FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
08-110-9001
Choate Mental Health Center (MI Division)
Mental Health Services Division
December 5, 2007

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Choate Mental Health Center, a state-operated mental health facility located in Anna. The facility is comprised of a division for persons with mental health issues and a division for persons with developmental disabilities. This report is pertinent to services within the mental health services division. The specific allegation is as follows:

1. Choate Mental Health Center (MI Division) failed to follow a recipient's wishes related to end of life measures.

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-100 a) and The Health Care Surrogate Act (Act) (755 ILCS 40/5 and 40/65).

Statutes

Section 5/2-100 (a) of the Code states, "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services."

Section 40/5 of the Act states, "The legislature recognizes that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to forgo life-sustaining treatment. Lack of decisional capacity, alone, should not prevent decisions to forgo life-sustaining treatment from being made on behalf of persons who lack decisional capacity and have no known applicable living will or power of attorney for health care."

Section 40/65 of the Act states, "(a) An individual of sound mind and having reached the age of majority or having obtained the status of an emancipated person pursuant to the Emancipation of Minors Act may execute a document (consistent with the Department of Public Health Uniform DNR [Do Not Resuscitate] Advance Directive) directing that resuscitating efforts shall not be implemented. Such a document may also be executed by an attending physician. Notwithstanding the existence of a DNR order, appropriate organ donation treatment

may be applied or continued temporarily in the event of the patient's death, in accordance with subsection (g) of Section 20 of this Act, if the patient is an organ donor. (b) Consent to a DNR Advance Directive may be obtained from the individual, or from another person at the individual's direction, or from the individual's legal guardian, agent under a power of attorney for health care, or surrogate decision maker, and witnessed by 2 individuals 18 years of age or older. (c) The DNR Advance Directive may, but need not, be in the form adopted by the Department of Public Health pursuant to Section 2310-600 of the Department of Public Health Powers and Duties Law. A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform DNR Advance Directive or a copy of that Advance Directive is a valid DNR Advance Directive. A health care professional or health care provider, or an employee of a health care professional or health care provider, who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

Complaint Information

According to the complaint, staff at Choate Mental Health Center administered Cardiopulmonary Resuscitation (CPR) when a recipient who had a Do Not Resuscitate (DNR) Order was found unresponsive. Information in the complaint indicated that CPR was continued until area ambulance personnel arrived to transport the recipient to a nearby hospital. The recipient was pronounced dead when he arrived at the hospital. The recipient was an adult who retained his legal rights at the time of the incident.

Investigation Information

To investigate the complaint, the HRA Investigation Team (Team), consisting of one member and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the Acting Administrator (Administrator). Both Team members spoke via telephone with the Director of Quality Medical Regulatory Compliance (Compliance Director) from a community hospital. The Coordinator spoke via telephone with the Administrator of the area nursing home where the recipient resided prior to this admission to the community hospital and Choate Mental Health Center. The Authority reviewed information from the recipient's clinical charts at Choate Mental Health Center, the nursing home, and the community hospital. Written authorization for the review was provided by the recipient's agent under a Power of Attorney for Health Care (agent). The Authority reviewed the following facility policies: Advance Directives, Living Will, Refusal of Death-Delaying Treatment Policy/Procedure; Department of Human Services Policy/Procedure entitled, "Advance Directives"; a Policy Statement entitled, "Refusal of Life Sustaining Treatment"; and the Recovery Handbook that is given to recipients upon admission to the facility.

Interview with Administrator

During the site visit, the Administrator stated that the recipient whose rights were alleged to have been violated had been a patient at the facility for only five days when he was found unresponsive. The Administrator informed the Team that the recipient had resided in an area nursing home prior to his treatment at the nearby community hospital. He stated that after the recipient received medical treatment at the community hospital, he was released with a statement from a physician at the hospital that his physical health was stable, and he was sent to Choate Mental Health Center for treatment of mental health issues. He stated that upon admission to the facility, the recipient did not have a documented terminal illness. He stated that a labor relation attorney at the facility reviewed the recipient's DNR Order and found it to be invalid. The determination was made due to the lack of witness signatures that is required on the Illinois Department of Public Health DNR Order. Additionally, the facility did not have documentation of the specifics of the recipient's Power of Attorney (POA).

