FOR IMMEDIATE RELEASE

Egyptian Human Rights Authority
Report of Findings
Hamilton Memorial Hospital
HRA# 17-110-9005

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations in the care provided to a patient at Hamilton Memorial Hospital (HMH) in McLeansboro, IL. The specific allegations are as follows:

1. **A person with a developmental disability was discriminated against.**
2. **The hospital provided inadequate care and treatment.**

If the allegations are substantiated, they would violate protections under: The Medical Patient Rights Act (410 ILCS 50/3); Hospital Regulations (77 IL ADC 250 et seq.); The Americans with Disabilities Act (28 CFR 35 et. al.) as well as the Code of Federal Regulations (42 CFR 482 et seq.) and (45 CFR 92 et seq.)

The allegations were discussed with hospital staff involved in the recipient's care, administrative staff at the hospital, family members and home staff. Relevant policies were also reviewed as were sections of the recipient's record with authorization.

Complaint Summary

The complaint alleges that a patient with a disability was discriminated against by being rushed out of her room and made to sit at the front door of the hospital waiting on her ride to arrive rather than letting her stay in her room. As a result, no discharge instructions were given to either her, the caretakers or her legal guardians. The complaint also alleged that the Hospital provided inadequate care and treatment by not treating the recipient's underlying problem of Dilantin toxicity and discharging her too soon

Interviews

A. Guardians and CILA Staff: The guardians explained that the recipient had slurred speech approximately 4-6 months before this incident and was in pain when she walked and she would fall suddenly. She was on Dilantin for seizure activity which had been increased in June or July due to the Dilantin levels in her system being low at her 6 month follow up with a neurologist. In September, the recipient fell in her room at her CILA (community integrated living arrangement) home around 1 p.m. on a Friday. She also had an unsteady gait so she was taken to the emergency department (ED) for treatment for a cut to her eyebrow and to ensure there were no underlying problems. At the ED a CT scan was completed because she could not tolerate the MRI. Her eyebrow was steri-stripped due to the glue gun not working. She was admitted for overnight observation around 8:00 p.m. One guardian was with her at the hospital from 1-8 p.m. and the house manager left around 9 p.m. Saturday morning around 8 a.m. the DSP (direct service personnel) went to the hospital to check on the recipient and while she was there no staff

talked to her or checked on the recipient for the hour she was at the hospital. Around 10 a.m., the other guardian arrived and stayed with her until they discharged her that afternoon. No physician or nurse came in while the guardian was at the hospital with the recipient. The recipient did not eat very well at lunch that day which the guardian thought was strange because she loves to eat. After lunch, around 1 pm, the guardian stepped out to get a soft drink and returned about 15 minutes later. Upon returning, the nurse told her that they had to take the recipient to get her dressed and discharged. The recipient did not want to stand up, two nurses had to transfer her to a wheelchair because she could not stand or put pressure on her feet. A third nurse was stripping the beds while they were transferring her to the wheelchair. That nurse asked where they were supposed to take her because the DSP had said it would be an hour before someone from the home could come to pick her up. After getting her dressed, they wheeled the recipient to the front door to wait and the nurse told her that there was a bench outside she could sit on if she wanted to, even though the CILA home staff had said it would be an hour before they could arrive. The guardian waited at the door with the recipient until CILA home staff arrived to take her home. No discharge instructions were given to her and no discharge paperwork was signed by either CILA home staff or the guardians. After arriving home, the CILA home staff found discharge paperwork which had been faxed to the home at 12:36 p.m. but there was no signature on the paperwork. No one had mentioned discharge to the guardian who was at the hospital, but she found out later that the Hospitalist had called the other guardian that morning and said they found no residual effects from the fall and would be discharging her that day. The Direct Support Person from the CILA home (DSP) also said that the hospital had called her around 1 p.m. and said that she would be ready to discharge in about an hour but had no other communication with her other than letting her know that they saw no reason to keep her and she would be discharged. The DSP said the hospital has always given them an hour to make transportation arrangements and that also gives the hospital time to get the patient ready for discharge. Typically, they are given discharge paperwork to sign and take home with them, but that was not the case on this day with this recipient. The discharge paperwork that was faxed to the home also had someone else's medication on this recipient's discharge medication paperwork. The house manager stated that she took the medication list, medical card and transfer sheet to the ED initially in case they would have to transfer her to another hospital. The guardian noted seven discrepancies in her discharge medication list and her admitting medication list. The discharge medication list included two prescriptions for Dilantin, one was 100 mg extended release capsule and stated to take 300 mg at bedtime and noted that the generic name was Phenytoin. Another prescription for Phenytoin 100 mg extended release was found with a dose of 200 mg to be taken daily. Norco to be taken as needed and Tegretol 400 mg to be taken twice daily were listed at discharge but not on her admitting medications. Paxil, Tums and Depro Provera were also listed and were not her prescriptions.

