Public Defender of Rights
OMBUDSMAN

TREATMENT FACILITIES FOR LONG-TERM PATIENTS



REPORT
ON SYSTEMATIC VISITS CARRIED OUT BY
THE PUBLIC DEFENDER OF RIGHTS 2017

The Public Defender of Rights

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MISSION OF THE DEFENDER

Pursuant to Section 349/1999 Coll., on the Public Defender of Rights, as amended, the Public Defender of Rights (Ombudsman) protects persons against the **conduct of authorities and other institutions** if such conduct is contrary to the law, does not correspond to the **principles of a democratic rule of law and good governance** or in case the authorities fail to act. If the Defender finds errors in the procedure of an authority and if the authority subsequently fails to provide for a remedy, the Defender may inform the superior authority or the public.

Since 2006, the Defender has acted in the capacity of the **national preventive mechanism** pursuant to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The aim of the systematic visits is to strengthen the protection of persons restricted in their freedom against **ill-treatment**. The visits are performed in places where restriction of freedom occurs ex officio as well as in facilities providing care on which the recipients are dependent. The Defender generalises his or her findings and recommendations concerning the conditions in a given type of facility in summary reports on visits and formulates general standards of treatment on their basis. Recommendations of the Defender concerning improvement of the ascertained conditions and elimination of ill-treatment, if applicable, are directed both to the facilities themselves and their operators as well as central governmental authorities.

In 2009, the Defender was also given the role of the **national equality body** pursuant to the European Union legislation. The Defender thus contributes to the enforcement of the right to equal treatment of all persons regardless of their race or ethnicity, nationality, sex, sexual orientation, age, disability, religion, denomination or belief. For that purpose, the Defender provides assistance to victims of discrimination, carries out research, publishes reports and issues recommendations with respect to matters of discrimination, and ensures exchange of available information with the relevant European bodies.

Since 2011, the Defender has also been monitoring detention of foreign nationals and performance of administrative expulsion.

The **special powers** of the Defender include the right to file a petition with the Constitutional Court seeking abolishment of subordinate legal regulations, the right to become an enjoined party in Constitutional Court proceedings on abolishment of an act or its part, the right to lodge action to protect a general interest or application to initiate disciplinary proceedings with the president or vice-president of a court. The Defender can also make recommendations to the Government concerning adoption, amendment or repealing of a law.

The Defender is **independent and impartial**, accountable for the performance of his or her office only to the Chamber of Deputies by which he or she was elected. The Defender has one **Deputy** elected in the same manner, who can be authorised to assume a part of the Defender's responsibilities. The Defender regularly informs the public of his or her findings through the Internet, social networks, professional seminars, round tables and conferences. The most important findings and recommendations are summarised in the **Annual Report on the Activities of the Public Defender of Rights** submitted to the Chamber of Deputies of the Parliament of the Czech Republic.

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SUMMARY

1

The Defender's employees visited a total of 8 treatment facilities for long-term patients chosen on the basis of information from the national register of healthcare providers.

2

Ill-treatment was found in one case, when the treatment facility did not comply with statutory requirements regarding restraining the patient using physical restraints (straps). The use of restraints (including sedatives) in treatment facilities in general presents the highest risk as it can easily lead to ill-treatment.

3

A sufficient and stable number of staff with regularly distributed days of work and days of rest is crucial for the quality of care. Even though the facilities complied with the minimum numbers of staff as specified by Decree, the employees were often overburdened and had insufficient time for individual tasks in caring for patients; therefore the employees performed a number of these tasks indiscriminately, regardless of the patient's individual needs and abilities.

4

Remedy of certain shortcomings cannot be done without increasing the material and human resources of treatment facilities. Many shortcomings can however be removed simply by a more sensitive approach of the staff and setting working procedures which will encourage individualised approach towards patients.

5

I believe that a comprehensive approach towards patients, which includes not only the satisfaction of their biological needs, but also their psychological and social needs, is of crucial importance. Therefore, I support the provision of therapy sessions, high-quality social counselling and availability of psychological care to patients in treatment facilities as they can have a positive effect on the patient's general condition.

INTRODUCTION

I have been focusing on the situation of the elderly in institutions for the past few years, whether through visits of retirement homes, special regime homes or facilities providing social services without authorisation. In doing so, I am trying to contribute towards prevention of ill-treatment and ensuring dignified living conditions for persons living there.

Mgr. Anna Šabatová, Ph.D.
Public Defender of Rights

Now I present the summary report on my visits to treatment facilities for long-term patients to the public.

As in any other type of facility, even in the treatment facilities I have found situations that were at variance with the human right to dignity, privacy and other human rights. It is up to the facilities to remedy some of them, the rest will require systemic changes.

At the same time, I would like to highlight and appreciate the work of the nursing staff. In most cases, the treatment facilities were understaffed, the employees were overburdened and even though they objectively could not provide the patients with care at an appropriate level (especially in terms of individualisation and support of self-reliance), they did everything in their power. In view of this finding, I consider improvement in the nursing staff numbers (and financial remuneration) in treatment facilities as the main task for the future.

Some of the visited treatment facilities and also the experts I have cooperated with during my visits called for a discussion on care in treatment facilities, which, according to them, is absent in this field of healthcare. Therefore, I would like to call for a debate and an effort to provide dignified conditions for the patients in treatment facilities through this report.

Systematic visits

1) Legal basis of the systematic visits

Based on the provisions in Section 1 (3) and (4) of the Public Defender of Rights Act, the Public Defender of Rights carries out systematic visits to places (facilities) where persons restricted in their freedom are or may be present. The cause of the restriction may either be the decision of a public authority or it may result from dependence on the care provided.

> The purpose of the visits is to strengthen protection against ill-treatment

The Public Defender of Rights has been carrying out systematic visits since 2006. The information on the generalised findings concerning the situation in the individual types of facilities is released to the public. The information is available online1 in order to serve as reference material on the recommendations of the Defender to the public and to facilities yet to be visited.

The purpose of the systematic visits pursuant to Section[1] (3) of the Public Defender of Rights Act is to strengthen the protection of persons against all forms of ill-treatment. Generally speaking, ill-treatment means a treatment which does not respect human dignity. In the extreme it can take the form of torture, cruel, inhuman or humiliating treatment or punishment; in its lesser forms it manifests itself as disrespect to human beings and their rights, a lack of respect for their social autonomy, privacy or their right to involvement in control over their own lives, and abuse of the dependence on care or a further intensification of such dependence. Formally speaking, ill-treatment may represent an infringement on the rights guaranteed by the Charter of Fundamental Rights and Freedoms, international conventions, laws and subordinate legislation, as well as the failure to implement the more or less binding instructions, guidelines, standards of care or principles of good practice.

2) Course of the visits

The systematic visits were unannounced, but they were carried out on site with the knowledge of the head of the facility. The visits were carried out by the authorised Defender's employees: lawyers and external consultants of the Office – physicians and general nurses.

Visits in the treatment facilities took two days and comprised of inspection of the premises, observations, interviews with the staff and the patients and study of the internal regulations and medical documentation. Photographic evidence was taken during the visits.

1 Cf. The Public Defender of Rights. Ochrana osob omezených na svobodě (Protection of Persons Restricted in their Freedom). Ochrance.cz [online] Available at: http://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/.

I sent the reports on the visits, which reflected my findings and contained my recommendations on how to achieve better practice, to the heads of the individual treatment facilities. Heads of all the treatment facilities visited responded to the report and informed me on the measures they adopted.

3) Information on the facilities visited

Defender's employees visited a total of 8 treatment facilities for long-term patients. Although "treatment facilities for long-term patients" are not defined in the Czech legislation and the term is also not widely used in the names of the facilities themselves, it is accepted by the general public and it is also used by the national register of healthcare providers. It was information from this register the Defender used to decide which facilities to visit.

The information on the facilities visited, their founders and capacities are given in the following table.

Name	Region	Founder	Capacity
Treatment Facility for Long-term Patients in Hradec Králové	Hradec Králové Region	Hradec Králové Region	99
Hospital of Follow-up and Rehabilitation Care	Prague	Interna Co., spol. s r. o.	100
Home of Home Care	Olomouc Region	ADP – SANCO, s. r. o.	50
Hospital of Follow-up Care Ledeč-Háj	Vysočina Region	Vysočinské nemocnice, s. r. o.	88
Treatment Facility for Long-term Patients Polní (part of the Hospital of the Brothers Hospitallers of St. John of God)	South Moravian Region	City of Brno	170
Department of Follow-up and Rehabilitation Care (part of the Podřipská Hospital with Polyclinic)	Ústí nad Labem Region	Podřipská Hospital with Polyclinic in Roudnice nad Labem s.r.o.	44
Department of Follow-up Care (part of the Town Hospital in Odry)	Moravian–Silesian Region	The town of Odry	75
Podkrušnohorská Hospital of Follow-up Care	Ústí nad Labem Region	Krušnohorská poliklinika, s. r. o.	55

Recommendations for the Ministry of Health

1) Staff in care and its financing

Treatment facilities must comply with a minimum number of healthcare professionals and other professional employees, but also increase their number above the minimum number in order to ensure the required quality, safety and availability of healthcare.[2]

All the treatment facilities visited met the minimum number of staff stipulated by the Decree. However, I found out that this number is usually not sufficient to ensure quality care. I found that there is no way in which overburdened and underpaid staff can meet all requirements on quality of provided care. I observed a lack of time for serving meals to the patients, ensuring personal hygiene, monitoring pain, treating decubitus ulcers and implementing alternatives to restraints.

Because the treatment facility management often considers minimum number of staff to be optimal, I believe that if we want to remedy the shortcomings in care provided to patients and ensure "quality, safety and availability of healthcare", there is no other way than to increase the minimum numbers of healthcare professionals and other professional employees.

I recommend that the Ministry increase the minimum numbers of healthcare professionals and other professional employees in treatment facilities for long-term patients and provide adequate financing.

2) Requirements on technical and material equipment of the facility

Further in the report I describe the errors found consisting in failure to meet requirements on minimum technical and material equipment of the treatment facilities.[3] In the following two paragraphs, I point out shortcomings that violate the patient's rights to privacy, dignity, safety or quality of the provided healthcare, even though the Decree was not violated in terms of the law.[4]

2 Part I, Paragraph 1 of Annex 3 to Decree No. 99/2012 Coll. on requirements for minimum number of staff to ensure provision of healthcare services, as amended by Decree No. 287/2013 Coll. (hereinafter also the "Decree on Requirements for Minimum Number of Staff to Ensure Provision of Healthcare Services").

