

Act Number:	09-108	
Bill Number:	243	
Senate Pages:	1123-1126, 1128-1131, 2807, 2811-2813	12
House Pages:	4521-4535	15
Committee:	Aging: 317, 319-320, 326- 333, 339-346, 348-349, 368- 370, 372-373, 393-397	31
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consent calendar, Mr. President.

THE CHAIR:

Seeing no objection, so ordered, sir. Mr. Clerk.

THE CLERK:

Calendar page 27, Calendar Number 371, File Number 531, substitute for Senate Bill 243, AN ACT CONCERNING TRAINING IN PAIN MANAGEMENT, favorable report of the Committees on Aging and Public Health.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

A little humor, Mr. President, is always good for you.

THE CHAIR:

Yes, ma'am. Good medicine. Yes, ma'am.

SENATOR PRAGUE:

Mr. President, I move adoption of this bill.

THE CHAIR:

Acting on adoption, ma'am, would you like to remark further?

SENATOR PRAGUE:

I would. Thank you. What the bill does is require each nursing home facility that is not an Alzheimer's special care unit, because the training

mandated for the Alzheimer's special care units is different from this pain management requirement, that each facility shall annually provide a minimum of two hours of training in pain management and recognition.

The training will be offered to all licensed and registered direct care staff, nurses aides and others who provide direct patient care to residents.

Frequently, in nursing homes, patients are nonverbal. It is a time of suffering for them if they have pain and they can't express the pain, where it is and how bad it is. And if the staff is trained to recognize this pain and manage it, patients will be better served.

Mr. President, through you, I'd like to recognize Senator Harris for an amendment.

THE CHAIR:

Senator Harris, do you accept the yield, sir?

SENATOR HARRIS:

Yes, Mr. President.

THE CHAIR:

Please proceed.

SENATOR HARRIS:

Thank you, Mr. President. Through you, for purposes of legislative intent, a question for Senator

Prague. Senator, the section that you were talking about in lines 19 to 23, you're correct. It starts on line 20, that there will be provision of a minimum of two hours of training in pain recognition and administration of pain management techniques. Then goes on to list types of providers that would be required to be trained. One of them is nurses aides -- are nurses aides. Nurses aides, is my understanding, actually do not give medication and it's not the intent of this bill, am I correct, to say that they need to be trained in providing medication just in pain management techniques?

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Through you, Mr. President, you're right, Senator Harris, nurses aides do not -- do not administer medication, but they certainly can use heating pads, they certainly -- if they recognize pain, can report that to the nurse on duty. And the nurse can do whatever she needs to do to help relieve the pain.

THE CHAIR:

Senator Harris.

SENATOR HARRIS:

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Thank you, Mr. President. I thank Senator Prague for her clarification for bringing forth this good bill.

THE CHAIR:

Senator Prague.

SENATOR PRAGUE:

Through you, Mr. President, I also think Senator Harris for clarifying this issue about nurses aides. I move, hopefully, that the circle will adopt this bill. There are too many people in nursing homes who can't express themselves, who need to have the care of people who know what they're doing.

THE CHAIR:

Thank you, Senator. Will you remark further on Senate Bill 243? Will you remark further? Senator Prague.

SENATOR PRAGUE:

If there is no objection, Mr. President, I'd like to move this to the consent calendar.

THE CHAIR:

Motion is on consent. Seeing no objection, so ordered, ma'am. Mr. Clerk.

THE CLERK:

Mr. President, that completes those items

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Yes. Thank you, Mr. President. Before voting -- calling for a vote on the first consent calendar, Mr. President, would move that all items previously noted for referral to various committees be immediately transmitted to those committees.

THE CHAIR:

Without objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Mr. President. Would now ask the Clerk to call the first consent calendar.

THE CHAIR:

Mr. Clerk, please make a roll call vote for the consent calendar, also.

THE CLERK:

Immediate roll call has been ordered in the Senate. Will all Senators please return to the chamber. Immediate roll call on the consent calendar has been called for in the Senate. Will all Senators please return to the chamber.

Mr. President, those items placed on the first consent calendar began the calendar page one, Calendar Number 364, Senate Joint Resolution Number 73; Calendar 122, Senate Joint Resolution Number 64. Calendar page 2, Calendar 123, Senate Joint Resolution

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Number 65; Calendar 124, Senate Joint Resolution
Number 66; Calendar 125, Senate Joint Resolution,
Number 67; Calendar 126, Senate Joint Resolution,
Number 68. Calendar page 3, Calendar Number 230,
House Joint Resolution Number 106; Calendar
Number 231, House Joint Resolution Number 107;
Calendar 232, House Joint Resolution Number 108.
Calendar page 4, Calendar Number 233, House Joint
Resolution Number 109; Calendar 234, House Joint
Resolution Number 110; Calendar 235, House Joint
Resolution Number 111; Calendar 236, House Joint
Resolution Number 112; Calendar 308, Senate Resolution
Number 14. Calendar page 5, Calendar Number 309,
Senate Joint Resolution Number 72; Calendar
Number 339, Senate Resolution Number 15; Calendar 340,
Senate Resolution Number 16; Calendar Number 387,
House Joint Resolution Number 116. Calendar page 7,
Calendar Number 105, Senate Bill Number 780. Calendar
page 11, Calendar Number 154, substitute for Senate
Bill 222; Calendar 157, Senate Bill Number 861.
Calendar page 20, Calendar Number 261, substitute for
Senate Bill 959; Calendar Number 262, substitute for
Senate Bill 960. Calendar page 22, calendar Number
313, Senate Bill Number 947. Calendar page 23,

Calendar Number 315, Senate Bill Number 1012;
Calendar 322, substitute for Senate Bill 488.
Calendar page 26, Calendar Number 366, substitute for
Senate Bill 784. Calendar page 27, Calendar 371,
substitute for Senate Bill 243. Calendar page 28,
Calendar Number 375, substitute for Senate Bill 1021.
Calendar page 29, Calendar 383, substitute for Senate
Bill 886.

Mr. President, that completes those items placed
on the consent calendar.

THE CHAIR:

Mr. Clerk, could you please call for a roll call
vote on the consent calendar again.

THE CLERK:

The Senate is now voting by roll call on the
consent calendar. Will all Senators please return to
the chamber. The Senate is now voting by roll call on
the consent calendar. Will all Senators please return
to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have
voted, please check your vote. The machine will be
locked. The Clerk will call the tally.

THE CLERK:

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Motion is on adoption of Consent Calendar

Number 1.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The consent calendar passes. The Senate will stand at ease.

Chamber at ease.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Yes, thank you, Mr. President. Mr. President, the next item we'd like to take up is on Senate Agenda Number 1, previously adopted. That is Emergency Certified House Bill Number 6715. Would ask the Clerk to call that item from Senate Agenda Number 1.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calling from Senate Agenda Number 1, Emergency.

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371, Senate Bill 243 would also move to place that item on the Consent Calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President. Also a few bills on the Calendar for purposes of referral to various committees or other markings, first of all, Mr. President, on Calendar page 6, Calendar 478, Senate Bill 141, Mr. President, would move to place that item on the foot of the Calendar.

THE CHAIR:

Motion is to place the item on the foot of the Calendar. Is there objection?

Seeing none, so ordered.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, on Calendar page 20, Calendar 141, Senate Bill Number 362 would also move to place that item on the foot of the Calendar.

THE CHAIR:

Motion is to place on the foot. Is there objection? Seeing none, so ordered.

SENATOR LOONEY:

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SENATOR LOONEY:

Thank you, Mr. President. Mr. President, I would yield the floor to any members who would be seeking recognition for purposes of announcements or points of personal privilege before making motion to adjourn for today.

THE CHAIR:

Are there announcements or points of personal privilege? Are there any announcements or points of personal privilege?

Senator Looney, do you wish -- Senator Looney, the Clerk confirms that there is a second agenda as well as a Consent Calendar on his desk.

SENATOR LOONEY:

Yes, that's right, Mr. President. Would ask for the Clerk to call the Consent Calendar at this time.

THE CHAIR:

Would the Clerk please call the Consent Calendar.