When the CILA home staff arrived to pick up the recipient, it took two people, one staff and one male family member, to load her into the van because they had to lift her as she couldn't bear weight. When they arrived at the CILA home, they took her to the restroom and had to lift her to the toilet. Normally, she is ambulatory with her walker and is not in a wheelchair. After using the restroom she asked to go back to bed. After the recipient lay down in bed, she vomited so they sat her up and the DSP took her vital signs. Her vitals were normal but her blood pressure was a little high, and she had slurred speech and was shaky. The guardian and her husband took the recipient in their personal vehicle to another hospital and the ED there completed lab work and admitted her to the hospital. Within an hour they knew that she had

Dilantin toxicity. She remained in that hospital from Saturday following discharge from Hamilton Memorial until Tuesday. They rechecked her Dilantin levels and discharged her when they returned to normal. The physician there told them that her falling was due to the Dilantin levels being too high.

B. Hospital Staff: The HRA interviewed staff which included the Hospitalist, Chief of Nursing and the Utilization Review Consultant along with the Hospital CEO. The recipient was admitted through the ED for overnight observation due to having a fall at her CILA home. In the ED a superficial laceration repair was completed along with a head CT (computed tomography) Scan due to the MRI (magnetic resonance imaging) being unreadable due to movement despite Ativan being administered prior to the test. Basic CBC (complete blood count) lab work was also completed. The head CT was normal and the recipient was admitted for overnight observation. The ED records did not show a medication list from home so the nurses called and confirmed the home medications and the hospitalist ordered those, but no new medication was given. The Hospitalist saw the recipient that evening and the next morning prior to her discharge. The Hospitalist spoke to the family on the phone prior to discharge and said that she would need a follow up with a neurologist upon discharge. The guardian had told her it was about time for her regular appointment but the Hospitalist told her not to wait and the guardian agreed to call early the following week.

The Hospitalist explained that just because someone is on medications that warrant levels tests, they don't automatically check the levels; they just do a basic CBC. However if symptoms exhibited warrant a levels check they would typically do that lab work as well. The Hospitalist stated that increased Dilantin levels can cause balance issues and blood pressure medications can also cause dizziness or weakness. The Hospitalist said that repeat lab work was not completed prior to discharge because there was no reason to do so as she had no fever and was not exhibiting any other symptoms to warrant repeat labs to be drawn. The HRA asked if the Hospitalist was aware of any transfer issues prior to discharge and was told that the recipient was standing at bedside and would transfer to the chair, and the nurses did not report any problems. The Hospitalist said that they were concerned about breakthrough seizures or that maybe she had seizures at night which caused her to wake up, and she prompted the home to call as well for seizure follow up with a neurologist the following week. No one had voiced any concerns to the Hospitalist regarding discharge and the Hospitalist stated that she was not aware that the other guardian was at the hospital when she called the co-guardian at home. She said typically they do not contact guardians for consents since the CILA home already has "blanket consent" for routine medications to be given and treatment to occur. The Hospitalist is familiar with this patient and has seen her before. She is typically sweet, hungry and tearful, usually wanting to go back home but she does not cause any trouble. She said the recipient feeds herself and she ate half of her lunch that day prior to discharge.