3 Decree No. 92/2012 Coll. on requirements for minimum technical and material equipment of medical facilities and home care contact offices (hereinafter also the "Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities").

4 Section 28 of Act No. 372/2011 Coll., on medical services and the conditions of their provision, as amended (hereinafter the "Healthcare Services Act").

Communication devices within reach of every patient

Treatment facilities are required to equip every room with a communication device connecting patient with a nurse.[5] In most facilities, only one signalling device (not allowing two-way communication) was installed in the rooms, by the bed of one of the patients. If other patients needed to contact the nurse, they had to shout or repeatedly hit the bed frame with their crutches. Thus, some could not get assistance and others decided to ignore their own needs.

I consider it necessary for each patient to be able to call assistance.

I recommend that the Ministry designates communication device connecting patient with a nurse as compulsory equipment of each bed in treatment facilities for long-term patients.

The obligation to establish a day room for patients

Treatment facilities can, but are not required, to establish a day room for patients, which can then serve as a dining room for walking patients. If no dining room is established, it is necessary to designate a space for walking patients' eating in every room.[6]

Day rooms are beneficial for many reasons. Dining and spending time together with others activates the patient and helps him or her maintain social habits. The possibility to change their monotonous environment motivates patients to move. In the day room, the patient can also receive visitors in a dignified manner (see chapter 10.2) or have a private conversation with a physician (see chapter 8.1).

I recommend that the Ministry stipulate an obligation to establish a day room for patients in treatment facilities for long-term patients.

3) Support for the provision of palliative care

Same as the other people, terminally ill and dying patients have the right to respect for and protection of their dignity. Society is obliged to allow them to die with dignity, in a suitable environment and while receiving appropriate care.[7] Palliative care serves to alleviate the suffering and maintain the quality of life of terminally ill patients.[8]

5 Part I, Paragraph 3 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.

6 Part I, Paragraphs 1 (h) and 3 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

7 Recommendation of the Committee of Ministers of the Council of Europe to the Member States of 12 November 2003 on the organisation of palliative care.

8 Section 5 (2)(h) of the Healthcare Services Act.

In the Czech Republic, palliative care is unfortunately generally considered a part of hospice care. None of the treatment facilities visited provided systematic palliative care (see chapter 23). This care is not only needed for patients in the terminal stage of an oncological disease, but also by geriatric patients who are often suffering from a large number of serious illnesses or by patients in an advanced stage of dementia.[9] These patients are using the services of treatment facilities for long-term patients.

Palliative care must be available to all who need it.[10]

I recommend that the Ministry support extension of palliative care in treatment facilities for long-term patients.

4) The concepts of living will and declaration in anticipation of incapacity

With effect as of 1 April 2012, the concept of living will was introduced into the Czech legislation[11]; the concept of declaration in anticipation of incapacity was introduced with effect as of 1 January 2014.[12] I found that the medical staff in the facilities visited did not know these concepts or was not able to use them properly. In some cases the staff confused them with euthanasia.

The right of the patient to express a wish regarding his or her future treatment in the event of future incapacity to express consent or disapproval of the provision of healthcare services and the manner of provision thereof (and the obligation to respect such wish) follows not only from the law, but also from international treaties[13] binding on the Czech Republic.

The treatment facilities lack information on possibilities and conditions of use of these concepts, official documents are not available to them and the staff have no sources for learning about this issue.

I recommend that the Ministry raise awareness of the staff of treatment facilities for long-term patients about the concepts of living will and declaration in anticipation of incapacity and their correct use.

9 Standards of palliative care established by the Czech Society of Palliative medicine in 2013.

10 Part I, Paragraph 2 of Annex to Recommendation of the Committee of Ministers of the Council of Europe to the Member States of 12 November 2003 on the organisation of palliative care.

11 Section 36 of the Healthcare Services Act.

12 Section 38 et seq. of Act No. 89/2012 Coll., the Civil Code, as amended by Act No. 460/2016 Coll. (hereinafter the "Civil Code").

13 Article 9 of the Convention of the Council of Europe for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine and Article 12 of the Convention on the Rights of Persons with Disabilities.

5) Use of restraints and reducing the frequency of their use

The use of restraints is permissible only after a failed attempt to calm the patient down by less severe measures and in situations where it is clear that milder measures would not achieve the desired effect, where, however it is necessary to choose the least restrictive measure corresponding to the purpose of its use.[14]

In view of the findings from the visits, I am convinced about the necessity to strengthen the right of a patient to personal and psychological integrity, to reduce the frequency of use of restraints and to control their use.

I recommend that the Ministry supplement the requisites of a report on the use of restraints[15] with information on the use of less severe measures including assessment of their efficiency.

I recommend that, in order to reduce the frequency of use of restraints, the Ministry change:

- **processing of individual plan for managing restlessness;**
- **taking account of the use of restraint in fulfilling the plan of care;**
- **prohibition of prescribing restraints for future instances and**
- **the principles of ordering and administering sedatives (for more information see chapter 12.2).**

6) New infractions (formerly administrative offences) in the area of healthcare

The use of restraints is associated with a number of conditions and obligations. For example, restraints may only be used to avoid a direct threat to life, health or safety of a patient or other persons, and only during the time when the reasons for their use exist.[16] The provider must appropriately inform the patient or his or her legal guardian of the use of restraints, the provider must supervise the patient for the duration of the restraining and record the use of restrains into the patient's medical records[17]. The

14 Section 39 of the Healthcare Services Act, in the wording effective from 31 May 2017.

15 Section 1 (2)(k) of Decree No. 98/2012 Coll., on medical records, as amended.

16 Section 39 (2) of the Healthcare Services Act.

17 Section 39 (3) of the Healthcare Services Act.

Healthcare Service Act does not allow punishment for non-compliance with these obligations (unlike analogous regulation of the Social Services Act).

The use of restraints constitutes substantial interference with the patient's dignity and integrity; therefore I do not consider private-law means of defence (action for the protection of personal rights) sufficient to ensure good practice.

I recommend that the Ministry newly classify non-compliance with defined obligations regarding the use of restraints as infraction (formerly administrative offences).

7) Supervision for staff of treatment facilities for long-term patients

Healthcare providers have no obligation to promote direct care by the staff though an independent qualified expert (supervisor) as is the case in the area of social services. [18]

> "The staff of treatment facilities are under great emotional pressure"

The Ministry of Labour and Social Affairs describes this standard as "the real privilege of workers in helping occupations, who are under great emotional pressure and burden of the human distress they face in their occupations on a daily basis". [19] Care provided in treatment facilities for long-term patients is in many regards similar to care provided in residential social service facilities. Patients usually stay there for a long time; therefore they will likely establish a personal relationship with some of the staff, who then often witness their passing away as well as all the associated difficulties.

Although the treatment facilities' staff need support to cope with the emotional stress associated with their professions, I found that the healthcare services providers do not provide them with such support.

I recommend that the Ministry provide supervision for healthcare professionals and other professional employees of long-term care treatment facilities – support through an independent qualified expert.

18 Paragraph 10 (e) of Annex No. 2 to Decree No. 505/2006 Coll., implementing certain provisions of the Social Services Act, as amended.

19 Quality standards of social services. Collected interpretative documents for providers. Outputs from the thematic debate meetings and work of expert teams for individual areas of Standards of Quality in Social Services.

Recommendations for the treatment facilities

1) Patients' room

Size and capacity of the room

A patients' room must have a minimum area of 5 m^2 per bed, total minimum area of 8 m^2 and there has to be enough space between the beds for work of the staff, patient's movement and manipulation with instruments, material and beds.[20] if this requirement is not met, the staff have to manipulate with the patients' beds during their work, which results in inconvenience for the staff and increased risk of fall should the patients' beds remain unbraked for a prolonged period of time. The absence of an adequate manipulation area also results in impossibility of using patient lifts and other means for easier patient handling.

Findings from the visits:

- In the facilities visited, the Defender's employees encountered four, five and, in isolated cases, even six beds in a room.

The problem lies in ensuring privacy during personal hygiene, toilet use etc. It must also be taken into account that hospitalisation in this type of facilities is usually long-term and in many cases, the patient does not have any other space where he or she can spend time with his or her family (in one of the facilities visited, I recommended a reduction in the capacity of a room due to relatively small spacing between beds, which forced the visitors to stand by the bed of their family member).

> "High number of beds in a room inevitably means violation of the right to privacy"

Recommendations:

- Decrease the capacity of rooms.
- Adapt the rooms' capacity to their size.

20 Part I, Paragraph 3 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

Room furnishings

There must be an electric outlet and localised lighting by each bed. Each room must be furnished with a washbasin in case it is not connected to a bathroom, shower or lavatory with a washbasin; furthermore, there must be a dedicated area for dining of walking patients if there is no separate dining room.[21]

When considering furnishings of the room, we have to take into account also the patient's right to respect, the right to be treated with dignity, understanding and respect for privacy in provision of healthcare services.[22]

Furnishing of the room is directly related to its capacity. I believe that unless the requirement for adequate room capacity will be taken into consideration, it will not be possible to ensure a safe and dignified environment with appropriate privacy for the patients and to achieve the standard specified by the aforesaid decree.

High-capacity room with lack of space between beds

Findings from the visits:

- The rooms were not furnished with a table or sufficient number of chairs according to the number of patients in the room. In a number of cases, the missing chairs were substituted with toilet chairs during serving of meals or the toilet chairs served as an ordinary storage space.
- Localised lighting was often missing or was located only by some beds.
- There were missing curtains between individual beds which could be pulled together if needed in order to create privacy for the patient.

21 Part I, Paragraph 3 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

22 Section 28 (3)(a) of the Healthcare Services Act.

If the furniture in the room is movable, it must be possible to secure it against movement, especially in case of nightstands and dining tables. Movable furniture is dangerous for patients; if they lean on it, they might fall. Movable furniture increases the risk of fall and may be the cause of serious injury.

Recommendations:

- The room must be a safe and dignified environment for a patient; it must provide at least a basic degree of privacy.
- Comply with compulsory room furnishing specified by the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.
- Furnish the room with a necessary amount of furniture; if the furniture is movable, it must be secured against movement.

Lockable space for storing the patient's personal belongings

A changing room, which (if not established) may be replaced by lockable cabinets, is one of the basic facilities of an in-patient department.[23]

During hospitalisation in a treatment facility for long-term patients, it is justified to consider it standard that the patients have their own clothes and items of daily use at their disposal and that said items can be stored in the room if basic measures against their loss of theft are taken. This increases the patients' feeling of a natural environment.