THE CLERK:

Mr. President, the items that have placed on the first Consent Calendar, there are three items beginning on Calendar page 8, Calendar 537, Substitute for House Bill 6186; Calendar page 38, Calendar Number 155, Substitute for Senate Bill 451; and Calendar page

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39, Calendar 371, Substitute for Senate Bill 243. Mr. President, that concludes those items placed on the Consent Calendar.

THE CHAIR:

Would the Clerk please announce that the Senate is voting on the Consent Calendar.

THE CLERK:

A roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber. The Senate is now voting by roll call on the Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

Would all Senators please check the board to make certain that your vote is properly recorded. If all members have voted, the machine will be locked, and the Clerk will take a tally.

THE CLERK:

Motion is on adoption Consent Calendar Number 1.

Total Number Voting 34

Necessary for Adoption 18

Those voting Yea 34

Those voting Nay 0

Those absent not voting 2

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THE CHAIR:

The Senate Calendar is adopted.

Is there further business on the Clerk's desk?

THE CLERK:

Mr. President, the Clerk is in possession of Senate Agenda Number 2, dated Wednesday, May 20, 2009. Copies have been distributed.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Mr. President, yes, thank you, Mr. President. Mr. President, I move all items on Senate Agenda Number 2, dated Wednesday, May 20, 2009, to be acted upon as indicated and that the Agenda be incorporated by reference into the Senate Journal and the Senate Transcript.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Yes, thank you, Mr. President. For a Journal notation. Mr. President, Senator Prague after the lengthy debate of a bill earlier today missed the call on the Consent Calendar because of an illness in her family. She had to leave to visit her daughter in the

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Those absent and not voting 9

In concurrence with the Senate.

DEPUTY SPEAKER McCLUSKEY:

The bill is passed in concurrence with the
Senate.

Will the Clerk please call Calendar Number 434.

THE CLERK:

On Page 13, Calendar Number 434, Substitute for
Senate Bill Number 243 AN ACT CONCERNING TRAINING IN
PAIN MANAGEMENT. Favorable Report of the Committee on
Public Health.

DEPUTY SPEAKER McCLUSKEY:

The honorable lady from the Town of West
Hartford, Representative Bye you have the floor,
Madam.

REP. BYE (19th):

Good evening, Mr. Speaker. Mr. Speaker, I move
for the acceptance of the Joint Committee's Favorable
Report and passage of the bill.

DEPUTY SPEAKER McCLUSKEY:

The question is acceptance of the Joint
Committee's Favorable Report and passage of the bill.
Will you remark?

REP. BYE (19th):

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Thank you, Mr. Speaker. What this bill does is, it requires all nursing facilities, nursing home facilities instead of only those with Alzheimer units, to provide at least two hours of annual training in pain recognition and administration of pain techniques to all licensed and registered direct care staff and nurses aides who provide direct patient care.

I urge adoption. I urge passage of the bill, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Thank you, Madam. Will you remark? Will you remark on the bill? Representative Sayers of the 60th, you have the floor, Madam.

REP. SAYERS. (60th):

Thank you, oh, excuse me. Thank you, Mr. Speaker. The Clerk has in his possession an amendment, LCO Number 7196. I ask that he call it and I be allowed to summarize.

DEPUTY SPEAKER McCLUSKEY:

Will the Clerk please call LCO Number 7196 to be designated House Amendment Schedule A.

THE CLERK:

LCO Number 7196, House A, offered by
Representatives Olson and Sayers.

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DEPUTY SPEAKER McCLUSKEY:

Representative Sayers.

REP. SAYERS (60th):

Thank you, Mr. Speaker. This amendment removes the residential care homes from the bill. Residential care homes are a nonmedical model. It is beyond the scope of practice of the staff that is there, and they cannot administer PRN medications, those (inaudible) medications required for pain management.

I move adoption.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is adoption of House Amendment Schedule A. Will you remark on House Amendment Schedule A? Representative Miller?

If not, I will try your minds. All those in favor of House Amendment Schedule A signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER McCLUSKEY:

All those opposed, Nay. The Ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?
Representative Frey of the 111th, sir, you have the

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floor.

REP. FREY (111th):

Thank you, Mr. Speaker. Perhaps it's appropriate we're doing a bill on pain management tonight after a couple of the bills we've taken up.

But I want to urge support of this bill as amended. Most nursing homes that I'm aware of already offer, already do pain management training for their nonAlzheimer units areas, but I think it makes sense to codify that, and I would urge adoption. Thank you.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks. Will you remark further on the bill as amended? Representative Perillo of the 113th, sir, you have the floor.

REP. PERILLO (113th):

Mr. Speaker, thank you very much. Just a few questions for the proponent of the bill if I may, through you.

DEPUTY SPEAKER McCLUSKEY:

Proceed.

REP. PERILLO (113th):

First, just so I can understand what kind of training would be offered, is there a standardized curriculum that is offered in pain management and the

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treatment of it, or is that left up to the specific nursing facility?

Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Bye.

REP. BYE (19th):

Thank you, Mr. Speaker. Through you, my understanding is that this bill requires two hours of training. I would imagine that there's some specifics, but this doesn't outline it. We're leaving that to the expertise of the facilities where that takes place.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Thank you very much. A follow up question to that, if I could, through you, sir.

There are obviously, and the bill refers to licensed and registered direct care staff. Obviously, there are different levels of certain occasional licensure, anything from licensed practical nurse, nurse's aides, up to registered nurses, obviously they all have a different scope of practice.

Would a nursing facility have to tailor its

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training in different training programs for each individual scope of practice, or would there be one standard training for all scopes of practice? Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Bye.

REP. BYE (19th):

Thank you, Mr. Speaker. Through you, the home can decide to do it in a manner, which they seem fit. If the home decides that their direct care staff needs a different training than a higher level staff, they may do it that way, but it's two hours of training.

What's happening is, patients who are not Alzheimer's patients generally request pain care, you know, pain medication twice as often as Alzheimer's patients.

Alzheimer's patients have difficulty communicating, and this class would help the staff recognize signs of pain because of the communication difficulty, so it would really be up to the home, but it's an important training.

Thank you. Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

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REP. PERILLO (113th):

Thank you, Mr. Speaker, and I have just one final question. What would this mean in terms of cost for the nursing facility? Is this the kind of training that could be offered in house at little to no cost?

I would imagine that for two hours they would, you know, the nursing facility would still have to pay a staff for that, but even beyond that, is this a level of training that nursing facilities would have to bring someone in for to teach, or like I said, is that available within the facility? Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Bye.

REP. BYE (19th):

Through you, Mr. Speaker, as Representative Frey indicated, most nursing homes are already offering this training to their staff, so it doesn't add a burden.

There are only 18 facilities currently that don't have anyone with a diagnosis of Alzheimer's out of 249 facilities, so it's my understanding that this would mean very little extra burden.

And in fact, when you look at the testimony about the bill, there was no testimony against the bill. So

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I believe the nursing homes want to do the right thing and plan to do this.

But as Representative Frey said, it codifies it for us. Thank you. Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, I thank you very much, and I thank the gentle lady for her answers. I agree. This seems to be something that makes sense and I will be supporting it today. Thank you, sir.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks. Will you remark further on the bill as amended? Will you remark further on the bill as amended? Representative Sayers, you have the floor, Madam.

REP. SAYERS (60th):

Thank you, Mr. Speaker. I rise to tell you what an excellent job this bill is. I want to thank Representative Bye for brining this bill forward.

Right now in order to be one of the quality indicators from the federal government, in order to be in compliance with the Title 18 and Title 19 program in our nursing homes is that they have to look at the

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pain management, and in order to do that properly, they do need this training. .

A couple of years back we passed legislation that required that the state, that the nursing homes provide that at unlocked Alzheimer's units as well as some of our assisted living.

Right now, this means that throughout the nursing home they're going to be providing that same type of training, only in a lesser amount, and because they already need to do that in order to be in compliance with the federal requirements in order to receive Medicare and Medicaid money, many nursing homes already do this.