The staff was also questioned regarding discharge procedures and they explained that typically, the patient will stay in the room until they are discharged from the hospital. The CILA home staff usually comes to the nurses' station; nursing staff go over the discharge instructions and CILA home staff signs that they received the instructions. After that, the patient is free to leave. The hospital's policy requires that a signature be present on discharge paperwork. In this case the CILA home staff called and asked for another copy of the discharge instructions which was faxed to the home. The other nurse identified as being present during this discharge process was on a leave at the time of the HRA interview and was unable to be questioned regarding this recipient's discharge.

After discharge the CILA home staff contacted the hospital's quality assurance department regarding the lab results from the other hospital showing elevated Dilantin levels. That issue was addressed with the ED supervising physician and a memo went out to all ED groups that if a patient comes in with medications which require levels to be checked to do so while they are in the ED.

Record Review

A. Hamilton Hospital Records: The ED Triage Form listed 15 medications, no known allergies as well as the injury to the right frontal area and right temple which occurred prior to arrival. It was noted that a fall risk assessment was completed and no fall risk was identified. The progress notes detailed that Ativan was given and she was taken for scans and knee X-Rays were normal; CT of the head noted no bony abnormalities and it was also noted that the MRI of the head was unreadable. The discharge disposition stated that a report was given to a nurse via a phone call and included the patient's care and treatment and medications given to the patient in the ED as well as the patient's home medications. All questions were answered. The report was acknowledged and care was transferred to another nurse at 9:45 p.m.

Patient Progress Notes showed vital signs were taken periodically throughout the overnight hours and throughout the day on Saturday morning. Routine medications, including Dilantin were also given.

The Discharge Instructions stated to *"assist when ambulating, follow up with [primary physician] next week. Call [neurologist] for follow up next week."* The discharge diagnoses are listed as *"increasing falls, R periorbital hematoma."* The Discharge Summary noted a chief complaint of pain in her head and knee following a ground level fall. It also noted frequent neuro checks where no deficits were noted. It also noted she was *"alert and oriented to person. Pleasant and cooperative and in no acute distress."* A total of 28 discharge medications were listed although only 15 were listed as routine medications upon admission. Eight of the additional discharge medications were to be given as needed and were typical over-the-counter medications, however, 8 were listed to be given daily. Of the daily medications, one was an additional seizure medication, another was an antidepressant medication, another was a birth control medication and a fourth was an antibiotic. The rest were over-the-counter type medications. Four of the medications listed as admission medications list were not on the discharge medication list. The physician electronically signed the form documenting that he personally examined the patient and agreed with the plan to discharge with "no further neuro workup at this time."

B. Subsequent Community Hospital Records: The patient was admitted to another community hospital the same day as discharge from HMC. That hospital's discharge summary listed a discharge diagnosis of Dilantin toxicity. The discharge orders were for a diabetic diet and follow up with neurologist to have Dilantin levels rechecked 8 days following discharge. The discharge medication list showed a change in her Dilantin medication which was decreased and it was noted that an additional prescription for Dilantin under another name was removed from her medication list. The list included 20 medications 7 of which were over-the-counter or "as needed" only and it also indicated which medications had been given and when to take the next dose of others.

C. Public Health Survey: Hamilton Memorial Hospital provided the HRA with a copy of a public health survey that was completed regarding a complaint public health received regarding the same issues as the HRA complaint. The Department of Public Health found one deficiency of failing to reconcile medications appropriately upon discharge. The CEO of HMH informed

the HRA that as a result of this survey, they redesigned their medication reconciliation process, educated staff and have continued monitoring by risk management and reported the findings to the combined safety/quality committee for identification of any further needed changes. The HRA reviewed the hospital's plan of correction which stated that all medication will be reconciled prior to discharge; all nursing staff and discharging providers would be educated on the medication reconciliation process. Compliance with the medication reconciliation process was to be monitored by the completion of the reconciliation compliance worksheet with all findings being forwarded to the combined safety/infection control/performance improvement committee. The medication reconciliation compliance worksheet and monthly audit sheet were attached for review along with the educational materials used to train staff. It noted that the risk manager would be responsible for assuring and monitoring effectiveness of the patient medication reconciliation process. The Department accepted this plan of correction and the matter was closed.

