles thrown at their legs and wanting the nurse fired.

Per the Risk Manager, the current status of the patient's complaint is as follows: after an internal investigation, the complaint was unsubstantiated. The facility hasn't received any feedback from the Illinois Department of Public Health (IDPH) and was unsure if the patient was notified of the outcome, which offered a suggestion of effective patient relations training for the nurse in question to complete. The nurse in question, never had any prior patient complaints. Per the Risk Manager, there have been no additional complaints filed by this patient or on the patient's behalf, since their last admission, nor has any documentation requesting a release of records been received.

2nd ED Nurse

The HRA interviewed the 2nd ED Nurse, who stated recalling the patient and reviewing the medical records. In reviewing the medical records, the HRA inquired of the Nurse what type of water was given (a cup or a water bottle) and per the nurse, the patient was given a water bottle while they were sitting in a chair in the ED room for the urinalysis. Per the ED Nurse's recollection of the patient, there were no reports of experiencing dry mouth, no request of medical records, no complaints of water bottles being thrown and there were only complaints of patient wait times. In reviewing the medical record, it was pointed out that the patient requested removal of the IV and the ED Nurse recalled that the patient allowed the IV to be removed and they wanted to leave. The ED Nurse stated there was a conversation that was had where it was explained to the patient what it meant to leave (AMA), due to not all of the tests being completed, the patient understood that and still wanted to leave. The HRA inquired about the patient's exit and the ED Nurse stated it occurred by, "pushing the patient out in a wheelchair into the bay area while they waited for the car to warm up."

The HRA inquired if it was normal for staff to escort patients out of the ED or to alert security about the escort. Per the ED Nurse, it is normal for them to walk or escort patients out, but they wanted to alert security because the location of this escort was not a normal one and wanted them to be aware of the situation.

Legal Counsel

The Legal Counsel pointed out that the usage of the term "elopement" in the medical records, can have implications and different meanings in various settings and does not provide an appropriate picture of the patient's actions, The Legal Counsel, reminded the staff that the term elopement should not be used or mean Against Medical Advice (AMA), and the hospital currently does not have a specific policy on AMA. In reviewing the medical records, per the Legal Counsel, the patient did not request to speak to patient relations but did express issues with the wait time. A patient's records are accessible upon discharge (either AMA or regular hospital release), per Legal Counsel.

Conclusion

Complaint: The patient's right to receive proper care via a treatment and discharge plan was ignored.

Per the Illinois Administrative Code*, "The hospital shall provide basic and effective care to each patient. No person seeking necessary medical care from the hospital shall be denied care for reasons not based on sound medical practice or the hospital's charter, and, particularly, no person shall be denied care on account of race, creed, color, religion, gender, or sexual orientation*" (77 Ill Admin Code 250.240 (c-3)).: In reviewing the Illinois Administrative Code for discharge planning, " e*very hospital shall develop* and implement policies and *procedures to provide the discharge notice* required in subsection (e)(5*). The policies and procedures may also include a waiver of the notification requirement in either or both of the following cases: when the patient voluntarily desires to leave the hospital before the expiration of the 24-hour period* (77 Ill Admin Code 250.240 (e-6b)." It was determined from the site visit interview notes and upon examining the nursing notes, an individual treatment plan and discharge plan were not developed due to the patient leaving the ED four hours later and before the conclusion of any tests as well as the patient's refusal to complete a urinalysis. **A rights violation is not substantiated.**

Complaint: The right to be free from abuse and neglect was ignored.

Per the Illinois Administrative Code,*" No administrator, agent, or employee of a hospital or a member of its medical staff may abuse a patient in the hospital* (77 Ill Admin Code 250.260(c-3)". The patient reported being hit with a water bottle in the legs; in the medical notes and in the site interview, the ED nurse reported handing the patient a water bottle to assist in the requested test. It was also discovered during the site visit, that an internal investigation was completed, and a complaint was filed with IDPH. The Illinois Administrative Code states, "*all internal hospital reviews shall be conducted by a designated hospital employee or agent who is qualified to detect abuse and is not involved in the alleged victim's treatment. All internal review findings shall be*

documented and filed according to hospital procedures and shall be made available to the Department upon request (77 Ill Admin Code 250.260(c-6)". Per the internal investigation, the hospital did not find evidence of the patient being hit and there was no information or follow-up from IDPH. **A rights violation is not substantiated.**

Complaint: The right to medical records was denied.

Per the Code of Federal Regulations, Title 45, Public Health, *"Right of access. Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, (*45 CFR § 164.524(1)". In the medical records and site visit interviews, there was no mention or reference to the patient requesting a copy of their records upon leaving the facility. **A rights violation is not substantiated.**

Overall Suggestion

The HRA offers the following suggestion:

1. **Northwest Medicine Hospital - Kishwaukee** ensure and stress the importance of staff reviewing the requested records, before the HRA Site Visit to provide accurate recall and recollection of patient interactions and medical records.

The HRA would like to thank the staff and administrators of Northwest Medicine Hospital - Kishwaukee for their cooperation with this investigation.