As well as the registered licensed staff, the certified nurses aides really need to know because they are the persons that see the residents most days. They care for these residents firsthand. They need to be able to know what signs to look for, what type of information to bring to that licensed staff so that they can be part of the plan for pain management.

So I want to again thank Representative Bye for this very important bill. Thank you.

DEPUTY SPEAKER ALTOBELLO:

Thank you, Representative Sayers. Representative

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Miller of the 122nd, you have the floor, sir.

REP. MILLER: (122nd)

Thank you, Mr. Speaker. I made an inquiry of one of my convalescent homes that's around the corner to my home, and the operator of the home indicated to me they had a doctor on call all the time. He was always at the residence, and that he thought that maybe this would be a little overkill.

He'd have to have his nurses have two hours' worth of training. He has enough trouble now trying to keep nurses, not the standard, but the number of nurses that are required because there's such a shortage of nurses in the state as well as hospitals and convalescent homes. So he thought it might be a little costly for him, and the fact that maybe it's not needed.

The one thing nurses do, and I can attest to that is that if you're in pain, they try to ease your pain, and it's not some course they have to take to find out what's wrong with you. If you're complaining, they're going to give you something. Depending upon the severity of the pain that you tell them you have, they're going to give you something that's going to ease that pain.

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So I support the bill. I'm not sure that we really need it, but hopefully it will do some good.

Thank you.

DEPUTY SPEAKER ALTOBELLO:

And I thank you, Representative Miller.

Representative Hetherington of the 125th, you have the floor, sir.

REP. HETHERINGTON (125th):

Thank you, Mr. Speaker. If I may, a question or two to the proponent.

Through you, Mr. Speaker, is there a course of study that leads to certification in pain management?

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Bye.

REP. BYE (19th):

Through you, Mr. Speaker, I'm not sure if there is a specific class. As I said, this is a training that the homes are required to offer to assure that their direct care staff understand the signs of pain.

I'm sure there are guidelines that the nurses have, but this is to make sure the direct care staff have access to the information about recognizing signs of patients who are in pain who cannot communicate

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that verbally.

DEPUTY SPEAKER ALTOBELLO:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you. As I read it, it appears that this requirement is in effect now for Alzheimer's facilities but not for the other nursing sites that are referenced.

Through you, Mr. Speaker, is that right?

DEPUTY SPEAKER ALTOBELLO:

Representative Bye.

REP. BYE (19th):

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER ALTOBELLO:

Representative Hetherington.

REP. HETHERINGTON (125th):

I see. And I see, so how is the satisfaction of this requirement established by a facility?

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Bye.

REP. BYE (19th):

Through you, Mr. Speaker, I would imagine it has to be established like many things. When the

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Department of Public Health comes in and inspects they're assured the staff has had two hours of training on this, on pain management and recognizing pain for patients:

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you. Through you, Mr. Speaker, is there a distinct program of instruction in pain management?

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Bye.

REP. BYE (19th):

Through you, Mr. Speaker, many of the nursing home facilities purchase a standard training in this area, so it is available for them to purchase. The vast majority of them are offering it already.

Through you, Mr. Speaker.

DEPUTY SPEAKER ALTOBELLO:

Representative Hetherington.

REP. HETHERINGTON (125th):

Thank you. I thank the gentle lady, and I will be supporting this bill. Thank you, Mr. Speaker.

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DEPUTY SPEAKER ALTOBELLO:

Further on the bill as amended? Further on the bill as amended? If not, staff and guests please retire to the Well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber.

DEPUTY SPEAKER ALTOBELLO:

Have all the Members voted? Have all the Members voted? Please check the board to make sure your vote is properly cast.

If all Members have voted, the machine will be locked. Will the Clerk please take a tally.

And would the Clerk please announce the tally.

THE CLERK:

Senate Bill Number 243 as amended by House A.

Total Number Voting 142

Necessary for Passage 72

Those voting Yea 142

Those absent and not voting 9

DEPUTY SPEAKER ALTOBELLO:

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The bill as amended is passed in concurrence with the Senate.

Would the Clerk please call --

The bill is passed not in concurrence with the Senate. It was a House A. My error.

And we will continue to Calendar Number 574.

THE CLERK:

On Page 21, Calendar Number 574 --

SB810

DEPUTY SPEAKER ALTOBELLO:

Representative Lawlor of the 99th, you have the floor, sir.

REP. LAWLOR (99th):

Thank you, Mr. Speaker, I move acceptance of the Joint Committee's Favorable Report and passage of the bill in concurrence with the Senate.

DEPUTY SPEAKER ALTOBELLO:

The question before the Chamber is acceptance of the Joint Committee's Favorable Report and passage of the bill in concurrence with the Senate. Please proceed, sir.

REP. LAWLOR (99th):

Thank you, Mr. Speaker. This bill is, does not make a major change in state law. It's not really a substantive change at all.

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STANDING
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COMMITTEE
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jl/gbr SELECT COMMITTEE ON AGING

10:00 A.M.

REP. SERRA: Any other questions from the committee?

Thank you.

DEB POLIN: Thank you.

REP. SERRA: Next up is Nan Shaffer -- Nancy Shaffer. Sorry.

NANCY SHAFFER: Good morning Senator Prague and Representative Serra and members of the Select Committee on Aging. My name is Nancy Shaffer and I am the State Long-Term Care ombudsman and I'm here today to speak on behalf of the aging and disabled residents of Connecticut in our long-term care settings.

By way of background, I just want to mention that I hold a Master's degree in Human Development Gerontology and that I came to the state ombudsman position in 2006 after 18 years of experience in long-term care in skilled nursing facilities.

And just very briefly to follow up on your comment, Senator Prague, in my 18 years in a skilled nursing facility, I can't tell you how many times people would say to me, Isn't that awfully depressing. How can you work in that kind of environment? And that always surprised me because if you are in that environment for a while and get to know the folks that you're serving, it's a wonderful place to be in terms of the people that you get to know. And sometime if I ever had, you know, a few moments of your time, I could tell you some really amazing and terrific stories about those good people.

But I just wanted to tell you that because I want you to know that I do have practical

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management assume responsibility for ensuring proper training, supervision and support of its staff. And they should be held accountable when these essential safeguards are not in place and the resident suffers as a result.

Better equipping direct caregivers to do their work through proper training, supervision and support is the responsibility of the facility's owner and manager. It is also the owner and manager's responsibility to ensure that all workers are screened for criminal background checks. Facilities must be fully staffed with qualified workers for the safety and well-being of the vulnerable persons they serve. When investigation of an abuse/neglect crime finds that the owner and/or manager has not fulfilled all of these obligations, they should be held accountable.

I urge your support of Raised Bill Number 876.

I included on the back of my testimony, on the last page, I just received yesterday afternoon an e-mail with a very brief newspaper article about a very recent, February 12, 2009, situation of a caregiver of a nursing home in Farmington, who apparently stole one of the resident's credit cards, and spent about \$382 on that credit card before that was discovered.

I'd also like to talk with you today about Senate Bill Number 243, An Act Concerning Training and Pain Management. I think this bill simply clarifies that nursing homes as well -- nursing homes with and without a special Alzheimer's unit should be providing pain management. As people age or become incapacitated due to medical and/or psychiatric disabilities, it becomes more

difficult for them to express their needs and so it's important for the staff to have very good training on assessment recognition of pain management needs.

House Bill Number 5600, An Act Concerning Access to Comprehensive Factual Information Regarding Long-Term Care Facilities. The Ombudsman program fully supports full disclosure for consumers. At the time of admission, the resident and family have many questions, but they also may not know all the questions that they might want to be asking. By providing more comprehensive information at the outset, the consumer has readily available to him or her the information as the need arises. At the national level, many long-term care advocates are supporting mandates to publish the Five Star Quality Rating System -- System in a variety of venues. Including this in the admission information and patient bill of rights provides the consumer with further information to make the right decision under their set of circumstances.

And I would just add as a caveat that I think that the Five Star Rating is one piece of information available and should be looked at in the context of overall information the consumer can glean.

An Act Concerning a Single Point of Entry, as Deb just testified, the Ombudsman program also fully supports this piece of legislation. Even professionals and others who have been navigating this system would agree that there's just a labyrinth of details that make it difficult and to give a consumer a single point of entry only makes good sense.