The Administrator stated that CPR was started when staff found the recipient unresponsive and not breathing. He related that facility staff continued administrating CPR until ambulance paramedics arrived. He stated that the ambulance emergency services personnel administered CPR until the recipient arrived at the area hospital where an emergency room physician pronounced him dead. He informed the Team that the Department of Human Services, Office of the Inspector General was contacted regarding the recipient's death. An autopsy was conducted and the findings indicated that the recipient's death was due to Severe Pneumonia and Cardiovascular Disease.

The Administrator informed the Team that CPR is always administered to a recipient who resides within the mental health services division of the facility if that recipient is found unresponsive, determined to not be breathing and without a pulse. He informed the Team that individuals who have mental health issues and are medically fragile are usually treated at a community hospital that has a psychiatric unit rather than Choate Mental Health Center. He related that the facility is not considered a medical hospital.

According to the Administrator, there is no documentation in the recipient's clinical chart that indicated that the recipient or his agent were informed that this specific DNR was invalid or that the facility does not honor invalid DNR orders. The Administrator related that he was not aware of any contact between the facility staff and nursing home staff regarding the validity of the DNR.

Compliance Director

When the Team spoke via telephone with the Compliance Director of the area community hospital, she stated that the recipient was sent to the community hospital from the nursing home. The Compliance Director related that the recipient was hospitalized because he had lost a considerable amount of weight, was not eating, and was having some behavioral problems. She stated that after the medical issues were addressed, the recipient was discharged from the community hospital and transferred to Choate Mental Health Center for evaluation and treatment of the mental health issues. She stated that when the recipient returned to the community hospital emergency room on June 27, 2007, he was unresponsive. She stated that CPR was commenced at Choate Mental Health Center and had been continued by ambulance

service paramedics until the recipient arrived at the community hospital's emergency room. Upon arrival in the emergency room, the recipient was pronounced dead. The Compliance Director stated that the recipient had a DNR Order that specified that CPR should not be administered. The Compliance Director did not question the validity of the DNR.

Nursing Home Administrator

The Nursing Home Administrator informed the Coordinator that the recipient was sent from the nursing home to an area hospital for evaluation on June 21, 2007 after he complained of discomfort and pain in his stomach. She related that the recipient's appetite had decreased, and he had lost a considerable amount of weight. She stated that the recipient was admitted to the hospital for a one-day observation and discharged on June 22, 2007 to Choate Mental Health Center for treatment of his mental health issues. She informed the Coordinator that after residing at the facility for several days, the recipient was found unresponsive. She stated that he was sent to an area emergency room where he died.

According to the Administrator, staff at Choate Mental Health Center did not contact the nursing home regarding the validity of the DNR or to request documentation regarding the recipient's POA. The Administrator did not express any concerns regarding the validity of the DNR.

Record Review

Nursing Home Clinical Chart

A. Physician's Notes

The Authority reviewed information from the recipient' clinical chart at the nursing home where he resided prior to his hospitalization.

A Physician's Progress Note dated 04/28/07 indicated that a psychiatrist had increased the recipient's psychotropic medication because "he had been throwing things around and striking people." The physician documented that the recipient was "close to admission to Choate but has settled down quite a bit according to staff."

A Physician's Progress Note dated 06/01/07 indicated that the physician had seen the recipient and reviewed his medications. According to the documentation the recipient had experienced some weight loss after having pancreatitis, which resulted from the recipient taking the medication Depakote. However, the physician recorded that the recipient's appetite had improved. Additional documentation indicated that the recipient was still having some

maladaptive behaviors, such as pushing and "poking" others, even though the psychiatrist had made multiple changes in his psychtropic medications.

B: Nurses Notes

Documentation indicated that on 06/12/07, the recipient's maladaptive behaviors could not be controlled. He threw his breakfast tray and repeatedly hit others. As a result of these actions, the recipient was sent to a community hospital with a psychiatric unit outside the immediate geographical area. After evaluation, the recipient was discharged on 06/14/07, and he returned to the nursing home.