If a patient is incapable of using the cabinet key, staff should take over responsibility for the key. This fact should be recorded in the patient's records. It must be comprehensibly and, if needed, repeatedly explained to the patient where his or her belongings are and it must be ensured that he/she can use them.

Recommendation:

- Provide patients with lockable space for storing personal belongings in the room and ensure, if possible, having regard to the patients' individual abilities, that the patients have keys.

23 Part I, Paragraphs 1 and 12 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.

Signalling device by the patient's bed

Signalling device in the room is a basic communication device connecting a patient with a nurse. It is a mandatory equipment of the room[24] and serves the patient to call for assistance. Therefore, it is necessary for the signalling device to be functional and within reach for every patient in the room. Placement of the signalling device for example only by the door to the room is completely inadequate for bedridden patients.

Findings from the visits:

- In some facilities, the patients could not reach the signalling device from their beds or the signalling device was not functional. The patients tried to call for assistance by calling for the facility's staff or by banging against the bed frame with help from other patient or they made no attempt to call for assistance in order to not disturb other patients or out of fear from the nurses' reaction.

The treatment facility is obliged to under all circumstances provide the possibility to call for assistance; leaving the patient without reachable signalling device is risky and may result in endangering the patient's health and life. In case the signalling device is damaged, I believe it is appropriate to record the date the damage occurred and the subsequent time of repair in the repairs book. In case the signalling device is damaged, it is necessary to ensure that the medical staff check on the patient more often. Same approach must be taken in case of a patient who can't use the signalling device, in order to ensure the patient will not be left without assistance and that, for instance, his or her bladder voiding regimen will not be disrupted.

> "Some patients could not reach the signalling devices, devices of other patient were not functional"

If the signalling device is to serve its purpose as a security measure, it should be also always ensured that the staff will react immediately after the device is used.

Recommendations:

- Provide reachable and functional signalling devices for every patient.
- Ensure immediate reaction of the staff to the use of a signalling device.
- Make visits to patients who cannot use the signalling device so often that they will not be left without assistance in case of complications and to ensure their bladder voiding regimen is not disrupted.

24 Part I, Paragraph 3 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

Appearance of the room

Room is a space where the patient should feel safe and dignified. At the same time, it is a place where the patient spends most of the day during his or her often long-term stay in the facility. Therefore it is necessary to consider ways to motivate the patient through therapeutic effects of the environment of his or her room, as even this is an integral part of the general treatment. It is no less important for the environment to be clean and odourless. For motivation of the patient, it is crucial that the patient has personal belongings, such as photographs of the patient's family members at his or her disposal.

One way to make the environment of the room more pleasant

I appreciate rooms with colourful walls, pictures and other wall decorations or flowers on the windowsills. Window curtains, colourful bed linen etc. are another ways to make the room feel like a home. These aesthetic and other elements can transform the room into a friendly environment which will help the patient adapt to the medical facility and help more pleasant what may become a very long stay.

Findings from the visits:

- The Defender's employees found that the facilities often did not pay adequate attention to the field of view of bedridden patients. Television in the room, magnetic blackboard with photographs of family members or pictures were placed on the wall behind the patient and hence outside of his or her field of view.

It is necessary to realise that the patient does not have just physiological needs but that even a whole day of looking at a white wall poses a risk (it may cause hallucinations in some patients). The patient's field of view is also an important means to his or her motivation. Therapeutic elements placed outside the patient's field of view do not serve their purpose and their potential is not utilised. If the patient has weak eyesight and cannot see well at distance (for example the opposite wall), it is necessary to work with the area where the patient can see. For that, it is possible to make use of notice boards placed at the foot of the bed, music stands placed on the bed and other equipment that can be used to hold the patient's pictures, photographs and other personal belongings so that the motivating elements reach into the patient's field of view as much as possible.

Recommendations:

- Make the environment of the room more pleasant through inter alia personal belongings of the patients.
- Pay attention to the field of view of bedridden patients and use all available means to their motivation.

2) Bathroom and lavatories

Bathroom design

The patients in treatment facilities for long-term patients are characterised by increased difficulty of nursing care. Therefore, lavatories and bathrooms in the facility should be barrier-free by default. Adjusting the facility to specific needs of the patients also in this regard will increase patients' self-reliance, decrease the risk of fall and, in addition, increase the effectiveness of the nursing staff's work.

The staff should shower bedridden patients in a horizontal position; the bathrooms should be designed for that. Showering bedridden patients in sitting position is more difficult for the staff and risky for the patients.

Recommendation:

- Provide sufficient number of barrier-free lavatories and bathrooms allowing horizontal showering of bedridden patients.

Equipment of the lavatories

In the shared lavatories, there often was not any toilet paper, soap or towels. The patients had to carry toilet paper on them, which is uncomfortable for every patient with walking difficulties or for patients who use some kind of compensation aid. The necessity to carry toilet paper increases the risk of fall and also exposes the patient to a rather humiliating situation at the lavatory, when the patient forgets to take the toilet paper or has no paper left. At the same time, the toilet paper, soap and towels should be placed in such a way that they can be reached by a person in a wheelchair. Even this seemingly insignificant measure can preserve the self-reliance of patients and support regular bladder voiding regimen.

Recommendation:

- Provide toilet paper, soap and towels for patients at the lavatories. Provide toilet paper in the toilet stalls.

Ensure privacy during performance of hygiene

The patient has a right to privacy during performance of hygiene. Therefore, the lavatories and showers must be equipped in such a way as to provide at least basic degree of privacy. Toilets for men and women must be separate. [25]

25 Part I, Paragraph 10 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

In some facilities, the bathrooms were used for showering multiple patients at once. The conditions were not always suitable. Showers were not separated and patients had no privacy when showering. Bathrooms should be equipped with curtains or other means for ensuring privacy or the hygiene of patients should be performed individually.

> "Patients have the right to privacy during performance of hygieney"

Often, the lavatories could not be locked or some other, at least provisional means of indicating their occupancy was missing. It poses no risk to the client if he can lock himself in the stall by using a lock or other means which can be unlocked by the staff if needed.

The lavatory should be also equipped with signalling device that the patient can use to call for assistance. In order for the signalling device to serve its security purpose, it must be located within reach of the (sitting) patient.

Recommendations:

- Equip bathrooms with curtains or other means for ensuring privacy.
- Separate lavatories for men and women.
- Provide means of safe locking of lavatories (with the possibility of them being opened from the outside) or, at least a suitable means of indicating occupancy of a lavatory.
- Equip lavatories with reachable and functional signalling device.

3) Environment of a treatment facility

Orientation in time and place

For a patient, the treatment facility is an unknown environment. The patient can be disoriented, especially if he suffers from a cognitive disorder. Undesired consequences of this include wandering, confusion, anxiety and staying inside the room. Safe environment for the patient can be created by utilising appropriate aids, modifications, markings or pictograms. The goal of these measures is to make orientation in the facility easier for the patients, especially patients suffering from dementia syndrome as one of the symptoms of dementia is the loss or distortion of orientation in reality.

Technical and organisational aspects of the treatment facility must be adapted so that they improve the patient's orientation in space and stop him from unintentionally leaving the facility.

Examples of orientation signs for persons with dementia

Findings from the visits:

- Patients with dementia were concentrated in large rooms where they remained the whole day. Their rooms could be mistaken easily, the furniture was identical, the doors were not differentiated by colour, there were no stimuli (colourful posters) located over the bed of persons with dementia or in their field of view. Thus, the patients were looking at bare walls and were getting lost in space. In many cases, they were not systematically worked with and no therapist focused on them.

Designating rooms with labels containing the patient's surname or by indistinct numbers and the use of common indicators is not sufficient. A patient with impaired orientation can have difficulties searching not only his or her room but also sanitary facilities or the nurses' station. In this regard, the treatment facility can do a lot for its patients through clear orientation signs.

In this regard I appreciate the practice in one of the facilities visited, where a special part of the facility was reserved for patients with dementia. The entrance to this department was appropriately secured against arbitrary leaving of patients with cognitive impairment (the doors were opened by pressing a button above the door and simultaneously pulling the handle). The patients were accommodated in double-bed rooms. Door to every room was designated by a colourful motif. Adjustable chairs for patients, a nurse's desk, a TV and an aquarium were all stored in the common premises. The walls in the common premises were decorated with natural motifs and, when accompanied, it was possible to enter the garden directly from the common premises.

Example of room differentiation

In practice, the following methods have been proven effective:

- equipping the corridors with clear, guiding direction indicators;
- designating the doors with pictograms indicating the purpose of individual rooms (for example the patient's room or sanitary facilities);
- designating areas intended for patients, so that they do not leave the treatment facility by mistake;
- equipping the exit from the premises with a device which can only be opened by an oriented person (for example by entering an indicated numerical code) or inconspicuous exit from the department.

Orientation in time can be aided by placing a clock in individual patient's rooms. However, it is appropriate to choose a type of clock that makes no sound, i.e. ticking, which can be very disturbing, especially at night. Patient's orientation in time can be also aided through the publication of an approximate daily regime at the treatment facility. In order for the publication of daily regime to aid patients with cognitive impairment, it is necessary to ensure its comprehensibility.

Recommendation:

- **Support the patients' ability to orient themselves in space and time through appropriate tools.**

Day room for patients

If established, the day room for patients is one of the basic operation rooms of a medical facility.[26] It is an area which can serve both therapeutic and private activities, visits of family members or social contact between patients. It can alleviate patient's discomfort caused by a greater number of beds in a room, but it can be also used to host therapeutic activities, which were often performed on beds or in corridors. The visits performed revealed that day rooms for patients are overlooked even though, in my opinion, day rooms should be a standard. It may be the result of a lack of space. However, some facilities can establish day room simply by changing the purpose of a room.

Examples of day (and dining) rooms in the facilities visited

26 Part I, Paragraph 1(h) of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

Recommendation:

- Establish day rooms for patients.

Dining space

Training of a patient's personal care activities includes dining. Patients have the right to dine in peace and in a dignified manner, they have the right to social interaction (for more detail, see chapter 14.1).

A day room can serve as a dining room for walking patients, if it is established.[27] If there is no day room or dining room, conditions for dignified dining must be created in the patient's room.