Lastly, Senate Bill Number 664, An Act Concerning Billing for Assisted Living

REP. SERRA: Next up is Ron Knight, Susan Grosso and Susan Flannigan. Three of them 43 and 56. Good morning.

RON KNIGHT: Good morning. To the committee, my -- I am Ron Knight of the Connecticut Hospice, here with my colleagues, Susan Grasso and Soozie Flannigan and we're here to offer testimony in support of Committee Bill Number 243, An Act Concerning Training in Pain Management.

We, the Connecticut Hospice, are advocates for ongoing education and training of nursing home staff in pain recognition and management -- sorry. We're supportive in pain recognition and management and support this bill. The Connecticut Hospice, under the auspices of the John D. Thompson Hospice Institute for Research Education and Training is firmly committed to raising both public and professional awareness of treatment of pain among elderly populations residing in this community, and to bring forth our expertise to assure optimal recognition, assessment and relief of pain and suffering for all patients.

We believe it is the patient's right to receive comprehensive assessment and management of pain and symptoms. Pain recognition and administration of pain management techniques are a patient's right.

We find all nursing home staff, including CNAs, are eager to understand and learn the principles of good pain management and we the Connecticut Hospice, through education, are dedicated to assisting them to improve pain management outcomes for our patients regardless of diagnosis. We have two fellowships in hospice and palliative care for

nurses and physicians with syllabuses that concentrate on the core goal to improve quality of life through education and pain recognition and symptom management.

Susan, can you give more details, please?

SUSAN GRASSO: Thank you. Hi, my name is Susan Grasso and I'm the director of complementary medicine at Hospice. There are a few addendums and additions in my presentation from the written copy of the presentation that you received.

Pain management has three components. Pain has three components. There is physical pain, emotional pain, and spiritual pain. And our interdisciplinary team consists of physicians, nurses and complementary therapists. This is a newly recognized field that works with stress management and pain management providing optimum results at minimum cost. Our team also includes social workers, pharmacists, volunteers, pastoral care people, home health aides, nutritionists and people in the arts, including music therapists. We address all levels of pain: Physical, emotional and spiritual.

The core of our practice is pain and symptom management. In the nursing home environment, we provide the interdisciplinary approach to pain management. We treat the patients from diverse and cultural and socioeconomic backgrounds, patients with multiple diagnoses at different levels of comprehension and responsiveness.

As we have stated, the Connecticut Hospice strongly supports this bill for pain recognition and pain management education for direct care nursing home staff. And I gladly

invite any questions you might have about complementary therapy or Hospice. Thank you.

RON KNIGHT: Included in our written testimony you'll see a short recipe for a two-hour pain management program which shows the specific members of the interdisciplinary team, as Susan was referring to.

Soozi, is there anything that you'd like to add?

SOOZI FLANNIGAN: I just want to say that we are already caring for people in nursing homes and providing pain management and anything we can do to support other nursing home administrators to meet this goal, we're happy to help.

REP. SERRA: Thank you.

Any questions from the committee?

Senator Kissel.

SENATOR KISSEL: Hi. I appreciate your testimony. I'm just wondering how you would define the distinction between emotional pain and spiritual pain. I can understand that there's a mental component and a physical component, but you're sort of drawing a line between emotion and spirit, and I'm just wondering how you draw that line.

SUSAN GRASSO: Well, Soozie can follow up. We, at Hospice, find that mental pain has to do with the intellectualizing of pain. People who attempt to control or hide what they are really feeling by just not saying anything about it. People who are embarrassed about their pain. What happens with a patient, what happens with the person who gets a terminal

diagnosis or any severe diagnosis, the first thing that goes is their identity. The first thing to leave them is their feeling that they are worthwhile and in control of their environment.

Spiritual pain is based not on any collection of religious doctrine or, you know, formalized theory. Spiritual pain really has to do with the subtleties with a person's relationship with what they might consider someone, a higher power that controls the universe, and even more directly, it influences their ability for honesty and open-mindedness and ability to cope with the overwhelming -- what they feel are burdens that an illness brings about.

Soozi?

SOOZI FLANNIGAN: I don't know if that helped you at all, but emotional -- emotional pain can manifest itself in depression, anxiety, anger and spiritual -- the spiritual component that we address are making sense of things. You know, with -- as we age, the loss, your belief system, finding some inner peace with these changes in life as we age or with a severe illness.

SENATOR KISSEL: And my second question is, I appreciate everything that Hospice and hospice programs do throughout the state of Connecticut, and is the -- is your notion regarding the advantages of an interdisciplinary model specific to those individuals facing terminal diseases or would this apply to anyone that has maybe a long recovery period or who has undergone any kind of disease that has pain as an element. It could be severe arthritis or something like that.

RON KNIGHT: I would answer that by saying the fortunate thing -- the fortunate aspect of the introduction of hospice care was his recognition of the -- his recognition of how important it is for these different disciplines to communicate with each other in treating a specific patient. And if it was our choice, this manner of approaching a patient's illness would permeate throughout all of -- wherever the patient, you know, might be, Hospitals, home care, nursing homes, wherever. We're just fortunate that early on it was, you know, indoctrinated into hospice care.

I think in our personal experience you'll find that the most difficult thing -- one of the most difficult things to have come about is for one medical discipline to talk to another medical discipline and to come up with a group think as to what might best apply to, you know, that individual. Well, within Hospice, that's endemic to, you know, how we render our care.

SOOZI FLANNIGAN: It is cancer and noncancer diagnosis, dementia, ALS, all kinds of illnesses that we could be helpful with for pain management.

SENATOR KISSEL: Thank you.

(Inaudible.)

CECELIA SULLIVAN: Good morning Senator Prague, members of the committee. My name is Cecelia Sullivan. I have provided testimony on two bills, 5600 An Act Concerning Access to Comprehensive Factual Information Regarding Long-Term Care Facilities, as well as Bill 243, An Act Concerning Training Pain Management for Nursing Home Staff.

I am asking you -- I am pleading with you to pass these bills. My husband Joe a few years ago, was a resident of the Connecticut Veterans' Hospital. He went in as a respite patient and then was reassigned as a permanent patient when a long-term care bed became available. At the time of his admission in February of 2006, I was not given a patient bill of rights. I was not told he may not age-in-place. I was not told the facility lacked accreditation. I was not told he may not have his need for pain recognized. I was not told staff may or may or not be trained in comfort care and pain management. And I was not told I'd be considered an integral member of his care team.

In April of 2007, I spoke with the assistant hospital administrator and I told her my job was to take care of Joe. I asked her what her job was. And she said it was to take care of him as well.

July 6, he left the special care unit, which had staff dementia trained. They were very much into sharing communication. He went into respiratory crisis and was transferred off the unit. It was a nightmare. Staff was neither dementia trained, nor Hospice trained.

On the respiratory unit, he was under pain managed. He was nonverbal, severe dementia. He had his hip fractured. It went undiagnosed one to two weeks. He was transferred to St. Francis Hospital. From there he went back, not to the hospice unit as I requested, but to respiratory, where when I was asking staff pleading with them to give him pain manage -- pain medication, I was told it's not four hours yet. The order says four hours. They did not have a clue.

Two days later, I went to the special care unit nurse practitioner and demanded Joe be moved. I said I'm not leaving this facility until he is, and I'm prepared to stay. He was moved to the hospice unit again. They did not have a comprehensive knowledge of what comfort care and pain management is. On the respiratory unit, he was undermedicated. On the hospice unit, he was overmedicated and when into toxicity. My daughter-in-law is a hospice care nurse, I relied on her.

We had people. We had communication skills and it didn't work. Please don't let that happen to anybody else.

Thank you.

SENATOR PRAGUE: This is unbelievable.

CECELIA SULLIVAN: It is. It is. And had I -- when Joe was on the special care unit, he got care that was appropriate and best for him. It was when he went into crisis, staff on the respiratory unit was neither dementia trained, nor comfort care and pain management trained. Then when I finally got him moved to the hospice unit, there was a lack of knowledge. I heard people say, staff wants to do the right thing, but if they're not educated, if they don't have sufficient training, if they don't have supervision by qualified staff, it all breaks down. I was relying on my daughter-in-law.