Recordings in the Nurses Notes dated 06/16/07 and 06/20/07 indicated that the recipient had a very poor appetite. Documentation indicated that the recipient had complained of pains in his stomach on 06/15/07, 06/26/07 and 06/20/07. A Nursing Note dated 06/20/07 recorded that the recipient was sent to an area emergency room; however, he was not admitted to the hospital at that time. Documentation indicated that the recipient returned to the emergency room on 06/21/07. At that time he was admitted for 24-hour observation and evaluation. On 06/22/07, the record indicated that the recipient was discharged from the area hospital and sent to Choate Mental Health Center for evaluation of the psychiatric issues. A 06/22/07 Nurses Note indicated that a physician at the community hospital documented that the recipient was medically clear for discharge, and he felt that all of the recipient's previous behaviors, such as lack of appetite and weight loss were due to his psychiatric problems. An additional 06/22/07 Nurses Note indicated that a counselor from Choate Mental Health Center had contacted staff at the nursing home to determine if the facility was holding a bed for the recipient. The Nurse documented the following: "I told her absolutely, we would take [the recipient] back as soon as he was stable."

C. Illinois Statutory Short Form Power of Attorney for Health Care (POA)

A POA Form dated 08/10/2006 indicated that the recipient had named a member of his family to make all decisions for him, upon his incapacity, concerning medical treatment, hospitalization and health care as well as decisions to withhold or withdraw any type of medical treatment or procedure, even though death might ensue. The document indicated that another family member was named as successor in the event the individual named as the primary agent should die, become incompetent, disabled, or refuse to accept the office of agent. The Form was signed by the recipient and witnessed by an individual other than the agent or successor. The POA granted power to the agent to make any decision to obtain or terminate any type of health care, including life-sustaining measures.

D: Do Not Resuscitate (DNR) Order

An Illinois Department of Public Health DNR Order form dated 09/27/06 was reviewed. The recipient's physician and his agent under the POA signed the document.

It was indicated in the Legal Representative's Signature of Consent for Patient Lacking Decision Making Capacity section of the Order that if the patient lacks decision-making

capacity, then a signature should be obtained in this witness section of the Order. There were no signatures in the witness section of the Order.

Hospital Clinical Chart Review

A. Short Stay Summary Form (Form)

According to the Form, the 60-year-old male nursing home resident was brought into the emergency room at the hospital secondary to the concerns of the family, nursing home staff and his primary care physician. The recipient had not been eating well and had lost approximately 30 pounds within the previous six months. He had experienced episodes of agitation, violent behavior, and had thrown objects at others. According to the physician completing the Form, the recipient had occasionally complained of abdominal discomfort in the past, including the day of his admission on 06/21/07. An abdominal CT scan that had been completed a day prior to admission did not indicate any acute pathology. The physician documented that after multiple discussions with the family, nursing home staff and the recipient's primary care physician, the recipient was admitted as an inpatient. The admission was implemented to assure that the recipient had adequate hydration, and he was medical cleared for placement at Choate Mental Health Center in order that evaluation and treatment for his violent behaviors and agitation might be addressed.

According to the documentation, the recipient was started on IV fluids and a mechanical soft diet shortly after admission. Although he did not experience any episodes of abdominal pain, he had occurrences of agitation, throwing objects at others, and had attempted to pull out his IV lines. The physician documented that the community mental health agency had conducted an evaluation and determined that the recipient should be placed at Choate Mental Health Center. Documentation indicated that when the recipient's agent was contacted, she agreed with the placement.

According to the Form, the recipient was discharged from the hospital and admitted to Choate Mental Health Center on 6/22/07. Final diagnoses were listed as follows: paranoid schizophrenia with agitation, history of atrial fibrillation, gastroesophageal reflux disease, mild mental retardation, and history of acute pancreatitis.

B Patient Information and Transfer Form (Transfer Form)

Documentation in the Transfer Form indicated that the recipient had a DNR and that a family member was a POA agent for the recipient's medical needs. The Transfer Form was completed at the nursing home where the recipient resided and sent with the recipient to the emergency room at the community hospital.