Policy Review

HMH Discharge planning policy states that the RN will begin discharge planning at the time of patient admission and the RN will complete a patient discharge summary at the time of discharge. The RN is required to "*complete a written patient discharge summary or transfer sheet at the time of discharge which includes: The following as a minimum:*

a. *Date, time and method of discharge*
b. *Date and time of follow up appointment and phone number if possible*
c. *Diet instructions*
d. *Health problem instructions/Educational Discharge Instructions as applicable*
e. *Special care instructions including adaptive equipment as applicable*
f. *Discharge medications which have been reconciled by MD*
g. *Referral information*
h. *Hospital phone number with instructions to call with any needs or concerns that arise during first 48 hours post discharge*
i. *Pending test results*
j. *Activity*

The RN will ensure that the patient or family member signs the Patient Discharge Summary and ensures the patient or family member understands discharge instructions. The original of the sheet is given to the patient/family and a copy remains with the chart."

Statutes

The Medical Patient Rights Act (410 ILCS 50/3) establishes the following rights *"(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law*"

Hospital Regulations (77 IL ADC 250.1510) require that *"2) An adequate, accurate, timely, and complete medical record shall be maintained for each patient… 4) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness,*

promptness, and clinical pertinence. 5) The hospital shall establish requirements for the completion of medical records and for the retention period for medical records. Definite policies and procedures pertaining to the use of medical records and the release of medical record information shall be issued, and discharge diagnoses shall be expressed in terminology of a recognized disease nomenclature [terms]."

Hospital Regulations (77 IL ADC 250.240) require that *"The hospital shall have written policies for the admission, discharge, and referral of all patients who present themselves for care. Procedures shall assure appropriate utilization of hospital resources, such as preadmission testing, ambulatory care programs, and short-term procedure units…3) The hospital shall provide basic and effective care to each patient. No person seeking necessary medical care from the hospital shall be denied such care for reasons not based on sound medical practice or the hospital's charter, and, particularly, no such person shall be denied such care on account of race, creed, color, religion, gender, or sexual preference…d) Discharge Notification*

1) The hospital shall develop a discharge plan of care for all patients who present themselves to the hospital for care.

2) The discharge plan shall be based on an assessment of the patient's needs by various disciplines responsible for the patient's care.

3) When a patient is discharged to another level of care, the hospital shall ensure that the patient is being transferred to a facility that is capable of meeting the patient's assessed needs.

4) Whenever a patient who qualifies for the federal Medicare program is hospitalized, ***the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital.*** *The notification shall be provided by, or at the direction of, a physician with medical staff privileges at the hospital or any appropriate medical staff member. The notification shall include:*

A) The anticipated date and time of discharge.

B) Written information concerning the patient's right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone number to call if the patient intends to appeal the discharge. This written information does not need to be included in the notification, if it has already been provided to the patient. (Section 6.09 of the Act)

5) Every hospital shall develop and implement policies and procedures to provide the discharge notice required in subsection (d)(4). The policies and procedures may also include a waiver of the notification requirement in either or both of the following cases:

A) When a discharge notice is not feasible due to a short length of stay in the hospital by the patient. The hospital policy shall specify the length of stay when discharge notification will not be considered feasible.

4) When the hospital does not provide the services required by a patient or a person seeking necessary medical care, an appropriate referral shall be made."

The Americans with Disabilities Act (28 CFR 35.130) prohibits discrimination and states *"a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity…"*

(b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others…
(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service…
(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities...
(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association."