At one point she came to visit after working, asked me questions about his medication, I couldn't answer. I went out to the nurse's station, introduced my daughter-in-law, and said, She's a nurse. She's a hospice nurse. I need her to have access to Joe's records. I

wrote, I give Susan Sullivan permission, and I said to the nurse, this is a legal document. You can tell her whatever she needs so that I can know. Joe was very vulnerable. He was the most vulnerable. I needed the best information and I was out of the loop.

SENATOR PRAGUE: Now, I -- Linda Schwartz.

CECELIA SULLIVAN: Linda Schwartz has the healthcare background and a military background, and had I not witnessed, experienced, I would have said this would not have happened on her watch, but it did.

SENATOR PRAGUE: That's totally unbelievable. And with your permission, I'd like to send your testimony over to her so something like this would never happen to anybody else. If I -- if you think about it and if you give me your permission, I will send it over to her.

CECELIA SULLIVAN: You have my permission to do so.

SENATOR PRAGUE: Good God. Thank you.

CECELIA SULLIVAN: Thank you.

REP. SERRA: I just saw Susan. Is she -- come on, come on.

SUSAN GIACALONE: Sorry.

REP. SERRA: Good morning

SUSAN GIACALONE: Good morning Representative Serra, Senator Prague. For the record my name is Susan Giacalone, I'm here on behalf of the Insurance Association of Connecticut. I have written testimony, so I will try to keep my comments brief.

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SUSAN GIACALONE: And the amount of coverage depends on the coverage the insured had purchased --

SENATOR PRAGUE: Bought -- yeah, bought to begin with.

SUSAN GIACALONE: And the length of it and duration of it.

SENATOR PRAGUE: Yeah, okay. Thank you.

SUSAN GIACALONE: Thank you very much.

REP. SERRA: Burton Weinstein, please. Morning.

BURTON WEINSTEIN: Thank you. My reason for being here this morning is that I believe that the best thing I can do with my life or anyone can is to reduce the quantum of human suffering in the world. My qualifications for being here are first that I've had a 47-year-long career in which a great many cases have been plaintiff medical malpractice including some against hospitals all over the state, with some considerable success.

My wife, unhappily, developed a pancreatic cancer and she had the world's best treatment at Yale. Now I've been in a lot of hospitals over the years and I can tell you that the precise care given at an institution like Yale, world class. The -- I call them "giblet gurus" have all the equipment in the world, but things being as they were.

In November of 2007, she was admitted to Hospice and she died in April -- I'm sorry -- in February of 2008. So I had four months with all those years of med/mal experience involving many hospitals, for the first time

SB243

to observe a hospice. And, of course, I brought with me a healthy amount of skepticism, if not cynicism, given my career. I was surprised, frankly, to find that the level of caring was so great. And the care that was given, in terms of concerns, was so cost-effective. And by "caring" I mean the ability to listen, to observe and to pay attention, not only to the patient but to the families, the loved ones and especially to the staff because the strain of dealing with the kind of terminal illness and suffering that hospices do, puts a tremendous strain on you. You cannot imagine what staff people suffer when a young child is admitted to a hospice. I had four months of opportunity to observe that.

And caring is cost-effective. If all it takes is to convince staff people that this is not a paper trail, this is -- well, what I've done over the years and I'm of counsel in my firm. Of counsel is that, that's why I qualify for this committee. Of counsel I define is that large area between seniority and senility. I think I may be at the midpoint. I have had an opportunity to see how at Hospice, people are trained to stop and pay attention, and I've seen how it reduces human suffering.

I attended a training session for volunteers at Hospice given by Susan Grasso who's in charge of alternative medicine. And the effect it had on them, to hear how just that little human contact can alleviate suffering was astonishing. Over the years I've hired many, many, many people. Every -- in fact, everybody in the office now I've hired, and I told every one of them, there is no such thing in this office as a piece of paper. There's only a piece of somebody else's life. And if you cannot think of it that way, I don't want

you. On the other hand, if you can see everything in this office being a piece of somebody else's life, then I can guarantee you'll never have so much fun for so little money.

I've had people who've been there since 1960 one of the first people I hired, and they appreciate the dignity and self-respect that comes from caring about other people and as I say, caring is cost-effective.

The question that is faced so often is the struggle between the quantity of life and the quality of life. Quantity, pushing at any cost to the last moment is one thing. At a certain point -- well, it takes a certain kind of ego to say If I die. We're all going to be there. At a certain point paying attention to the quality of life, especially toward the end is so important, and I've seen this with my wife, and I was astonished to see how emotional as well as physical, how it was taken care of. Medication is fine. But just pumping people full of pain killers and narcotics and saying well, as long as we get a -- some beat, not a flat line, we're doing our job, raises some important questions. That is not the way Hospice carries on. And the care that they give to everybody is so important. I have seen it, I have seen it work. And I've come here today to tell the Committee that attention to that kind of care is -- both reduces the quantity of human suffering, and is very cost-effective.

I thank you for your courtesy and any consideration these remarks received. Any questions, I'll be happy to answer them.

REP. SERRA: Senator Prague.

SENATOR PRAGUE: Mr. Weinstein, thank you for coming here today. I'm sure it's got to be painful. Are you suggesting that at Hospice, there's a special kind of training in pain recognition and pain management?

BURTON WEINSTEIN: Oh, yes.

SENATOR PRAGUE: So we should look for that kind of -- they must have a curriculum, they must have some standard --

BURTON WEINSTEIN: Yes, as I say, I attended a course because I couldn't quite believe what I was seeing and hearing, so I just dropped in on a training session. And the effect is palpable; you can see it. The sensitivity, the stopping and listening and looking, and the sharing concerns really do make a difference.

SENATOR PRAGUE: It was at Hospice that they offered the course?

BURTON WEINSTEIN: Yes.

SENATOR PRAGUE: In Branford?

BURTON WEINSTEIN: Susan Grasso gave it, and it was quite impressive.

SENATOR PRAGUE: Okay. Thank you.

BURTON WEINSTEIN: Thank you.

REP. SERRA: Thank you. Next up is Meg Morelli.

A VOICE: (Inaudible.)

REP. SERRA: Okay. We'll skip over to Rosemary Mahon. Morning.

ROSEMARY MAHON: Good Morning. Good morning Senator Prague, Representative Serra, and members of the Aging Committee. My name is Rosemary Mahon and I'm here today to ask that you support Senate Bill 243. This bill would require all facilities that care for residents with Alzheimer's, not just facilities with specialized care units or programs, to provide two hours of pain management education to all direct care staff annually.

In the state of Connecticut, there are approximately 249 nursing homes. Of these 249, 70 facilities state that they have a specialized care unit or program for Alzheimer's residents. In some of these facilities, once a resident is no longer of flight risk or behavior concern, they are moved from the specialized Alzheimer's unit to the general nursing home population. There are 18 facilities that do not accept anyone with Alzheimer's, but the remaining 161 facilities admit residents with Alzheimer's in all stages of the disease, and place them with the general nursing home population.

By limiting the Alzheimer's training and pain education to only the facilities with specialized care units or programs, fails to address the needs of the residents in the remaining 161 facilities. These residents are suffering from the same affects of the devastating illness, yet the staff will not receive the education about the care, treatment, and progression of Alzheimer's, especially in the areas of pain assessment and management.

Studies have shown that nursing home residents, who are cognitively intact, receive twice the amount of pain medication as those residents who have cognitive impairments, such

as Alzheimer's. Residents can live in the end stage of Alzheimer's for up to two to three years. During this time, residents have usually lost their ability to verbally communicate their needs, fears, and pain. Nonverbal signs and behaviors are their only means of communication about -- and I'm sorry education about nonverbal communication is desperately needed.