Clinical Chart at Choate Mental Health Center

A. Illinois Department of Human Services Uniform Screening and Referral Form (USARF)

A community mental health representative completed a USARF at 12:45 PM on 06/22/07 at the area hospital. According to the documentation the recipient had been agitated. He pulled IV lines, "abused" staff and threw objects. He had lost approximately 30 pounds because he had refused to eat. Documentation indicated that there had been multiple modifications in his treatment in an attempt to assist the recipient in regaining control. However, all interventions had failed. Documentation indicated that the recipient had been admitted to another community hospital with a psychiatric unit earlier in June 2007. According to the crisis worker completing the USARF, the recipient was in need of involuntary admission and immediate hospitalization. The record indicated that the nursing home would accept the recipient for readmission when his condition was stabilized.

B. Treatment Plan Review (TPR)

An initial Treatment Plan was completed on 06/22/07. According to the Intake Note, the recipient had a previous hospitalization at community hospital with a psychiatric unit from 06-12/07 to 06/14/07. The problem areas listed included the following: aggression, assault due to psychosis, mild mental retardation, and a history of atrial fibrillation.

The recipient's TPR contained a goal for his thought to become reality focused enough that he could understand and follow an aftercare plan. A target date of 06/29/07 was listed.

The following objectives were listed to assist the recipient in reaching the goal: 1) take medications as prescribed; 2) identify his psychiatrist and social worker; 3) seek case management services provided by the community mental health clinic for the purpose of arranging transition linkage and aftercare services; and 4) be able to engage in verbal discussion, physical activities and skill building.

C. Progress Notes

A Registered Nurse (RN) documented at 1:05 PM on 06/27/07 after passing by the recipient's dorm and observing him sleeping on his bed that the recipient was snoring and appeared to be resting well. The RN recorded that he went into another recipient's dorm where he stayed for approximately 5 minutes and then returned down the hall. The RN documented that when he passed the recipient's room this time, he did not hear him snoring and stopped to "check" him. He noted that the recipient did not appear to be breathing and was unresponsive. The RN recorded that he notified the Medication Nurse and requested that an Automated External Defibrillator (AED) be brought to the recipient's dorm. The RN documented that CPR was commenced immediately and that the AED was used until emergency medical staff arrived at 1:20 PM and transported the recipient to the hospital at 1:25 PM. The HRA did not observe any documentation that indicated that the RN was aware of the existence or status of the recipient's DNR.

Another RN recorded that she was in the conference room when unit staff called her over the radio at approximately 1:12 PM on 06/27/07 and requested that she come into the chartroom. When the RN arrived on the unit she noted that two staff members were going down the hallway

with the AED and the "code bag". She documented that the staff members informed her that the recipient was not breathing, had no pulse and was not responding to verbal stimuli. She recorded that CPR was initiated and the AED was applied. The RN documented that no shock was ordered after the AED analyzed the recipient's cardiac status; however, CPR was continued until the ambulance staff arrived to transport the recipient to the emergency room.

Similar accounts of the incident were recorded in the progress notes by three mental health technicians, another RN, a social worker, a nurse practitioner, and a facility psychiatrist.

According to a 2:25 PM Nurses Note, the recipient was pronounced dead at 1:42 PM by an emergency room physician at the community hospital. The RN recorded that the recipient's agent was contacted regarding the recipient's death, and she agreed that an autopsy would be advisable.

D. Medical Emergency Log (Log)

Documentation in the Log indicated that an RN walked down the hall at 1:05 PM on 06/27/07 and heard the recipient snoring. The Log indicated that when the RN walked backed down the hall he could not hear the recipient so he stopped to examine him. Upon examination, the RN noted that the recipient did not have a pulse. Documentation indicated that three additional RNs were contacted at 1:10 PM, and the ambulance service, facility physician, and hospital security were notified at 1:12 PM. Documentation indicated that the RNs and the facility physician responded within two minutes. The ambulance services and hospital security arrived a 1:20 PM, eight minutes after notification. Medical Emergency Actions were implemented at 1:12 PM when CPR, the AED, and oxygen were commenced. No pulse and no respirations were recorded at 1:10 PM. The AED was connected at 1:10 PM. According to a 1:21 PM recording in the Log, the AED had been connected since 1:10 PM with no shock indicated. At that time, the recipient had no pulse, respiration or measurable blood pressure. When the recipient was transferred to the community hospital at 1:25 PM, there was no change in his condition.