In this matter, the Council of Europe Committee of Ministers requires that all patients, not only the walking ones, can eat at the table.[28]

> "The manner of dining can have activation potential for patients"

The manner of dining may have activation potential for patients Otherwise, it may worsen the patients' feelings of a lack of self-reliance and dependency on other person.

Findings from the visits:

- One facility did not have any dining room or a designated dining space; patients were eating in sitting or horizontal position at overbed tables.
- Designated dining area was simultaneously used as a storage area for all sorts of instruments and medical supplies.
- The number of chairs in a room was lower than the number of patients placed there.

Recommendation:

- Provide a place for dignified dining.

Departments with limited access

Patients have the right to be provided with healthcare services in an environment that is as non-restrictive as possible; at the same time, the facilities are obliged to ensure security of the services provided.[29] Some facilities dealt with these seemingly contradictory requirements by designating special

27 Part I, Paragraph 1(h) of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities

28 Part 3.3, Paragraph III. Council of Europe Committee of Ministers Resolution of 12 November 2003, on food and nutritional care in hospitals.

29 Section 28 (3)(k) of the Healthcare Services Act.

departments with limited access for patients who are often disoriented and may arbitrarily leave the facility and expose themselves to danger (see chapter 3.1). There can be no objections if only patients of this kind are placed in the department with limited access. The problem arises when the capacity of other parts of the facility is full and all new patients are automatically sent to said departments. In that case, it is appropriate to install doors which an oriented patient can open and leave the department at any time (for example, by entering an indicated numerical code).

Recommendation:

- **Implement a system of limiting access which will not restrict patients and other persons for which it is not desirable in free movement.**

4) Payments in the facility

Financial participation of patients in the care provided

Hospitalisation in a medical facility is usually fully reimbursed from patient's health insurance. In the facility, there can be a limited number of rooms with above-standard equipment (I do not consider television an above-standard equipment). Patients should have the possibility of using said rooms and paying for the above-standard equipment. In a situation where such rooms are the only option or their equipment does not significantly exceed the standard for an in-patient medical facility, a payment from the patient cannot be required. This is all the more true for payment for a room with an adjustable bed as instruments for provision of care for bedridden patients, including an adjustable bed, are among the mandatory equipment of an in-patient department of both aftercare and long-term care.[30] Similarly, arrangement of ordinary matters and assistance in exercise of the patients' rights should not be subject to payment and, in the basic scope, should be provided within the framework of social work.

Findings from the visits:

- The facility offered its patients stay in single-bed, double-bed and three-bed rooms. According to the price list displayed on a notice board: "Payment for above-standard rooms in treatment facility for long-term patients from 1 January 2014", patients pay CZK 40 for a three-bed room, CZK 70 for a double-bed room and CZK 100 for a single-bed room per person per day. According to the head physician, the difference in price for rooms is based on certain above-standard equipment (for example a larger selection of TV channels, Internet connection, etc.). On the facility's website was the following statement: "Fee for above-standard rooms: (equipment: TV, WIFI, fridge, adjustable bed, radio with CD player)." However, it was clear from the price list on the notice board that the price was based on the number of beds in the room. The head physician stated that no fee was charged for stay in six rooms, but the remaining rooms were subject

30 Part II, Paragraphs 3.1 and 4 of Annex to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.

to a fee. Patients questioned were not able to choose between standard and above-standard rooms. The difference between standard and above-standard room was not obvious as equipment in all the rooms was approximately the same and there were no significant differences.

- The facility offered its patients stay in single-bed and double-bed rooms. All rooms were listed as above-standard. Above-standard services consisted in equipping the room with an adjustable bed, sanitary facility, television and Internet connection. Even room adjustment for bedridden patients was considered above-standard. Patient's payment for a double-bed room was set at CZK 300 per day or CZK 500 per day for a single-bed room. Moreover, patients also had the option to pay for the assignment of a key worker who would provide assistance in exercise of rights, legitimate interests and arrangement of personal matters. The facility did not offer any rooms other than above-standard rooms, so the stay there always required financial participation of the patients..

Recommendation:

- **Do not admit patients for hospitalisation on condition of their financial participation.**

Donations from patients

The Civil Code limits the possibility of a donation agreement between patient and a provider. "Donation to a person who operates a facility which provides healthcare or social services, or to a person who manages or is employed in such a facility, is invalid if it occurred at the time when the donor was in the care of such a facility or otherwise received its services."[31] Placement in a medical facility can significantly affect the donor's will as can create a feeling of dependence on the facility or need to repay for services provided. At the same time, through the quoted provision, the Civil Code prevents situations when non-provision of a donation would result in worse care or denial of care altogether.

Findings from the visits:

- The facility offered conclusion of a donation agreement immediately upon admission of a patient or during first contact with the patient's family or close persons. The offer to conclude a donation agreement was related to additional fees for accommodation in a room with less beds. However, the patients concluded from the manner of submission of the offer to conclude a donation agreement that they must conclude the agreement.

Treatment facilities for long-term patients have to deal with a number of financial difficulties. However, any potential donation from a patient has to be voluntary, without expecting consideration, and any donation can only be requested after the patient has been discharged from the facility. Any requesting that a patient provides a donation to the facility at the time when he is provided care by the facility is at variance with good morals and absolutely unacceptable as a practice of a facility even if the patient's decision had no effect on the quality of care provided.

31 Section 2067 (1) of the Civil Code

Recommendation:

- Donations from a patient may be requested and received only after the patient has been discharged.

Complaints, internal regulations

Patients have the right to be acquainted with internal regulations of the medical facility[32]; internal regulations provide for basic rights and obligations of the patients in relation to the relevant facility.

One of said rights is the patients' right to file a complaint against procedure of the provider in provision of healthcare services or against activities related to healthcare services[33]; the facility must draw up rules for dealing with complaints and make said rules publicly available in the facility and on its website.[34] Complaint mechanism represents patients' basic defence in the area of provision of medical services and, simultaneously, the simplest way of ensuring remedy.

> "Treatment facility must draw up rules for handling complaints"

Findings from the visits:

- Internal regulations or rules for addressing complaints were not drawn up or were not available to patients.
- The naming and contents of the facility's documents referred to the provision of social services, not healthcare services. This may create a false impression that the facility provides social services and not healthcare services.
- On the wall in one of the treatment facility's corridors, there was a sign which informed that it was possible to contact a client centre. It informed of the possibility to fill out anonymous questionnaires and also stated that there were wooden collection boxes located in every department. However, there were no boxes anywhere in the facility. According to the facility's staff, the sign was several decades old and there was no client centre anymore.
- The mechanism for addressing complaints was unclear and completely informal. According to the staff, complaints were usually addressed to the head physician, physicians or head nurse and subsequently discussed during meetings.
- Complaint mechanism was replaced by a book of wishes and complaints placed with the head nurse.

Having regard to the nature of individual documents, I consider it important for the internal regulations and rules of complaints to be easily accessible to patients not only at the moment of admission for hospitalisation but also during their entire stay in the treatment facility, in a comprehensible manner.

For this, notice boards located on individual floors can be used; the documents can be placed in day rooms, dining rooms but also in individual patients' rooms. Documents should be also provided to patients by the facility staff upon request.

32 Section 28 (3)(d) of the Healthcare Services Act.

33 Section 93 (1) of the Healthcare Services Act.

34 Section 93 (4)(a) of the Healthcare Services Act.

Complaint mechanism should be clear and reviewable. If a complaint is not anonymous, the facility management must inform the patient about the manner of its resolution within 30 days.[35]

Recommendation:

- Make the internal regulations and rules for addressing complaints accessible to patients.

6) Granting consent to hospitalisation and consent to provision of healthcare services

Medical services may only be provided to a patient with his or her free and informed consent.[36] Any healthcare and other acts defined in Section 2 (2) of the Healthcare Services Act must be considered healthcare services.

The provider's statutory procedure in acquiring patient's consent to hospitalisation and provision of healthcare services is described in more detail in Annex 1 to this report.

Acts which require patient's consent

The law stipulates that written consent is required if stipulated by a special legal regulation or if specified by the provider, having regard to the nature of the healthcare services provided.[37] The provider is obliged to draw up a list of healthcare services whose provision requires written consent.[38]

In some facilities, the patient grants his or her consent with some specific acts which may be performed during hospitalisation already at the time of admission for hospitalisation. It includes for example the insertion/replacement of a permanent urinary catheter, taking blood samples, vaccination and administration of infusions or examination per rectum. In such cases, the patient's consent cannot be considered informed and thus valid. I base my opinion on the requirements on provided information laid down by the Healthcare Services Act. These are extensive both with respect to information on possible complications and alternatives and with respect to the necessity to take the patient's individual situation and medical condition into account.[39] The patient should be informed about his or her medical condition prior to granting consent to a specific act, which cannot be done in advance and without knowing its development.

Thus, consent granted in advance or indiscriminately can be easily called into question. If some of the interventions for which the consent was granted in advance is considered, the patient's current opinion has to be ascertained.

35 Section 93 (3)(b) of the Healthcare Services Act.

36 Section 28 (1) of the Healthcare Services Act.

37 Section 34 (2) of the Healthcare Services Act.

38 Section 45 (2)(h) of the Healthcare Services Act.

39 Section 31 of the Healthcare Services Act.

Recommendations:

- Draw up a list of healthcare services whose provision at the facility requires written consent.
- Request consent of the patient (or consent of some other authorised person, if applicable) with provision of healthcare services every time a medical professional proposes an act that is subject to consent.

Multi-item forms of consent to hospitalisation

In some facilities, the patient grants consent to, for example, taking and keeping photo-documentation of decubitus ulcers, for persons gaining authorisation to perform healthcare profession to peruse the patient's medical records or to publication of information gained in relation to treatment in scientific journals, along with consent to hospitalisation. In that case, it is necessary to ensure that the patient fill out all fields of the form in order to declare what the patient agrees/disagrees with. Otherwise, anyone can add anything into the form at a later date. All fields of the form must be filled in or, in case the patient has no opinion on the matter, crossed-out. It holds in this respect that if the patient does not express his or her opinion regarding the care in question, it shall hold that the patient does not agree with it.

Recommendation:

- Properly fill in individual fields of the form for granting consent to hospitalisation, so it is evident and conclusive what the patient agrees or disagrees with.

