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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 16<sup>th</sup> (facility report says 17<sup>th</sup>), 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.

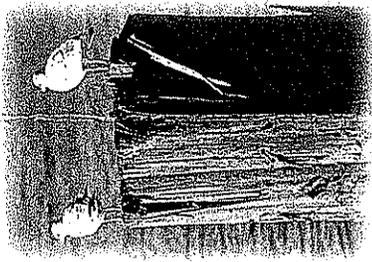
Since Joe's death, I have been asking questions about his care once he left the safety of the Special Care Unit. My requests for specific information such as: 1) who determined Joe would be transferred to the Respiratory Unit instead of the Hospice Unit from St. Francis; 2) what was the patient staff 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.



## 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.

## 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 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](http://hospicesect.org)

**HOSPICE SOUTHEASTERN CONNECTICUT**

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



## What is Healing Touch?

**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.

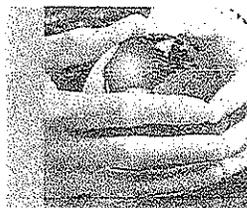
**Healing Touch** is a complementary (or integrative) energy therapy that can be used in conjunction with traditional therapies. **Healing Touch** utilizes light or near-body touch to clear, balance and energize the human energy system in an effort to promote healing for the mind, body and/or spirit.

The goal of **Healing Touch** is to promote a state of balance in the human energy system by creating an optimal environment for the body's innate tendency for healing to occur.

## What are the benefits of Healing Touch?

**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](http://www.HealingTouchInternational.org)



### BODIES IN BALANCE

Holistic Care for Body, Mind & Spirit

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