Additional documentation in the Log indicated that the facility director was notified at 1:15 PM and the agent at 1:37 PM. The recipient was pronounced dead at 1:42 PM and the County Coroner was contacted at 2 PM.

E. Additional Information

The Authority was not provided with any records pertinent to the facility's review of the DNR and determination that the document was invalid. Nor was their any information regarding staff at the facility discussing the validity of the DNR with the recipient's agent. A copy of the DNR was included in the facility's records; however, the POA was not a part of the recipient's clinical chart.

According to the American Heart Association, an automated external defibrillator (AED) is a computerized medical device that checks a person's heart rhythm and recognizes a rhythm that requires a shock. The device can advise, through voice prompts, lights and test messages, the life saving steps that are needed.

Policies

Department of Human Services (DHS) Advance Directives Policy

The Policy is as follows: "Every individual being served in Department of Mental Health and State-Operated Developmental Centers/Programs has the right to make decisions regarding his or her medical care, including the decision to discontinue treatment, to the extent permitted by law. Each Center/Program shall assist the individual in the exercise of his or her rights, and shall inform the individual of his or her responsibilities in the exercise of those rights. Each Center/Program shall ensure compliance with the federal Patient Self-Determination Act (a part of OBRA 1990) and shall endeavor to comply with the individual's wishes regarding the type of care the individual wishes if he or she becomes terminally ill or incapacitated, and unable to communicate his or her wishes."

According to the Policy, a DNR is defined as follows, "Physician orders to not resuscitate a person if he or she becomes unconscious due to cardiac arrest. A DNR order is not an advance directive that is initiated and signed by the individual, but is an order that implements an individual's wishes expressed in an advance directive or as understood by a surrogate. For individuals receiving services at Centers/Programs, DNR orders may be issued and implemented subject to the provisions contained in this Directive."

A Durable Power of Attorney for Health Care is defined as, "A written document in which an individual specifies in advance who should make health care treatment decisions for him or her if the individual becomes unable to make those decisions for himself or herself."

In the General Procedures section of the Policy, each Center/Program is mandated to maintain written policies and procedures related to advance directives. During the intake process at each Center/Program, a competent individual should be provided with a Statement of Illinois Law on Advance Directives, a document that provides information concerning the individual's right under Illinois law to make decisions concerning medical care and the right to make advance directives. On admission, Center/Program intake staff will ask every adult, or his or her representative, if he or she has an existing advance directive and designate the directive on the admission form. If the individual indicates that a valid advance directive exists, Center/Program intake staff will ask the individual or the individual's representative to provide the original document to be copied and returned. The information should be documented in the recipient's clinical record and a copy of the directive taken to the unit for inclusion in the individual's record. The supervising nurse in the unit will notify the attending physician of the existence of the document and note the date and time of the notification. The attending physician will also document in the individual's clinical chart the place, date, and time he or she was notified of the existence of the advanced directive. The provisions of the advanced directive will be respected and incorporated in the treatment plan. The HRA was not presented with any information

regarding a facility policy that would mandate the administration of life-saving measures when a recipient had an advanced directive to the contrary.

Choate Mental Health Center …Advanced Directives, Living Will, Refusal of Death-Delaying Treatment Policy/Procedure

According to the Policy/Procedure, "Medical and Behavioral/Mental Health Advance Directives specify how decisions about treatment should be made if a patient becomes incompetent. An advance directive allows each patient to state his/her choices for health care or to name someone to make those choices for him/her." Upon admission to the facility, each recipient and/or his/her parent or guardian is given written information about advance directives and a Statement of Illinois Law on Advance Directives by the Department of Public Health. Documentation and/or changes in Advance directives or recipient preferences are made on an Advance Directive Attestation Form by the admitting RN, noting whether or not the recipient, parent or guardian has executed an advance directive. If the recipient, parent or guardian chooses to execute an advance directive and does not have the required form, an appropriate referral with be made to the Guardianship and Advocacy Commission.