Patient arriving from department of acute care

I regard as problematic also the practice when facility does not require consent to hospitalisation from a patient who arrives from department of acute care in the same facility. The reason is chiefly the different nature of care which is provided by the department of acute care and by the treatment facility for long-term patients. The contents and goal of the provided care are different, so the patient must have the opportunity to reject further hospitalisation. If the transfer is not accompanied by any formal act, the patient may easily remain uninformed and will not be asked his or her opinion. Hospitalisation of a patient is, from the viewpoint of the law, possible only based on the patient's (or legal guardians) consent or on the basis of court approval. Therefore, it is necessary to require consent to hospitalisation even from a patient transferred from some other department. A demonstrable record in documentation including specification of individualised plan of therapy planned for stay in the treatment facility signed by the patient can serve as an alternative.

Recommendation:

- Require consent to hospitalisation also for patients who arrive in the treatment facility from an acute care department of the hospital under which the treatment facility for long-term patients belongs and document the consent.

Declarations in anticipation of incapacity and living will

In provision of healthcare services, it is necessary to allow the patients to make a declaration in anticipation of incapacity[40] or a living will[41], and respect those. I consider both of these concepts good tools in cases where the patient is afraid that he or she will be unable to participate in decisions regarding the form of treatment in the future, even though he or she would like to. During the visits, the Defender's employees found that physicians (and medical staff in general) were not sufficiently acquainted with concepts of living will and declarations in anticipation of incapacity. These are relatively new concepts which were introduced into the Czech legislation on the basis of international commitments of the Czech Republic. However, I expect patients to make use of them with increased frequency and therefore, I recommend providers of healthcare services to provide their staff with training in this area.

Recommendation:

- Educate the staff in the area of declarations in anticipation of incapacity and living will.

7) Patient with a limited legal capacity

The Healthcare Services Act determines special rules for granting consent to provision of healthcare services for patients with limited legal capacity.

Primarily, it should be noted that limited legal capacity by itself does not mean it is possible to make decisions on behalf of the patient. For the provider's procedure, the range of limitations[42] and the current ability of the patient to perceive information and express his or her opinion are decisive.

The provider of healthcare services must first establish whether the limited legal capacity relates to the area of provision of healthcare services. If not, the consent is to be granted by the patient. If yes, the provider (physician) is obliged to find out the patient's opinion on the provision of proposed healthcare

40 Sections 38 through 44 of the Civil Code

41 Section 36 of the Healthcare Services Act.

42 The law uses the simplified term "patient with limited legal capacity" for cases when the legal capacity of a patient is limited in such a way that the patient is not eligible to assess provision of healthcare services or consequences of their provision (Section 28 (3)(e)(2) of the Healthcare Services Act).

services if this is appropriate taking account of the patient's cognitive and volitional "maturity".[43] This obligation applies even if the consent is not granted by a patient but by his or her legal guardian. However, situations may occur when the consent of a legal guardian of a patient with limited legal capacity will not suffice if the patient will seriously object to interference with his or her integrity.[44]

Also, the provision of information on medical condition in the sense of Section 31 (1) of the Healthcare Services Act is not bound to legal capacity of a patient; treatment facility is obliged to inform all patients, except those who are not able to perceive said information at all due to their medical condition.[45]

Information on limitation of legal capacity must always be based on a court ruling. It is certainly not easy to obtain all supporting documents; on the other hand, the mere information about limitation of legal capacity does not provide sufficient guidance to the healthcare services provider. For this reason it is always necessary to look for more details and to document the state of affairs (request a copy of the ruling in question from the patient or his or her legal guardian).

Awareness concerning the extent of limitation of legal capacity and the specific patients concerned are important not just for granting consent to provided healthcare. Therefore, there must be an appropriate system of exchange of information between the medical/social worker and other members of the medical staff.

Findings from the visits:

- Staff knew that the patient's legal capacity is limited, but they did not know the exact extent of this limitation; for some patients, it was not possible to find a copy of the court ruling on limiting their legal capacity and/or appointing a legal guardian in the documentation.
- The medical staff in one of the facilities visited stated that a social worker should know the number of persons with limited legal capacity. To the contrary, the social worker stated that she did not need to know this information and that the department's staff were the ones who knew it.

Recommendations:

- **Respect legal regulation of granting consent to provision of healthcare services to patients with limited legal capacity.**
- **Determine and record the extent of limitation of the patient's legal capacity.**
- **Inform all members of staff who come into contact with the patient in question about his or her limited legal capacity (including the extent of the limitation).**

43 Section 35 (1) and (4) of the Healthcare Services Act.

44 Pursuant to Section 100 (1) of the Civil Code it shall hold that in the event of interfering with the integrity of a minor who has reached at least the age of fourteen years and has not acquired full legal capacity, and who seriously objects to the intervention, although his or her legal representative consents to it, the intervention may not be performed without court approval. This also applies where an intervention is carried out on an adult person without full legal capacity.

45 Section 31 (4) of the Healthcare Services Act.

8) Medical confidentiality, maintaining confidentiality

The right to respect for privacy in provision of healthcare services in accordance with the nature of healthcare services provided is one of the basic patient rights.[46] This patient right corresponds to obligation of the provider and other persons specified by the law to maintain confidentiality of all facts they have learned in connection with provision of healthcare services to a patient.[47]

The obligation to maintain confidentiality relates to all facts, i.e. a term notably broader than just the patient's medical condition. It includes details of the patient's family life and his or her background, financial situation, previous hospitalisations, etc.

Breach of the confidentiality obligation constitutes an administrative offence punishable by a fine of up to CZK 1,000,000;[48] however, the effect of such breach on the patient may be substantially more serious.

Rounds of the ward

Exchange of information on the patient between staff is very important, just as provision of information to the patient on the progress of hospitalisation and his or her medical condition are very important. Protection of the patient's privacy is equally important.

Place suitable for private conversations with a physician

46 Section 28 (3)(a) of the Healthcare Services Act.

47 Section 51 (1) and (5) of the Healthcare Services Act.

48 Section 117 (3)(d) and (4)(a) of the Healthcare Services Act.

Findings from the visits:

- In almost all the facilities visited, rounds of the ward took place in rooms, while other patients were present. Physician informed patients of their diagnoses in their rooms, in the presence of other patients. Thus, everyone in beds heard what the physician and other medical staff say about the patient's medical condition (what awaited him or her, what examinations were going to be performed etc.).
- Staff discussed medical condition before entering the patient's room while the doors to other rooms were open.
- Examination of a patient and passing of instructions regarding further treatment between medical staff also took place in rooms.
- In the facility, there was not enough area where a physician (or persons selected by the physician) could talk to patients privately.
- No private conversations with patients regarding their medical conditions were held.

In the described cases, other patients can hear personal and sensitive information. Information could be provided with more respect. Medical staff who take part in rounds of the ward can communicate sensitive information about the patient to each other in privacy of their office and not mention it needlessly while visiting the room. Walking patients should also be offered to discuss personal and sensitive information elsewhere than in the room.

On the other hand, I have no objections against proper marking of beds by name and surname of patients as such measure prevents the risk of accidental mix up of patients for example when administering medication.

Recommendations:

- **Protect the patients' privacy and, unless circumstances do not allow, not to disclose sensitive personal information regarding their medical condition in the presence of other patients.**
- **Offer walking patients the possibility of a private physician-patient conversation.**

Provision of information on a patient's health to close persons

During admission to healthcare, the patient can designate persons who may be informed about his or her medical condition and peruse his or her medical records; at the same time the patient can determine whether said persons may grant consent or disapproval of the provision of healthcare services on his or her behalf. The patient can appoint persons or declare a ban on the provision of information about his or her medical condition to any person at any time after admission to care; at the same time, the patient can annul the appointment or withdraw the declaration of a ban on the provision of information about his or her medical condition at any time.[49]

49 Section 33 (1) of the Healthcare Services Act.

Report on the patient's wish constitutes a part of his or her medical record; the report shall be signed by the patient and a member of medical staff. The report also contains the patient's notice on how information about his or her medical condition may be disclosed,[50] i.e. verbally, by phone or in writing. It is up to the patient to decide and the choice is limited only by justified obstacles on the part of the treatment facility. It must be taken into account that families or close persons of some patients live far away from the facility, or abroad. They too have the right to be provided with information about the patient's medical condition if the patient agrees. By using a suitable manner of communication, the facility will prevent unfavourable treatment of them.

It is unlawful for a facility to limit the number of persons who may be informed about the patient's medical condition or not to allow patients to select a manner of disclosure of information to third parties.

To the contrary, I consider it a good practice when authorised persons can receive information about the patient's current medical condition over the phone, on the basis of a password agreed upon in person and duly recorded.

Recommendation:

- **Leave the choice of people who can be informed of the patient's state completely up to the patients, and not limit the number of such people and the manner of providing information.**

9) Patient as a partner

The general approach of staff to patients should be based on respect for human beings as such, and on the knowledge that patients are not people who came into the facility with no previous life experience and with no future. Regardless of their intellect and the level of their communication skills, it is necessary to view patients as respectable people and treat them accordingly.

Communication between staff and patients

It is quite common in facilities taking care of elderly patients that the staff treat them as children. Although the staff in the facilities

50 Section 33 (1) of the Healthcare Services Act.

visited communicated with the patients in a positive manner, the Defender's employees noticed some inappropriate use of diminutives, familiarities, and addressing individual patients in plural forms.

Findings from the visits:

- The Defender's employees noticed the following addressing: "What is the matter, sweetie, come on, nom-noms." "boys", "honey", "baby girls", "missie", "sweetie", "sunshine", "kitty-cat", "darlings", "baby dolls", "kitten" "Carrie" (and other diminutives of the patients' first names)"Let's have some drinky-poos."
  "Now open wide!"
  "Come on, madame, let's have nom-noms."
- After an employee in one of the facilities found out that a toilet and the floor around it had been heavily soiled, she stormed into the patients' room and asked who had done it, in a very inappropriate manner.

> "Using diminutives to address the patients must be rejected"

Even though using diminutives to address the patients might be the sign of good relationship of the staff and the patients, it must be rejected. Patients are adult people and positioning them into the role of a child, using diminutives and pet names, is inappropriate. Patients are in a dependent position and the style of communication is set by the staff. The way of addressing patients reflects the attitude of the staff to the patients. This trend puts patients into the position of a child and incompetence, and is seriously demeaning.

Recommendation:

- **Ensure correct addressing of the patients and appropriate communication, not putting the patients into the position of a child, not using diminutives to address them.**

Designation of the personnel

Patients have the right to know the names and surnames of the medical professionals and other specialists directly engaged in the provision of healthcare services and of persons who are preparing for the medical profession in the facility.[51] In other words, the patients are entitled to know who is taking care of them and the personnel have the duty to be properly identified by their name and surname and to introduce themselves to less oriented patients. Clothing colour differentiation distinguishing various groups of staff also significantly contributes to the patients' orientation. For the clothing colour differentiation to be effective, the patients must be aware of it (for example, in the form of explanation on the notice board). The team composition (name and work assignment) should also be clearly displayed at a place in the facility where the patients commonly spend time.