In 2003, a year after my grandmother was admitted to an Alzheimer's specialized care nursing home, she became critically ill from an undetected, large perirectal abscess that was 16 centimeters in length, and two to three centimeters in width. The wound remained undetected, until she was transferred to a local hospital five days later. After surgery she required extensive dressing changes that involved packing the wound two to three times per day; required four people to assist; and took 45 minutes to complete because of the location of the wound. My mother and I had to advocate for appropriate doses of morphine to keep her comfortable during these painful dressing changes. Since she had lost her ability to verbally communicate completely, if it had not been for our constant advocating for medications and educating the staff about her nonverbal signs of pain and discomfort, she would have suffered agonizing pain and fear in silence.

Six months later when she was dying from the complications of the abscess, I truly learned how poorly educated the nursing home staff was about pain assessment and management. As the abscess continued to tunnel through her body and sepsis set in, my mother and I were at her bedside around the clock. I had to repeatedly ask to have her morphine dose adjusted to meet the needs of her pain. Later, after reviewing

my grandmother's medical record, I found that throughout her entire stay in the nursing home, the nursing home staff rarely performed any form of pain assessment, most noticeably in the last few days of her life.

I also encountered nurses who were not comfortable calling the physician on call to adjust the dose of her morphine even as she shuttered and violently shook in her bed when repositioned as she inched closer and closer to death. One nurse stated she wanted to see if my grandmother could work through her pain first before administering any more pain medication.

I have been a nurse caring for dying children and their families for the last 12 years. I was horrified by how poorly my grandmother was treated, assessed and cared for by some of the nursing home staff. It was unacceptable care.

After begging for hours for the nurse to contact the physician on call to increase her inadequate morphine dose, the nurse finally called and received an order to increase the morphine. My grandmother died before receiving it.

The need for more education about the care for people with Alzheimer's, understanding the disease process and how to assess and manage pain, and not only people with Alzheimer's but anyone who is cognitively impaired, is essential to having quality, knowledgeable and compassionate nursing care provided to all residents. These residents are at the mercy of the staff to meet their most basic needs. If the care within a specialized Alzheimer's facility could be so poor, how could it be believed that the need for Alzheimer's education and pain management is not needed in

all facilities caring for residents with this disease?

I ask that you make a difference in the lives of the people with Alzheimer's, their families who watch them suffer, and the thousands and thousands of people to come in the future as this disease claims more and more lives each year.

Thank you for your time.

REP. SERRA: Thank you.

ROSEMARY MAHON: Thank you. Thank you for putting the bill forward again for me. I'm just glad you're willing to put it up again.

SENATOR PRAGUE: We'll take it to the chairs of the Public Health Committee.

ROSEMARY MAHON: Thank you.

SENATOR PRAGUE: Both Representative Serra and I --

ROSEMARY MAHON: Thank you.

SENATOR PRAGUE: (Inaudible.)

ROSEMARY MAHON: Thank you very much. I appreciate it.

REP. SERRA: Thank you.

Is there anybody here who hasn't testified before us who wants to say anything?

A VOICE: (Inaudible.)

REP. SERRA: At this time we're going to close public hearing.

(T9)

Senate Bill 243 Testimony
An Act Concerning Training in Pain Management

Public Hearing on February 19, 2009

Good Afternoon Senator Prague, Representative Serra, and Members of the Aging Committee,

My name is Rosemary Mahon and I am here today to ask that you support SB 243, An Act Concerning Training in Pain Management. This bill would require ALL facilities that care for residents with Alzheimer's not just facilities with "specialized care units or programs," to provide two hours of pain management education to all direct care staff annually.

In the state of Connecticut, there are approximately 249 nursing homes. Of these 249 homes, 70 facilities state that they have a "specialized care units or programs" for residents with Alzheimer's. In some of these facilities, once a resident is no longer a flight risk or behavior concern, they are moved from the specialized Alzheimer's unit to the general nursing home population. There are 18 facilities that do not accept anyone with the diagnosis of Alzheimer's, but the remaining 161 facilities admit residents with Alzheimer's, in all stages of the disease, and place them with the general nursing home population.

By limiting the Alzheimer's training and pain education to only the facilities with a "specialized care unit, or program", fails to address the needs of the residents in the remaining 161 facilities. These residents are suffering from the same affects of this devastating illness, yet the staff will not receive the education about the care, treatment, and progression of Alzheimer's, especially in the area of pain assessment and management.

Studies show nursing home residents, who are cognitively-intact, receive twice the pain medication as those residents who have cognitive impairments, such as Alzheimer's. Residents can live in the end stages of Alzheimer's for 2-3 years. During this time, residents have usually lost their ability to verbally communicate their needs, fears, and pain. Non-verbal signs and behaviors are their only means of communicating, and education about non-verbal communication is desperately needed.

In 2003, a year after my grandmother was admitted to an Alzheimer's specialized care nursing home, she became critically-ill from an undetected, large peri-rectal abscess that was 16 centimeters in length, and 2-3 centimeters in width. The wound remained undetected, until she was transferred to a local hospital 5 days later. After surgery she required extensive dressing changes that involved packing the wound 2-3 times per day; required four people to assist; and took 45 minutes to complete because of the location of the wound. My mother and I had to advocate for appropriate doses of morphine to keep

her comfortable during these painful dressing changes. Since she had lost her ability to verbally communicate completely, if it had not been for our constant advocating for medications and educating staff about her non-verbal signs of discomfort, my grandmother would have suffered agonizing pain and fear in silence.

Six months later, when she was dying from the complications of the abscess, I truly learned how poorly educated the nursing staff was about pain assessment and management. As the abscess continued to tunnel through her body and sepsis set in, my mother and I were at her bedside around the clock. I had to repeatedly ask to have her morphine dose adjusted to meet the needs of her pain. Later, after reviewing my grandmother's medical record, I found that throughout her entire stay in the nursing home, the nursing staff rarely performed any form of pain assessment, most noticeably in her last few days of life. I also encountered nurses who were not comfortable calling the physician on-call to adjust the doses of her morphine even as she shuddered and violently shook in her bed when repositioned as she inched closer and closer to death. One nurse stated she wanted to see if my grandmother could work through her pain before administering any more pain medication. My grandmother's CNA, complained to my family about how difficult my grandmother was to care for during her 18 months in the nursing home during my grandmother's last 4 hours of life. Having been a nurse caring for dying children and their families for the last 12 years, I was horrified by how poorly my grandmother was treated, assessed and cared for by some of the nursing home staff. It was unacceptable care.

After begging for hours for the nurse to contact the physician on call to increase her inadequate morphine dose, the nurse finally called and received an order to increase the dose. My grandmother died before receiving it.

The need for more education about caring for people with Alzheimer's, understanding the disease process, and how to assess and manage pain in not only people with Alzheimer's but anyone who is cognitively impaired, is essential to having quality, knowledgeable, and compassionate nursing care provided to all residents. These residents are at the mercy of the staff to meet their most basic and desperate needs. If the care within a "specialized" Alzheimer's facility could be so poor, how could it be believed that the need for Alzheimer's education and pain management is not needed in ALL facilities caring for residents with this disease?

I ask that you make a difference in the lives of all people with Alzheimer's, their families who watch them suffer, and the thousands, and thousands of people to come in the future as this disease continues claim more and more lives each year.

Thank you for your time and consideration of this important issue!

Sincerely,
Rosemary Mahon, RN BSN
34 Birch Hill Drive
Tolland, CT 06084
860-872-9410
Rosemary.mahon@gmail.com

T6



Hospice Institute
For Education, Training and Research, Inc.