In the Durable Power of Attorney Section of the Policy/Procedure the following is stated: "If a patient has executed a written agency agreement which authorizes the agent to make health care decisions, (while competent, and prior to the filing of a petition for appointment of a guardian of patient), the decisions of the agenda shall be valid and binding."

In the Do-Not-Resuscitate Order (DNR) of the Policy, the following is stated: "A DNR order means that cardiopulmonary resuscitation (CPR) will not be started if your heart stops. A legally competent and capable patient and the attending physician decide together that the doctor should write a DNR order into the medical record. A DNR order still allows health care workers to administer the Heimlich maneuver or take other appropriate action in the event of an accident, such as choking on food." According to the Policy, attending physicians are responsible for advising the Network Manager of any patient for whom a DNR Order may be determined as warranted. Prior to implementation action to institute a DNR order the following should be ensured: "1) All requirements of the Illinois State Laws are adhered to regarding DNR orders. 2) All requirements of the Illinois Department of Public Health are met regarding DNR Orders. 3) Staff have been appropriately informed and inserviced regarding the DNR Orders. 4) The Clinical Director for the Office of Mental Health has been advised of the need for a DNR Order." The HRA did not observe any documentation in the Policy that addresses review of DNR for validity.

Mental Health Services Policy Statement…Refusal of Life Sustaining Treatment (Policy Statement)

According to the Policy Statement, "Patients who are legally competent and capable shall have the right to make decisions regarding their health care, including being afforded the opportunity to institute an Advance Directive at the time of admission…A DNR Order may be instituted for any person with a terminal condition, permanent unconsciousness or

incurable/irreversible condition in which death is eminent based on certification by a person's attending physician and a second physician who are not employed by the Clyde. L. Choate Mental Health and Developmental Center in accord with procedures and requirements of Illinois State Law and regulations of the Illinois Department of Public Health…"

Recovery Handbook

The Authority reviewed the Recovery Handbook that is given to recipients upon admission to the facility. A Statement Of Illinois Law On Advance Directives is included in the Recovery Handbook. The Statement is as follows: "You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement about how you want medical decisions made when you can no longer make them. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. Illinois has these advance directives: (1) health care power of attorney, (2) living will, and (3) mental health treatment preference declaration. If you make an advance directive, tell your doctor and other health care providers and provide them with a copy." Information is provided in the Recovery Handbook about a DNR. Recipients are informed that they may ask their physicians about a DNR, an order that means CPR would not be started if the recipient's heart stops. The following is documented, "You and your doctor may decide together that your doctor should write a DNR order into your medical chart. If you have an accident, such as choking on food, the DNR order still allows health care workers to give you the Heimlich maneuver or take other appropriate action." Recipients are informed that no facility, doctor, or insurer can make a recipient execute an advance directive. It is entirely the recipient's decision.

The Authority did not observe any documentation in the Recovery Handbook that indicated that an existing DNR, invalid or otherwise, would not be honored in the event that a recipient coded while hospitalized at the facility.

Summary

According to the complaint, Choate Mental Health Center staff did not honor a recipient's end of life decision specified in a DNR Order. In an effort to revive the recipient, staff administered CPR and used an AED when the recipient was found unresponsive, not breathing, and without a pulse. CPR was continued until paramedics arrived and transported the recipient to an area hospital where he was pronounced dead. During a site visit to the facility, the Administrator informed the Team that the recipient's DNR Order was invalid. He related that the DNR Order was presented to the facility when the recipient was admitted five days prior to his death. The Administrator stated that the DNR was reviewed and found to be unacceptable due to lack of witness signatures, an Illinois Department of Public Health requirement to ensure validity. The HRA reviewed a copy of the DNR Order that contained a physician's signature and the POA's signature; however, there were no witness signatures on the Order. The HRA did not observe any documentation in the recipient's clinical chart that verified that the facility had reviewed the DNR and found the Order to be invalid or that they attempted to investigate and remedy the matter.