51 Section 28 (3)(g) of the Healthcare Services Act.

Findings from the visits:

- When meeting the patients for the first time, some of the staff introduced themselves, some did not; the medical professionals did not introduce themselves, not even before performing a medical procedure.
- Some of the personnel had tags with their names, some had tags showing only their position.
- The name tags were difficult to read for the patients.
- There was no colour distinction in the clothing of different groups of the staff.
- The patients found the colour differentiation of the groups of workers confusing.

Recommendations:

- **Ensure that each member of staff introduces him/herself at least when meeting the patients for the first time.**
- **Ensure proper designation of the caring staff.**

Engagement of the patients in personal hygiene

Personal hygiene should be based on the patients' needs. The staff should take over such care only when the patients are not willing or able to wash themselves. To support the patients' self-reliance should always be one of the main goals of the care provided in the facility.

Findings from the visits:

- The staff failed to engage the patients in personal hygiene, regardless of their self-reliance and abilities.
- A staff member did not even introduce himself to a patient who had only been there for two days; he did not speak to her, just prepared her and took her to the showers.
- The staff were transferring patients to the showers during the morning hygiene routine. The staff talked to each other about their personal matters and did not address the patients at all. The patients then did not know what the procedure would be and what they would have to tolerate.

> "Being assisted by another person during personal hygiene is stressful for many patients"

Personal hygiene carried out with someone else's assistance is a stressful experience for many patients. Therefore, the staff should communicate with the patients sensitively and encourage them to engage as much as they can. At the same time, the staff should take a thoughtful and discreet approach to the patients during personal hygiene. This is the only approach of the staff that will support the patients' dignity and self-reliance, and which will reduce the patients' dependence on the care at the same time.

Recommendation:

- Encourage the patients' self-reliance and communicate with them during personal hygiene.

Taking away the identity cards and insurance cards

During the visits, the Defender's employees witnessed the practice of indiscriminate taking away of the patients' identity cards and insurance cards (hereinafter the "cards") on the patients' admission to the facility. The cards were then put into the individual patients' medical records available to the staff working with the records.

> "I find the indiscriminate taking away of the patients' identity cards inappropriate."

I find both the indiscriminate taking away of the patients' identity cards and their placement in the medical records inappropriate. Taking away the cards is only possible in justified cases when the card is taken away in order to prevent its misuse and to protect the patient (for example, a patient with dementia). Other patients should only be offered this as an option, as they can use the lockable area that should be available to them to store their identity cards.[52] If a patient's card is taken away, it is necessary to store it in a way ensuring that no third parties have access to it.

Recommendations:

- Limit taking away of the patients' identity cards and insurance cards.
- Secure the cards that have been taken away against misuse.

10) Visits

Time limit for visits

Being able to receive visitors is an exercise of the fundamental human right to private and family life. Patients have the right to receive visitors in the facility in accordance with the internal rules and in a manner that does not violate the rights of other patients.[53] The internal rules should respect this right and only limit it in justified cases where this is required by the operation of the facility The Defender's

52 Part I, Paragraphs 1 and 12 of Annex No. 4 to the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.

53 Section 28 (3)(i) of the Healthcare Services Act.

employees witnessed mainly a welcoming approach in the facilities as the patients were allowed to receive visitors outside the visiting hours based on agreement with the staff. I appreciate this approach; however, there were exceptions.

Findings from the visits:

- The visiting hours were set from 2 p.m. to 6 p.m. After that time, visitors could only come with the consent of the head of the facility. However, he was not present at the facility all the time, which caused problems, especially in cases of dying patients.
- The conditions under which visitors could come even after the visiting hours were not clear.
- The visitors of dying patients did not have the option to spend the night in the facility.

In justified cases, I consider the option to visit patients outside the visiting hours a standard, as it is not always possible or desirable for the patients' family to adapt to the facility's regime which is set universally. At the same time, patients and their families should both be aware of the conditions under which visitors can come outside the visiting hours, and the conditions should be achievable. I consider that allowing the patients to receive visitors at any time based on agreement with the staff is a welcoming approach. The facilities should be especially cautious in cases of dying patients and their visitors (see chapter 23).

Recommendation:

- **Make it possible for the patients' families to visit the patient also outside the visiting hours and actively inform the patient's relatives of such possibility.**

Environment for visits

The next step in exercising the patients' right to receive visitors is creating dignified conditions and privacy during visits. The visiting area (common room or multifunctional space) should be equipped so as to be accessible even to patients with reduced mobility. Visitors can also come to the patients' rooms, provided that they will not disturb other patients.

Findings from the visits:

- There was a visiting area in one of the facilities; however, according to the staff and patients, it had not been used, and the visitors visited the patients in their rooms. The confined rooms did not provide the visitors with enough space, and the visitors could then disturb other patients in the room.
- There was no visiting area in another facility; visitors could only visit patients in the patients' rooms with other patients present, or in the hallways. The visitors and the patients did not have enough privacy; the patients could not spend time with their families alone.

> The facility should ensure that the conditions for visits are dignified

- There was nowhere to sit for the visitors either; a visitor had to use the portable toilet chair to sit down.

Recommendation:

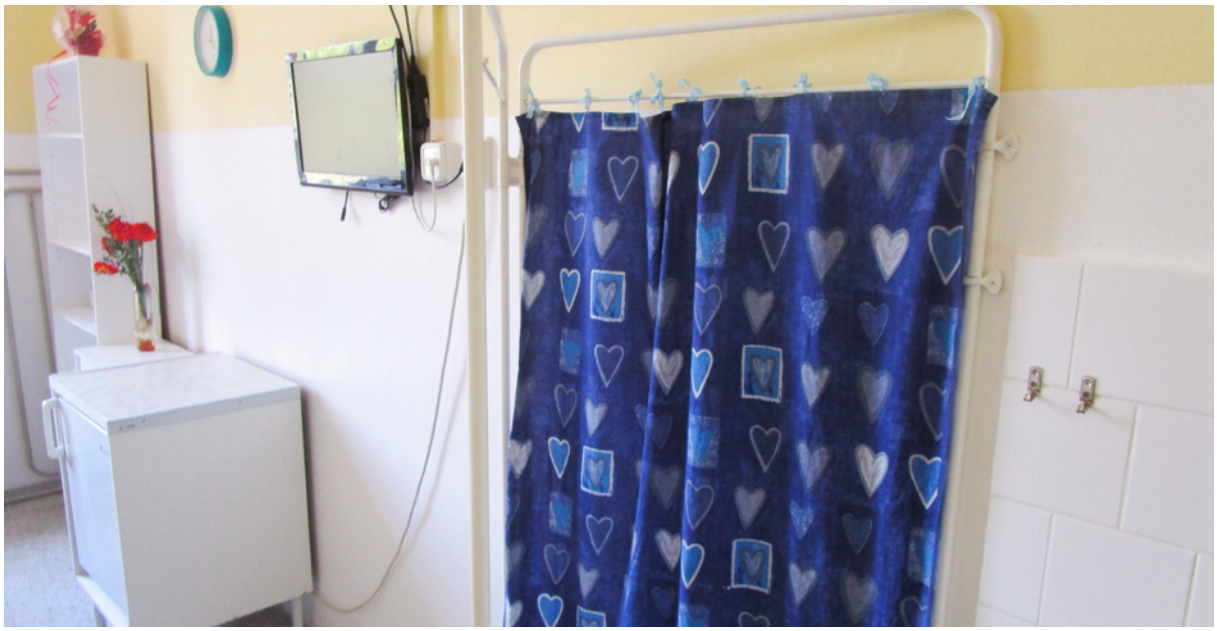
- Ensure privacy and a dignified environment for visitors.

11) Privacy in rooms, during personal hygiene, at the toilet

The room must be a dignified environment for a patient; it must provide at least a basic degree of privacy. The personnel's conduct must also protect the patients' dignity. The demands placed on facilities are high in this respect, but completely justified.

Findings from the visits:

- During the visiting hours, a patient sat on the portable toilet chair, while the door to the hallway was open and visitors of other patients were entering the room.
- The patients were using the toilet in front of other patients.
- While one of the patients was using the portable toilet chair, another one was given food. The toilet was not separated at all.
- There were six beds in the multiple-bed rooms. The staff always gathered all patients for personal hygiene. The patients were lying naked on their beds and each one was being washed by an orderly, regardless of the patients' gender. The orderlies did not use the screens and the door was open. Anybody could see the patients' private parts.
- The patients were transferred to the bathroom naked, sometimes in the hospital gown fastened at the back ("johnny gown"). While being transferred on a wheelchair or while doing exercise, the patients' thighs and genitals were exposed.
- As a result of insufficient clothing, private parts of some of the patients' were exposed even in their beds. A patient was being transferred on a gurney to the ambulance in her night gown. During the transfer she shouted for somebody to at least throw a blanket over her, as she was not wearing any underwear.
- Even self-reliant patients who were able to walk to the bathroom themselves were always supervised by the care personnel. This rule was applied indiscriminately, even though the presence of the medical staff when the patients were having a shower was unfounded.
- Self-reliant patients did not have the conditions for maintaining personal hygiene on their own. There were no sinks in the rooms and the number of showers in the facility was insufficient. During the morning hygiene routine, a patient came out of his room to the hallway, took off his gown and started washing himself, naked.
- A patient was naked on his bed, where other people could see him, waiting for the attendant to change his diaper



Screen suitable to ensure privacy in the rooms.

It is possible to avoid the shortcomings found partly by the staff being consistent (knocking before entering a room, closing the doors, using screens, asking the patients who can move themselves to vacate the room, limited number of staff present during self-reliant patients' personal hygiene). In the rest of the cases, it is necessary to apply measures that can be used in everyday care practice that will ensure the patients are shielded in a delicate situation. That makes the material background of the facility equally important, as well as thoughtful and consistent approach of the staff and setting the work tasks of the staff so that they can ensure patient privacy. The patients' dignity and basic rights are violated despite good healthcare, due to insufficient material resources combined with an inappropriately set working pace of the nursing staff.

