



**TESTIMONY  
OF  
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CONNECTICUT HOSPITAL ASSOCIATION  
PUBLIC HEALTH COMMITTEE**

**Tuesday, March 12, 2002**

**HB 5685, An Act Concerning The Use Of Physical Restraints On Persons At Risk**

**HB 5686, An Act Requiring The Screening Of Newborns For Metabolic Diseases**

**SB 547, An Act Concerning The Destruction of X-Rays**

Good morning Senator Harp, Representative Eberle and members of the Public Health Committee. My name is Carrie Brady and I am Vice President of Patient Care and Regulatory Services of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify this morning on several bills before the Committee.

CHA has concerns regarding **HB 5685, An Act Concerning The Use Of Physical Restraints On Persons At Risk**, which would require the Department of Mental Health and Addiction Services to adopt regulations regarding the use of restraints.

The use of restraints is heavily regulated and CHA is concerned that the bill will create confusion for providers. Providers using restraints already must comply with existing Connecticut statutes (Sections 46a-150 through 46a-154), federal statutes, federal regulations and detailed accreditation requirements. The regulations required by the bill would add yet another level of complexity to an already challenging array of requirements.

Many of the items discussed in the bill are already addressed in existing law. For example, subsection (8) requires “licensed psychiatrists and licensed physicians [to] monitor persons at risk who are in physical restraints at frequencies specified” in the regulations. Section 46a-152(e) of the Connecticut statutes already requires that “any person at risk who is physically restrained shall be continually monitored by a provider or assistant.” Federal regulations and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards also require providers to continually monitor the condition of a patient in restraints. In addition, federal regulations and accreditation standards impose specific requirements for the frequency at which a physician must reassess a patient in restraints and determine whether to discontinue the restraints.

We also have specific concerns about some requirements in the bill. Subsection (1) requires that a licensed psychiatrist meet in person with a patient no more than thirty minutes prior to the initiation of a restraint to determine whether the use of a restraint is necessary. It will not always be feasible for a patient to see a psychiatrist within thirty minutes prior to a restraint being applied. In some cases, a psychiatrist may be physically unavailable but could issue a verbal order for the restraint based on a description of the patient's condition. Subsection (1) also appears to limit the assessment to a licensed psychiatrist. It is imperative that any licensed independent practitioner be authorized to meet with the patient and order restraints, not just licensed psychiatrists.

We are also concerned about subsection (2), which requires that restraints be released when a patient is asleep or using the bathroom unless removal would result in immediate or imminent injury to the patient or others. Although a sleeping patient may not pose an imminent threat, there are circumstances in which it would be reasonable to leave restraints on a sleeping patient because the patient would become an immediate threat upon waking.

Subsection (9) requires notice to the patient's family whenever restraints are applied. Notification of the patient's family could be a violation of the patient's right to privacy. In addition, there may be circumstances in which the patient's family should not be notified, for example, if family members are abusive toward the patient. The JCAHO accreditation standards for restraint, by contrast, require notification of the family as appropriate, with prior consent of the patient.

We are also concerned about the operational difficulties in implementing subsection (10), which requires that "whenever possible", patients in restraints "are placed in areas that are visible to other personnel besides the personnel who are attending to the persons at risk." This requirement could adversely affect patient care because, depending on the patient's condition, it may be important to have the patient in a quiet, non-stimulating environment in order to facilitate stabilization of the patient and removal of the restraints.

Finally, we are concerned that subsection (8) discussed above could be interpreted to indicate that only physicians are capable of monitoring a patient in restraints, even though nurses often perform the monitoring and assessment.

CHA believes that existing law and accreditation standards are sufficient to address the items identified in the bill. We respectfully suggest that should the Committee deem it necessary to impose additional restraint requirements on providers, the Committee should amend existing Connecticut statutes to address its concerns, rather than authorize the Department of Mental Health and Addiction Services to create an entirely new set of requirements to overlay on existing restraint standards.

CHA supports the intent of **HB 5686, An Act Requiring The Screening Of Newborns For Metabolic Diseases**, which would add additional diseases to the newborn screening panel and would appropriate funds for the purchase of two tandem mass spectrometers used to process the tests.

CHA has two concerns. First, it is not clear what additional metabolic tests the state intends to perform on newborns. The bill adds language indicating that tests for “other metabolic diseases” shall be performed, but the existing language of the statute already allows DPH to test for the enumerated conditions as well as other “inborn errors of metabolism.” We presume that the Committee has particular tests in mind and we respectfully suggest that the language be amended to specifically identify the additional tests to be performed.

Second, the bill does not address whether DPH will increase its fees for newborn screening. Although we support expanded newborn screening for metabolic diseases, we must oppose any unfunded mandate that could further jeopardize our hospitals’ financial viability. We also note that the Committee should amend the bill to reflect that DPH, not the Department of Mental Retardation, will receive the funding for the mass spectrometers.

CHA appreciates the opportunity to submit testimony on **SB 547, An Act Concerning The Destruction Of X-Rays**, which requires the Department of Public Health to adopt regulations requiring physicians and other providers to notify a patient prior to the destruction of the patient’s x-rays. While CHA supports the intent of the bill, we have serious concerns relating to its implementation as it applies to hospitals.

CHA is concerned about the additional costs hospitals will have to absorb in order to implement this proposal. Patient demographic information is generally maintained in the medical record department, separate from the diagnostic imaging department. Coordinating individual patient mailings regarding x-ray destruction will be costly and time-consuming. This is further complicated by the varying time limits required for film retention, from five to twenty-five years depending on the type of record.

CHA supports the concept of allowing patients to preserve their x-ray films. Rather than individual notice, however, we suggest that hospitals be allowed to provide general notice about the destruction schedule for x-rays. We also note that filmless services, which allow electronic storage of films for extended lengths of time, may ultimately make this bill unnecessary.

Thank you for your consideration of our positions.

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