The Hospice Institute for
Education, Training and Research, Inc.

presents Testimony

in favor of

Committee Bill No. 243

An Act Concerning Training in Pain Management

Testifying.. February 19, 2009

Ronny Knight, MBA, FHFMA, Senior Vice-President of Planning

Susan Grasso, MEd. R.M., Director of Complementary Medicine

Soozi Flannigan, MSN, Co-Director of the Nursing Fellowship

Testimony
Committee Bill No. 243

An Act Concerning Training in Pain Management:

- We, The Connecticut Hospice, are advocates for the ongoing education and training of nursing home staff in pain recognition and management and support this Bill.
- The Connecticut Hospice and the John D. Thompson Hospice Institute for Research, Education and Training is firmly committed to raising both public and professional awareness of the treatment of pain among elderly populations residing in this community, and to bring forth our expertise to assure optimal recognition, assessment and relief of pain and suffering for all patients.
- We believe it is a patient's right to receive comprehensive pain and symptom assessment and management. Pain recognition and administration of pain management techniques is a patient's right.
- We find all Nursing Home Staff, including CNA's eager to understand and learn the principles of good pain management and we, The Connecticut Hospice, through education, are dedicated to assisting them to improve pain management outcomes for our patients regardless of diagnoses.
- We have two Fellowships in Hospice and Palliative care for nurses and physicians with syllabuses that concentrate on the core goal to improve quality of life through education in pain recognition and symptom management.
- Our interdisciplinary team of physicians, nurses, social workers, volunteers, pastoral care, home health aides, nutrition and the arts including music therapy and complimentary therapy address all levels of pain – physical, emotional and spiritual.
- The core of our practice is pain and symptom management. In the nursing home environment, we provide the interdisciplinary approach to pain management. We treat the patient with multiple diagnoses with different levels of comprehension and responsiveness from diverse cultural and socioeconomic backgrounds.
- As we have stated before, the Connecticut Hospice strongly supports this Bill for pain recognition and pain management education for direct care nursing home staff.

Recipe for a 2-hour Pain Management Program

Ingredients:

- Experience of many years in Hospice and Palliative Care training for pain and symptom management.
- Syllabuses of both, The J. Robert Galvin Hospice and Palliative Physician Fellowship and the International Norma F. Pfriem Hospice and Palliative Nursing Fellowship
- Interdisciplinary approach including:
 - Physician
 - Nurse
 - Social worker
 - Nutrition
 - Complementary therapy
 - Spiritual
 - Arts
 - Clinical Pharmacy

Cooks:

- J. Andrews, M.D., Hospice and Palliative Chief Medical Officer, Internal Medicine
- M. Renna, Ph.D., M.D., Hospice and Palliative Medicine Fellowship Director, Gerontologist
- M. Treantafilos, A.P.R.N., Hospice and Palliative Nursing Fellowship
- S. Flannigan, M.S.N.
- S. Grasso, Complementary Medicine
- J. Prota, R.Ph., Clinical Pharmacist
- Etc, etc



(T4)

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

LONG TERM CARE OMBUDSMAN PROGRAM
 25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033
 Telephone Number: (860) 424-5200 Fax Number: (860) 424-4966

SELECT COMMITTEE ON AGING

Public Hearing
 February 19, 2009

Good morning Senator Prague, Representative Serra, Senator Gaffey, Representative Bye and distinguished members of the Select Committee on Aging. My name is Nancy Shaffer and I am the State Long Term Care Ombudsman. I speak to you on behalf of the aging and disabled long term care residents of Connecticut. I am here to testify regarding proposed legislation before you today.

By way of my background, I hold a Master's degree in Human Development Gerontology and eighteen years of experience in the long term care setting in a variety of roles prior to my appointment as the State Ombudsman in 2006. I mention that because I think it's important to know that I have practical, hands-on long term care experience and a real understanding of residents' needs as well as direct knowledge of the long term care environment.

SB243
HB5600
SB489
SB664

S.B. No. 876 (RAISED) AN ACT CONCERNING LIABILITY OF NURSING HOME OWNERS FOR NEGLIGENCE AND ABUSE OF NURSING HOME RESIDENTS AND CRIMINAL RECORDS CHECKS

Many caregivers in Connecticut's long term care facilities provide loving and wonderful care to their residents. But in some cases, and one case is too many, residents are abused or neglected in ways that we all would describe as horrifying and tragic. Neglect and abuse cannot be tolerated or simply passed off as a "problem". It is a disgrace and it is time to establish an improved system of accountability.

The Long Term Care Ombudsman Program received approximately 2,000 complaints from residents and/or their family members during Federal Fiscal Year 2008. Of these complaints, roughly half were related to care, abuse and/or neglect issues. In some cases there was serious injury, even death as a result of the neglectful care.

I don't believe most caregivers go into their daily work anticipating or planning to provide poor care. I do believe that all caregivers in our long term care facilities must have proper training, supervision and adequate support to do their jobs. When they don't have that training, supervision and support mistakes happen, abuse/neglect occurs and the resident suffers. It is imperative that corporate management and facility level management assume the responsibility of ensuring proper training, supervision and support. And they should be

held accountable when these essential safeguards are not in place and the resident suffers as a result.

Better equipping direct caregivers to do their work through proper training, supervision and support is the responsibility of the facility's owner and manager. It is also the owner and manager's responsibility to ensure that all workers are screened for criminal background checks. Facilities must be fully staffed with qualified workers for the safety and well-being of the vulnerable persons they serve. When investigation of an abuse/neglect crime finds the owner and/or manager has not fulfilled all of these obligations they must be held accountable.

I urge your support of Raised Bill No. 876.

S.B. No. 243 (COMM) AN ACT CONCERNING TRAINING IN PAIN MANAGEMENT

This bill clarifies that nursing homes that do not have an Alzheimer's special care unit or program are responsible for providing pain management training to direct caregivers of residents. As people age or become incapacitated due to medical or psychiatric disability it may become more difficult for them to express their needs. These individuals are a significant portion of the population of long term care residents. It is therefore imperative that caregivers be trained to observe and assess pain and understand the best management techniques to relieve that pain.

H.B. No. 5600 (COMM) AN ACT CONCERNING ACCESS TO COMPREHENSIVE FACTUAL INFORMATION REGARDING LONG TERM CARE FACILITIES

The Long Term Care Ombudsman Program fully supports full disclosure for consumers. At the time of admission the resident and family have many questions, but they also may not know all the questions that should be asked. By providing more comprehensive information at the outset, the consumer has readily available to him or her information as the need arises. At the national level many long term care advocates are supporting mandates to publish the Five Star Quality Rating System in a variety of venues. Including this in the admission information and Patient Bill of Rights provides the consumer with further information to make the right decision under their set of circumstances.

S.B. No. 489 (COMM) AN ACT CONCERNING A SINGLE POINT OF ENTRY FOR LONG TERM CARE

Briefly, this proposed legislation makes good sense for Connecticut's long term care consumers. The numerous long term care programs and options available to the consumer are a labyrinth of details. Even professionals and others who have used the network of services and learned to navigate the system do not always have specific answers beyond their limited experience. A single point of entry provides the consumer reasonable access to information

(T7)

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Committee Bill No. 5600: AN ACT CONCERNING ACCESS TO
COMPREHENSIVE FACTUAL INFORMATION REGARDING LONG-
TERM CARE FACILITIES

and

Committee Bill No. 243: AN ACT CONCERNING TRAINING IN PAIN
MANAGEMENT FOR NURSING HOME STAFF

I am asking you to vote for passage of these bills. My husband Joseph (Joe) E. Sullivan was a severe dementia, non-verbal respite client on the Special Care Unit of the Connecticut Veterans' Hospital in Rocky Hill when a long-term care bed became available. Joe's status was changed from temporary to permanent.

At the time of Joe's admission in February 2006 I was not: 1) given a Patient's Bill of Rights' 2) told he many not age-in-place; 3) told the Veterans' Hospital lacked accreditation; 4) told staff may or may not be credentialed; 5) told he would be denied the Medicare benefit of hospice; 6) told staff could not or would not recognize his need for pain management and comfort care; and 7) told I may not be considered an integral member of his care team.

April 5, 2007 I spoke with Margaret Pantoja, Assistant Hospital Administrator. I told her my job was to take care of Joe. I then asked her, "what is your job?" She replied, "take care of Mr. Sullivan."

July 6, 2007 Joe went into respiratory crisis. He was transferred from the Special Care Unit, where appropriate and best care for him was available, to the Respiratory Unit where staff did not demonstrate dementia knowledge. My statements and comments about Joe's quality-of-life care were not acted upon by staff. I was told, "I and/or we have his chart." Joe was not a chart!

July 16, 2007 a team meeting was held regarding Joe's care. There were new people on the team. The team members determined Joe would have physical therapy. I was not invited to this meeting which would become the most important team meeting of Joe's life.