Recommendations:

- Secure material conditions that would allow for the patients' privacy in their rooms during personal hygiene, using the toilet chair or while nursing (for example by providing and using screens); set the staff's tasks so that they can ensure patient privacy.
- Avoid violation of the patients' privacy by engaging a thoughtful approach (closing the doors, knocking before entering a room, covering people, looking away, asking other patients to leave the room); ensure consistency of the staff.
- Ensure that self-reliant patients can maintain personal hygiene on their own and in privacy.
- Transfer the patients to the showers dressed.

12) Freedom of movement, safety

Patients' freedom of movement may only be limited to avoid a direct threat to life, health or safety of a patient or other persons, and only during the time when the threat exists.[54] The following can be used to limit patients' movement:

- **restraints**, for example belt restraint, straps, and psychopharmaceuticals,
- **operations and equipment for healthcare (especially nursing)**, which should help ensure the safety and comfort of the patient, such as bed rails, and
- **regime measures**, for example prohibition to leave the ward after certain time at night.

Restraints

Patients are entitled to healthcare in conditions as non-restrictive as possible.[55] Each use of restraints represents interference with the patients' fundamental right to maintain mental and physical integrity, which is why the use of restrains is only permissible after all other, more moderate, measures aimed at calming the patient down have been exhausted (with the exception of cases where using a milder measure would not lead to averting the imminent danger). At the same time, the least restrictive restraints corresponding to the purpose of use must always be chosen.[56]

Restraints should be the last resort for solving a crisis

For patients whose state of health might require the use of restraints, I recommend preparing and maintaining an individual plan of managing their restlessness and keep the plan in their medical records. The plan should contain information on how to avoid restlessness, how to react to it when it occurs, and how to use restrains in the most safe and sensitive way. In case of using restraints, I recommend analysing the use later and considering the analysis in implementing the care plan.

54 Section 39 (2) of the Healthcare Services Act

55 Section 28 (3)(k) of the Healthcare Services Act.

56 Section 39 (2)(c) of the Healthcare Services Act effective as of 31 May 2017.

The law stipulates that each use of restraints, including the reason for their use, must be recorded in the patient's medical records.[57] Pursuant to the Decree on Medical Records, the record should contain:

- **A.** record on the indication of the restraint, including specification of the kind, manner and purpose of the restraint, setting intervals and scope of check-ups;
- **B.** start and end time of application of the restraint;
- **C.** records on continuous evaluation of the reasons for using the restraint;
- **D.** records on continuous evaluation of the patient's medical condition during the use of the restraint;
- **E.** description of complications if they occur;
- **F.** name (or names) and surname(s) of the medical staff who indicated the use of restraint; if the use of restraint was not indicated by a physician, name or names of physicians who were properly informed of the use of restraint;
- **G.** if the use of restraint was not indicated by a physician, record on physician's evaluation of the reasons for using a restraint, including the time it was confirmed;
- **H.** information that the legal representative of the patient incapacitated of legal capacity or a minor patient was advised of the use of restraints.[58]

Findings from the visits:

- Most often, the Defender's employees noted that the records did not contain the time during which the restraint was used (or the start and end times), information on check-ups, and in some cases not even information on the person who indicated the restraints and in what manner.
- In one facility, the Defender's employees only found the following austere records on use of restraints in a patient's medical records: "In the evening, he seems to be confused, restless, pulls on his diaper despite the straps.", "Slightly restless, pulls on the straps.", "Aggressive again, had to be strapped.", "Confused, aggressive, non-cooperative, had to be strapped – risk of fall."

The provider is also obliged to keep central records of use of restraints, containing a summary of the number of cases of use of restraints per calendar year, for each restraint separately; the patients to whom restraints were applied shall not be identified in the central records. Use of restraints must be recorded in the central records not later than 60 days of the use.[59]

> "The provider is obliged to keep central records of use of restraints"

The matter of restraints indication is also problematic. The law stipulates that restraints may only be used if they are aimed at avoiding a direct threat to life, health or safety of a patient or other persons[60], and that indication must always be decided by a physician.[61]

57 Section 39 (3)(e) of the Healthcare Services Act effective as of 31 May 2017.

58 Section 1 (2)(k) of the Decree on Medical Records.

59 Section 39 (4) of the Healthcare Services Act.

60 Section 39 (2)(a) of the Healthcare Services Act.

61 Section 39 (3)(d) of the Healthcare Services Act.

Findings from the visits:

- The physicians indicated the use of straps pro futuro, for example "as needed" or "in case of restlessness", leaving it for the paramedical staff on duty to evaluate the patient and possible use of straps. The staff took use of this option especially during evenings and in the night time, when no physician was immediately available.

The above practice leaves the decision on use of restraints (in fact indication) for the paramedical staff, which I find to be at variance with the law. Paramedical staff may indicate restraints only in extraordinary cases that must be resolved promptly; the physician must be informed of such use without delay and must confirm that the indication is justified.[62] It is my request for the facilities that they respect the requirement of extraordinariness, make sure a physician is available, and do not use extraordinary measures as a standard.

Recommendations:

- Use restraints only in urgent cases.
- Prepare individual plans to manage restlessness.
- Record the use of restraints in accordance with the requirements of the Decree on Medical Records.
- Keep central records of use of restraints.
- Avoid indications of restraints pro futuro and assigning medical competences to paramedical staff.

Sedatives

Administering sedatives constitutes, depending on the circumstances, either a restraint or an ad hoc administration of the relevant medicine prescribed by the physician for specific, foreseeable situations within treatment of the patient's illness using pharmaceuticals. If administration of drugs is aimed at restricting the freedom of movement of a patient (walking, getting up from bed, touching objects or persons, etc.), this usually represents a restraint, as well as in cases when the drug is administered to a patient due to aggressive behaviour. However, administering a drug in order to relieve a certain unpleasant condition (perceived in the given case as "restlessness") does not represent a restraint where the physician has anticipated that the condition could arise on account of the manifestations of the patient's illness.

It is a common practice that physicians prescribe sedatives for the cases that the patient is "restless". In case of such a vague ordering, it is impossible to distinguish whether this constitutes a restraint, and

62 Section 39 (3)(d) of the Healthcare Services Act.

administration of the drugs is subject to Section 39 of the Healthcare Services Act, or whether it represents the ad hoc administration. I also recommend that the ordering should specify the maximum daily dose of the drug and the interval of administration. Accurate ordering of sedatives will help prevent excessive use of sedatives, which has been a pressing issue of the Czech healthcare system.

> Sedatives may constitute a restraint

The same rule applies to sedatives as to restraints, i.e. they should always be the last resort for solving a crisis or a problematic behaviour of a patient. Therefore, where sedatives are administered, I recommend including the information on the time of administration, description of the situation preceding the administration and the consequent effect in the records, so that the circumstances of the administration can be analysed and further care adapted.

Findings from the visits:

- A patient received sedatives before his bath, because he was restless and borderline aggressive while being washed. It was apparent from the records that on 22 September 2015 at 7:15 a.m., he attacked an orderly during his bath, despite having been given a sedative at 6:20 a.m. (1 amp. Tisercin IM); he was not given any more medicines after the incident. The record in the night report further states that on 30 September 2015, at 6:00 a.m., the patient was also given 1 amp. Tisercin IM, "for bathing". The drug was ordered for irregular administration and states "in case of restlessness" without any further commentary. The administration of the drug on 22 September 2015 was documented in the records merely by ticking a box on the ordering and noting down the time; the record from the round of the ward only stated "restless, aggressive, does not cooperate"; the entry in the nursing records was illegible (no details are available on the administration of the drug); there were more details in the record on an emergency, including description of the attack, but not the circumstances under which the drug was administered or an evaluation. The administration of the drug on 30 September 2015 was documented in the records merely by ticking a box on the ordering; there was no entry in the nursing records on the extraordinary administration of the drug, nor on the course of the bath; the reporting book, which does not constitute medical records, contained information on the time and reason for administration. The incident of 22 September 2015 was not mentioned in the care plan at all – the risk of aggression was not mentioned, even though the ordering for the reason of "restlessness" had been there before.

Recommendations:

- **Abandon the vague prescription of sedatives stating "in case of restlessness" and always formulate the ordering clearly and in a way that will exclude the possibility of various interpretations.**
- **State the maximum daily dose of the drugs and the interval of administration when ordering sedatives.**

- Keep detailed records about administration of sedatives; indicate the time of administration, describe the situation preceding administration and effect.
- Regularly analyse the circumstances of administration of sedatives and take it into account in planning further care.

Prevention of falls

A fall can worsen the quality of a patient's life, prolong hospitalisation and even bring elderly patients to a bedridden state.

While I am aware that there is no way a facility can entirely prevent patient falls altogether, it is important to eliminate them as far as possible. To this end, I recommend, in particular:

- monitoring and evaluating the risk of fall throughout the patient's hospitalisation and not just on admission;
- consistent recording of the risk of fall in the patient's medical records;
- making sure the nursing staff are properly advised of individual vulnerable patients (for example, by placing pictograms at the patient's bed);
- immediately addressing the patient's medical condition in case of a fall and taking measures to minimise future risk.

Proper evaluation of the risk of fall and establishing a plan for minimising it are intended to protect the patient against an excessively restrictive follow-up approach and provide further guidance e.g. for using bed rails.

Findings from the visits:

- During one of the visits, the Defender's employees saw a cleaner wiping the floor of the corridor without leaving a safe dry passage. The cleaner ignored the fact that the most of the patients in the facility were elderly people who often used a cane (walker) and a wet floor could be very unsafe for them. A good practice for the cleaner would be to wipe one half of the corridor in a longitudinal direction and proceed to the other half only after the first half has dried. The cleaner should always mark the wet half with a sign warning against the wet floor.

Recommendation:

- Ensure fall prevention.

Bed rails

Bed rails (or barriers) are a commonly used nursing tool aimed at preventing patients' falls from beds. However, using them may put the patient's dignity and health at risk (immobilisation, incontinence); therefore, I request that the following conditions be met when bed rails are used.

1. Bed rails may only be used to prevent a patient's fall, i.e. to ensure the patient's safety rather than making work easier for the staff. It is necessary to carry out an individualised assessment of the risk of fall as described in the preceding chapter.


The use of bed rails must always be adequate with regard to the risk

2. The use of bed rails must always be adequate with regard to the risk. The rule to be always followed is to use measures that are as non-restrictive as possible. Therefore, it is necessary to consider in the first place whether less restrictive measures could be used for fall protection, for example to lower the bed or place mattresses next to the bed, or to use partial bed rails or bed rails that the patient can lower from the bed. For patients with dementia, it may be appropriate to use pictograms explaining that the bed rails must be raised. The use of bed rails must be considered with particular care in relation to patients in whom bed rails provoke anxiety as they may attempt to remove or climb over them.