The Code of Federal Regulations (42 CFR 482.13) states that *"A hospital must protect and promote each patient's rights. (a) Standard: Notice of rights*
(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible…
(b) Standard: Exercise of rights.
(1) The patient has the right to participate in the development and implementation of his or her plan of care.
(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate…"

Regulations (42 CFR 482.43) also require hospitals to *"have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. (a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning…*
(c) Standard: Discharge plan.
(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.
(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.
(3) The hospital must arrange for the initial implementation of the patient's discharge plan.
(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care…

(d) Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

(e) Standard: Reassessment. The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs."

The Code of Federal Regulations (45 CFR 92.101) prohibits discrimination and states *"…an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies."*

Regulations (45 CFR 92.205) state that *"A covered entity shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity."*

The guardians informed the HRA that this recipient has both Medicaid and Medicare Advantage insurance.

Conclusion

The first complaint alleged a person with a developmental disability was discriminated against by being rushed out of her room and made to sit at the front door of the hospital to wait for her ride to arrive rather than letting her stay in her room and as a result no discharge instructions were given to either her, the caretakers or her legal guardians. The hospital staff that were interviewed explained that typically, a patient remains in his or her room until the time of discharge. The CILA home staff also confirmed that upon discharge of a resident, the staff usually comes to the hospital floor to the nurses' station and nursing staff review the discharge instructions and the CILA home staff signs that they received the instructions. After that, the patient is free to leave. In this case, the guardians and the CILA home staff had corroborating stories that the recipient was waiting at the front door of the hospital to be taken home and that no discharge instructions were given to either home staff or the guardians. Although there is no evidence that the patient was discriminated against because of her disability, her discharge process did not follow typical procedures and was all the more improper because she has cognitive and physical disabilities. The chart information reviewed also confirmed that there was no signature on the discharge instructions as required by the hospital's policy which violates discharge policies. Therefore, this allegation is **substantiated**. The following **recommendation** is made:

1. **Nursing and social service staff should be retrained on Hospital Regulations regarding discharge (77 IL ADC 250.240) and the hospital's discharge policy and ensure that discharge instructions are given at the time of discharge and that a signature is obtained from either the patient, caregiver or legal guardian at that time indicating understanding of discharge orders and instructions. Documentation of such re-training should be provided to the HRA upon completion.**

2. **Incorporate the Hospital Regulations requirements of 24 hour notice when feasible and specify the length of stay when discharge notification will not be considered feasible as outlined in 77 IL ADC 250.240 into the hospital's discharge policies.**

The following suggestion is also offered:

1. Although the policy does not state specifically that patients are allowed to stay in their rooms until the time of discharge, the hospital staff interviewed stated that this is standard procedure. The HRA suggests that the hospital review this practice with nursing staff and also consider adding this practice into the formal policy to ensure that a patient is allowed to remain in his or her room until the moment of discharge rather than being made to sit in a public area while waiting on family or friends to pick them up from the hospital.

The second allegation was that the hospital provided inadequate care and treatment due to not treating the recipient's underlying problem of Dilantin toxicity and discharging her too soon. The hospital records showed that basic CBC panel was taken as well as head and knee scans to check for injury from the fall and the recipient was admitted for overnight observation. The Hospitalist stated that they were concerned that the recipient was having or would have breakthrough seizures and that was the focus of treatment/monitoring and a follow up appointment with the neurologist was recommended. The Hospitalist said that typically lab work to test for increased levels of a medication is not completed unless symptoms exhibited warrant a levels check. The Hospitalist also stated that increased Dilantin levels can cause balance issues and blood pressure medications can also cause dizziness or weakness, however, repeat or additional lab work was not completed prior to discharge because there was no reason to do so as the recipient had no fever. The CILA staff stated that a list of medications was given to the ED upon arrival. The discharge disposition from the ED stated that a report was given to a nurse via phone call and included the patient's care and treatment, medications given to the patient in the ED and the patient's home medications. However, the discharge paperwork faxed to the home had someone else's medications incorrectly listed for this recipient. The Public Health survey also confirmed that medication reconciliation was not properly completed upon discharge. The HRA finds rights violation regarding care consistent with sound nursing and medical practices as required by the Medical Patient Rights Act (410 ILCS 50/3) and violations to the hospital's discharge policy. Therefore, the allegation is **substantiated**. The HRA finds that the issues were resolved prior to the completion of the HRA's investigation as follows:

1. The CEO of HMH informed the HRA that as a result of the Public Health survey, they redesigned their medication reconciliation process, educated staff on this new process and reported the findings to the combined safety/quality committee for identification of any further needed changes. The HRA acknowledges receipt of information regarding this new process and requests training records showing that staff has been educated on that new process as well as information regarding any other changes that have been implemented since the date of the investigation.

2. After discharge the CILA home staff had contacted the hospital's quality assurance department regarding the lab results from the other hospital showing elevated Dilantin levels. According to the Hospital CEO, that issue was addressed with the ED supervising

physician and a memo went out to all ED groups that if a patient comes in with medications which require levels to be checked to do so while they are in the ED. The HRA requests a copy of said memo for its records to show that issue has been resolved.

The following suggestion is also offered:

1. The Hospitalist was unaware of issues of the recipient transferring to the wheelchair when preparing for discharge and stated that previously she had been standing and transferring herself to the chair. Nursing staff should be more observant of changes in behavior and communicate those promptly to the attending physician if there are any concerns or changes in condition to ensure that a patient is not being discharged too soon.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Hamilton Memorial
HOSPITAL DISTRICT

To whom it may concern:

Please review the enclosed materials in regard to the substantiated complaint of the care provided, HRA Case number 17-110-9005.

The following information has been enclosed per your request for needed actions taken.

1. Nursing and social service staff were trained on Hospital regulations regarding discharge and that discharge instructions are given at the time of discharge and that a signature is obtained from either the patient, caregiver or legal guardian indicating understanding of the discharge orders and instructions.

a. See inservice education outline which includes, the statute 77 IL ADC 25.240, and discharge process.

b. See Standard of care Discharge Plan and Discharge of the Patient policy.

c. See inservice posting and inservice Sign in sheet, listing staff attendance.

2. Nursing and social service staff were trained on the 24 hour notice and the length of stay when discharge notification is not considered feasible as outlined in the Standard of Care Discharge plan.

a. See inservice education outline which includes, the statute 77 IL ADC 25.240, and discharge process.

b. See Standard of care Discharge Plan.

c. See inservice posting and inservice Sign in sheet, listing staff attendance.

3. As per your suggestion the Discharge of the Patient Policy was revised to include language that ensures that a patient is allowed to remain in their room until the moment of discharge.

a. See inservice education outline.

b. See the Discharge of the Patient policy.

c. See inservice posting and inservice Sign in sheet, listing staff attendance.

4. Nursing and Providers were educated on the redesigned medication reconciliation process after the completion of a Public Health Survey on 11-17-2016.

Hamilton Memorial
HOSPITAL DISTRICT

a. See inservice posting and Sign in sheet, listing staff attendance.

5. Emergency Department Provider were educated on medications which require levels to be checked while in the Emergency Department.

a. See enclosed memo form ED Director to Ed Providers as requested.

6. As per your suggestion the nursing staff has been re-educated on the need to be observant of changes in behavior and condition and to communicate those promptly to the provider.

a. See inservice education outline.

If you need any further information please contact Hamilton Memorial Hospital District Patty Blazier, CNO. Thank you so much for your input in improving our care at Hamilton Memorial Hospital.

Sincerely,

Victoria Woodrow

Interim CEO

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 17-110-9005

SERVICE PROVIDER: Hamilton Memorial Hospital

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document may be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

_X_ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

[signature]
NAME

CEO
TITLE

10/30/17
DATE