July 29, 2007 Joe had a coagulated blood skin care. My son had to ask staff to attend to it.

July 31, 2007 Ann Kelly, PT and I, separately, notified staff Joe had a change in behavior.

August 3, 2007 I learned Joe had a right hip fracture. He was transferred from the Veterans' Hospital to St. Francis Hospital for evaluation. From the Emergency Room I phoned the Veterans' Hospital and spoke with Ms. Pantoja, more than once, with medical updates. I asked Ms. Pantoja if I should be talking with the Discharge Planner. She replied, "Mr. Sullivan can be cared for anywhere in the hospital. I said, "Hospice."

Joe was returned back to the Respiratory Unit; same place where his right hip was fractured. According to UCONN Health Center and St. Francis medical reports **Joe's right hip fracture occurred 1-2 weeks prior to identification.** I watched Joe suffer for two days as staff denied him adequate pain medication. When I called attention to the fact that the dose given was ineffective, I heard, "it's not four hours yet." Joe needed comfort care and pain management. He did not receive it.

August 6, 2007 I spoke with Flora Drapeau, APRN, Special Care Unit. I demanded Joe be moved off the Respiratory Unit. I spoke with Deb Sutherland, APRN, Palliative/Hospice Unit. Joe was moved to the Hospice Unit.

Joe went from being under medicated on the Respiratory Unit to over medicated on the Hospice Unit. He went into toxicity. Staff did not demonstrate pain management training. I relied on my daughter-in-law, a hospice nurse, to provide me with information I was not getting from staff.

Joe did not receive care that was appropriate and best for him. Joe received care that was convenient for individuals who were neither adequately dementia nor pain management trained.

August 20, 2007 Joe passed into eternal peace.

Less than two months after Joe's death I met with Margaret Concannon, Hospital Administrator and Ms. Pantoja about Joe's end-of-life care. When I asked why I was not invited to the most important team meeting of Joe's life, July 16th (facility report says 17th), Ms. Concannon said, "we are the veteran's family." These five words summarized the flawed logic that led to Joe's suffering. During this conversation I was also told Joe's diagnosis was Cardio Pulmonary Disease. It was the first time I heard Joe had a new diagnosis.

Since Joe's death, I have been asking questions about his care once he left the safety of the Special Care Unit. My requests for specific information such as: 1) who determined Joe would be transferred to the Respiratory Unit instead of the Hospice Unit from St. Francis; 2) what was the patient staff ratio for all shifts on the Respiratory and Hospice Units; 3) the names and credential(s) of all staff, including veteran workers and/or volunteers who provided hands-on and/or direct care on all shifts have either not been answered or dismissed with the reply, "you already have it."

A nursing home facility represented as providing specialized care for individuals with dementia who also require respiratory monitoring and pain management care must be held accountable for services provided. Quality-of-life care should not be an option. There is a myth that someone with Alzheimer's/dementia does not feel pain. It is just that – a myth!

Department of Health's Wendy Furniss is quoted in a May 22, 2002 OLR Research Report titled "Veterans" Hospital Medicare Certification", 0530-R-0530" ... DPH survey's focus on site visits that **stress patient care delivery and outcomes**. Joe's patient care was inappropriate and the outcome was a right fractured hip unidentified for 1 – 2 weeks.

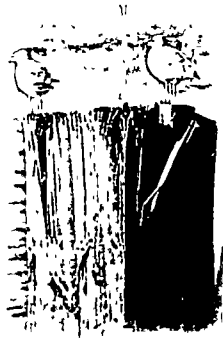
Joe's Special Care Unit admission was appropriate and best care for him. His treatment on the Respiratory Unit and Hospice Unit from staff not credentialed and/or knowledgeable about dementia care and pain management care was not.

Not all hospice programs are the same.

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Hospice Southeastern Connecticut ensures:

- The wishes, requests and dignities of the patient and family are incorporated into the hospice team's plan of care
- The hospice team develops an in-depth relationship with the patient and their family assisting with the physical, psychosocial and spiritual needs.
- Hospice care is provided through an interdisciplinary team of experts, not just one clinician. The team approach is a unique feature of hospice care. The team is the patient's physician, hospice medical director, nurses, social workers, home health aides, clergy and bereavement counselors.
- **Hospice Southeastern Connecticut** is made up of a team of over 40 professional and licensed staff members who work with the patient and their family members, providing information, choices, dignity and the best possible quality of life during the end of life process
- Hospice staff receive special training to effectively anticipate, assess and treat symptoms that cause physical, emotional and spiritual discomfort and distress
- Many of **Hospice Southeastern Connecticut's** nurses and most Home Health Aides are Hospice and Palliative Care Certified, meaning they specialize in end-of-life care.
- Many times **Hospice Southeastern Connecticut** services can be provided to a person whose place of residence is in a skilled nursing facility or assisted living facility. **Hospice Southeastern Connecticut** has relationships with over 17 of these facilities throughout New London County.
- **Hospice Southeastern Connecticut** has over 120 trained volunteers from the local community. The patient care volunteers support the caregiver, offer respite, companionship, assistance with household chores, complementary therapies for the patient, overnight vigil, pet therapy visits and help in many other ways



- Hospice care is available "on call" after the administrative office has closed; seven days a week, 24 hours a day. A nurse will make a visit any time if needed
- Bereavement support is available at any time, including before the patient's death, and is offered for 13 months after death.
- **Hospice Southeastern Connecticut** offers on-going bereavement support groups free of charge to anyone in the community

- A team of multi-denominational chaplains are available to **Hospice Southeastern Connecticut** patients and families
- **Hospice Southeastern Connecticut** has contracts with Lawrence & Memorial and The William W. Backus Hospitals to provide care in these locations for terminally ill patients
- **Hospice Southeastern Connecticut** has been located within and involved in caring for the community for over 20 years

When it comes to making decisions about the care of a loved one who is facing a life-limiting illness, there are so many choices to be considered.

Hospice Southeastern Connecticut's staff provides information, resources and guidance to support you in your choices for end-of-life care.

We are just a phone call away.

860.848.5699
hospicesect.org

What is important to me?

- To be informed
- To have choices
- To be free from pain and anxiety
- To be free from shortness of breath
- To be clean
- To have physical touch
- To have my financial affairs organized
- To be in my place of choice
- To be informed about my physical changes
- To achieve a sense of completion about my life
- To say goodbye to people
- To resolve unfinished business
- To make my own decisions about treatment preferences
- To have an advocate who knows my values and priorities
- To have my treatment preferences honored
- To maintain my dignity
- To keep my sense of humor
- To have a physician who knows me as a whole person, who I trust and who I can talk to
- To not die alone
- To have someone who will listen
- To have a nurse with whom I feel comfortable
- To have funeral arrangements planned
- To not be a burden
- To come to peace
- To not be connected to machines
- To discuss my personal fears
- To meet with clergy/chaplain
- To have family present

HOSPICE SOUTHEASTERN CONNECTICUT

*is an affiliate of: Lawrence & Memorial Hospital
and The William W. Backus Hospital*

Healing Touch is an energy therapy in which practitioners consciously use their hands in a heart-centered and intentional way to support and facilitate physical, emotional, mental and spiritual health.

Healing Touch is a complementary (or integrative) energy therapy that can be used in conjunction with traditional therapies. **Healing Touch** utilizes light or near-body touch to clear, balance and energize the human energy system in an effort to promote healing for the mind, body and/or spirit.

Healing Touch practitioners work to balance the human energy system by creating an optimal environment for the body's innate tendency for healing to occur.



Research studies suggest that there are a variety of benefits from **Healing Touch**. Preliminary studies have shown results that include reduction in pain, anxiety and stress; providing support during chemotherapy and surgery; improved mood; and reduced effects from trauma and chronic pain. One study indicated that **Healing Touch** can impact the dying process. Other benefits of **Healing Touch** found in a research study included providing additional support when withdrawing from substance abuse, enhancement of the immune system, and a deeper sense of spiritual connection.*

* Research available at

www.HealingTouchInternational.org



BODIES IN BALANCE

Holistic Care for Body, Mind & Spirit

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