The Administrator informed the Team that CPR is always given to a recipient when he or she is found without a pulse and unresponsive, even if the recipient has a DNR. However, no written policy was presented to HRA that indicated the facility's practice. When asked by the Team if recipients were informed upon admission of the facility's policy to implement CPR regardless of a DNR, the Administrator stated that he was not aware of any written or verbal notification. According to DHS and the facility's policies, recipients are verbally informed and notified in writing via the Recovery Handbook of the various advance directives and the recipients' right to have those directives honored.

Conclusion

Based on the HRA's observation of the DNR in question, the HRA has determined that the Order was invalid due to the mandates to have witness signatures on the DNR Order. Therefore, the allegation pertinent to the recipient listed in the complaint is unsubstantiated. However, the HRA found in this case that the facility failed to follow its own and DHS advanced directives policies specific to informing recipients and their representatives of information and rights related to advanced directives, clarification of an advanced directive upon admission and appropriate documentation of an existing advanced directive in the clinical record and treatment plan. DHS and facility policies mandate that the facility honor a recipient's advance directives; the HRA questions the administration's reported practice of giving CPR even when a DNR or other advanced directive is in place.

Recommendations

1. Choate Mental Health Center should follow its written policies and procedures pertinent to advance directives.

2. A copy of the advance directive should be incorporated in the recipient's clinical chart, as well as, appropriate documentation in accordance with the facility's written policy.

3. Staff members should be appropriately informed regarding all recipients advance directives and training should be provided to familiarize the staff with the components of the directives.

4. Documentation should be incorporated in a recipient's clinical chart when an advanced directive is determined to be invalid, such as the case listed in this incident, and the reasons for the invalidity clearly stated.

5. Information regarding a recipient's advanced directives should be incorporated in the Recipient's Individual Treatment Plan.

6. Whenever a DNR is reviewed by the facility and found to be invalid, facility staff should clarify the recipient's end of life decisions and provide assistance to validate

documents if required.

7. Ensure that policies are consistent with requirements under the Health Care Surrogate and Power of Attorney Acts.

8. Review the practice of giving CPR whenever there is a prohibiting DNR or other a advanced directive in place.

9. Reference updated DNR forms on the IDPH's website.

RESPONSE

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

Rod R. Blagojevich, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

CLYDE L. CHOATE MENTAL HEALTH CENTER
1000 NORTH MAIN • ANNA, IL 62906

January 17, 2008

Ms. Mary McMahan, Chairperson
Regional Human Rights Authority
#7 Cottage Drive
Anna, Illinois 62906

HRA No. 08-110-9001

Dear Ms. McMahan:

Thank you for the opportunity to respond to your concerns following your Human Rights investigation pertaining to the above-mentioned case. Our primary goal at Choate Mental Health Center is to provide recovery-focused care for the consumers we serve. We have reviewed the report, as well as the recommendations, forwarded by your organization. Our response, which includes an outline with target dates addressing this matter, is listed below.

Recommendation #1
Choate Mental Health Center will follow and ensure that its written policies and procedures pertinent to advance directives are in compliance with the Department of Human Services Program Directives. Choate Mental Health Center will review and modify as needed the current policy and procedure. If indicated, all involved staff will be retrained regarding the policy and procedure no later than May 30, 2008.

Recommendation #2
Choate Mental Health Center will make every effort to incorporate a copy of a properly executed advance directive(s) in the consumer's clinical record. However, the success of this effort remains dependent on the patient and/or guardian's willingness to comply with our efforts to obtain the necessary copies.

Recommendation #3
Choate Mental Health Center will ensure that staff members are appropriately informed and trained on the various components of advance directives by May 30, 2008.

Recommendation #4
When a consumer's advance directive(s) is considered to be invalid, Choate Mental Health Center

will document the notification of such invalidity to the consumer/representative in the clinical record. Staff will be educated and trained no later than May 30, 2008.

Recommendation #5
See Recommendation #2.

Recommendation #6
See Recommendation #4.

Recommendation #7
See Recommendation #1

Recommendation #8
Choate Mental Health Center will follow the Department of Human Services Program Directives to provide life sustaining treatment.

Recommendation #9
Consumers/representatives needing information of advance directive(s) will be referred to their private attorney or Attorney General's office for assistance.

Sincerely,

Bryant Davis
Acting Facility Director

Elaine Ray
Acting Quality Manager