3. When using bed rails in mobile patients (fall prevention in sleep), it is necessary to make sure the patient can leave the bed. For example, it is possible to use partial bed rails or bed rails that the patient can lower from the bed.

4. The law does not explicitly require medical facilities to indicate the regime of bed rail use in the medical records. Nevertheless, if the bed rail regime is indicated in a patient's records, the staff have clear instructions on the use of bed rails. In this respect, I consider it appropriate that the personnel on duty can use guidance in the form of a list authorised by the manager specifying the patients indicated for bed rails and the precise regime for their use.

Findings from the visits:

- A mobile patient who was able to go to the toilet on her own could not do so during night-time because of bed rails and had to use diapers to relieve herself.
- A record on the fall of a patient who climbed over the bed rails was found in the nurses' records.
- A patient's bed rails were not raised although the medical records indicated otherwise. The bed rails appeared to be ordered only formally in this case because the patient and the personnel did not plan to use them; the patient was able to move to the toilet chair and wheelchair without assistance so bed rails would pose an inacceptable restriction of movement. The physician's order did not correspond to the patient's medical condition at the time.
- A patient's bed rails were raised for the night without having this instruction noted in his medical records.

Recommendation:

- Respect the principles of proper and safe use of bed rails (see the text).

13) Prevention of malnutrition and dehydration

Considering the target group in question, I consider it as the norm that the facilities provide nutritional care including malnutrition prevention.[63] The risk of malnutrition must be continuously monitored and evaluated for every patient. Where the risk of malnutrition is identified, it is necessary to respond adequately and carry out a further evaluation of the patient's medical condition.

> The personnel must prevent malnutrition systematically

Malnutrition prevention includes monitoring of patients' nutritional status. This is a standard task for a general nurse that is performed without physician's supervision and indication.[64] Monitoring the nutritional status of patients facilitates an individual approach to the care for patients' nutrition and early detection of any nutrition-related problems.

I also consider it beneficial when the facility co-operates with a nutritional therapist – a role important to ensure a comprehensive nutritional care and proper standard of care.

Findings from the visits:

- Records of the monitoring of food and fluid intake did not always correspond to the actual state of affairs. The Defender's employees present in the serving of meals learned that the quantity of food consumed by some patients was recorded incorrectly by the medical personnel.
- A patient who was to be weighed once per week according to the physician's order was not weighed at all because the worker assigned to the task was ill.
- Laboratory examinations (measuring total protein and albumin values) were not performed for all patients and the examinations were not carried out continuously over time. As a result, the staff were not able to assess whether or not a patient's overall nutritional status was improving.
- There were neither standard body mass scales nor scales for weighing patients in a horizontal position in one of the facilities. Alternative methods for evaluating the nutritional status (such as measurement of arm circumference) were not in place.
- The facility did not keep any systematic records of food and fluid intake.
- The medical personnel were unaware of the quantity of food consumed by patients because the dishes were collected by the cleaner after lunch without advising the personnel whether a patient ate and how much.
- There was a lack of records for the fluid intake and output balance, including for patients with permanent urinary catheters. A patient had a maximum fluid intake per 24-hour period ordered by the physician. Even her fluid intake was not indicated in the medical records. The explanation provided by the staff was that the patient was self-reliant and checked her intake of fluid on her own.

63 An information leaflet of the Public Defender of Rights concerning the risk of malnutrition and possibilities of protection in social and medical facilities is available online at www.ochrance.cz.

64 Section 4 (1)(a) of Decree No. 55/2011 Coll., on the activities of medical workers and other professional employees, as amended by Decree No. 2/2016 Coll.

- Records for the fluid balance were kept for patients who did not drink enough or were catheterised. However, they could take drinks during the day on their own, used various drinking vessels or had their own drinks in PET bottles. In these circumstances, it was impossible to duly record the quantity of drinks consumed.
- The head physician of the facility stated that about 15% of patients received supplemental nutrition drinks, without there being any records of such food supplements, including for patients with the risk of malnutrition subjected to a monitored daily food intake.

The personnel must prevent malnutrition systematically. To this end, the facility should have in place a clear working procedure for staff. Prevention and treatment of malnutrition or dehydration must be individualised, always with a focus on every individual patient. Proper and accurate records must be kept whenever it is necessary to monitor a patient's food intake or fluid balance. This is the only way of properly evaluating or monitoring effectiveness of the prescribed treatment measures.

Recommendations:

- Consistently perform malnutrition prevention tasks, in particular by monitoring the risk of malnutrition (throughout hospitalisation), respond appropriately when malnutrition is detected and continue to evaluate the patient's medical condition (have a defined workflow in place).
- Set up a system of records for food and drinks which will not contribute to the risk of error (for example, place the record sheets at the patient's bed).
- Make use of the nutritional therapist's expertise in comprehensive patient care.
- Consistently monitor fluid balance in individual cases (catheterised patients, patients with an ordered maximum fluid intake).

14) Serving of meals and drinks

Culture of dining

Pleasant food serving and dining are important for everyone, not just for the protection of personal dignity. Food satisfies not only biological but also psychological and social needs. It also helps preserve and restore self-reliance. Food is part of comprehensive care. It is a social ritual which can bring patients together, makes them meet one another and communicate, share experiences and avoid isolation. Therefore, the staff should ensure that dining takes place in a pleasant environment.

Findings from the visits:

- The staff did not help patients with washing their hands and did not offer alternatives (such as a wet wipe).
- All patients ate with a spoon. The personnel did not issue forks and knives.
- Soup was served in mugs to all patients. Many patients received drinks in baby bottles.
- Patients ate unminced food without dentures. Consequently, they did not eat meat because they were unable to chew it.
- Even self-reliant patients ate in bed.
- A patient ate very near a table on which a bottle of urine was placed. Bed pans stood on the floor near a patient eating his lunch.
- The staff did not remove portable toilets before serving food and did not ventilate the rooms, leaving the smell inside.
- The staff were changing a patient's diapers without using a screen while the other patients in the room were eating their lunch.

Undignified serving of food

I consider the above practice undignified; it should hence be avoided. A large part of improvement can be achieved simply by a respectful and sensitive approach of the staff and by developing a time schedule for staff. Correct organisation of work gives the staff enough time to properly prepare patients for lunch and provide individualised eating assistance. Material means are only a negligible part of improvement (for example, proper dishes for geriatric patients, appropriate additional equipment of the room).

Recommendation:

- **Pay more attention to dining culture and understand it as part of comprehensive care, taking account of satisfaction of not just biological but also psychological and social needs and the interest in preserving and restoring self-reliance.**

Possible alternative to the serving of drinks in baby bottles

Serving food to patients requiring constant assistance

Food should be served in a serene atmosphere; disturbing elements must be eliminated in order to ensure patients can concentrate on food. When easting assistance is provided, it is necessary to pay attention to the patient, keep eye contact, notice his/her behaviour and respond appropriately. Encouraging a patient to sit during eating promotes his/her activation; bedridden patients must be positioned when food is served to them. Patients have the right to be treated with dignity and respect and should be encouraged to feel self-reliant. I again do not recommend infantilisation of patients, even if the motivation of the staff and facility is to be kind and improve the patient's situation as far as possible.

Findings from the visits:

- The persons who assisted patients requiring constant assistance in eating stood above them and served food from above, without keeping eye contact.
- Patients requiring constant assistance were served very quickly during lunch (soup, main course). Some patients were served in 3 to 5 minutes. After serving lunch, the employees proudly told each other how swift they were today.
- The patients who needed eating assistance were not able to influence how quickly the worker served food; any hints they gave were disregarded.
- A bedridden patient was not positioned by the workers during eating assistance, despite the fact that positioning was available, and the patient received food in a horizontal position.
- The worker who assisted clients with eating walked between two bedridden patients, alternately assisting both.
- The assisting workers addressed the patients with diminutives, baby talk and highly informal names during eating assistance..

Recommendations:

- **Take a serene approach when providing a patient with eating assistance; keep eye contact, pay attention to non-verbal communication and patient's behaviour, support his/her self-reliance.**
- **Actively encourage patients to sit during eating.**

Consistency of food

Modified consistency diet must be served to patients who have trouble swallowing for various reasons. This is a serious change in the patient's life. The patient perceives the loss of his/her self-reliance and loses the full experience of eating a meal. Therefore, blending meals should be the last resort. It is always preferable to process meals in a manner which enables the patient to experience the food's texture.

The Defender's employees noticed during the visits that individual components of the meal were blended together for patients. This was most often meat blended with the side dish or soup blended with the main course. This creates an unattractive meal that is unlikely to stimulate the patient's appetite.

This is an unacceptable practice. Even when a meal is blended, individual components should be separated. This is not just an unethical approach to patients. Separating components in blended meals can ensure that the patient eats the nutritionally more valuable component if s/he does not finish the whole portion and makes it possible to effectively monitor food and fluid intake as prevention of patient malnutrition and dehydration.

Recommendation:

- **Avoid blending all components of a meal together.**

15) Bladder voiding regime

One of the objectives of hospitalisation in treatment facilities for long-term patients is to train self-reliance and, as part of this training, normal emptying. The objective of proper nursing care is to keep patients continent as long as possible. Bladder voiding regime is an integral part of the treatment regime.

Findings from the visits:

- Bladder voiding was not trained at all in the treatment facility visited. Most of the continent patients who used toilet chairs during the day were given diapers for the night.
- The patients stated that it was prohibited to go to the toilet during night-time. Those patients who could go to the toilet during the day were forced to use the toilet chair in the room at night.
- The Defender's employees witnessed two situations in which a patient objected to the use of a one-off diaper and wanted a bed pan. The orderly did not wish to resolve the situation, answering that diapers were safer; in the second case the answer was that the patient could urinate in the diaper.
- An excessive number of patients had urinary catheters. In some cases the reason for inserting the catheter was not indicated in the records. Consequently, using the urinary catheter appeared to be a response to the patients' incontinence (even partial) intended to make the staff's work easier.
- According to the staff, catheters were inserted for the shortest possible time but they often had to reintroduce the catheter soon after removing it. However, the medical records did not contain any entries in this respect.
- A patient was transferred to the facility without any problems with urination; he was able to go to the toilet in the day-time or use a urine bottle. He was incontinent only in sleep. In response to this situation the urinary catheter was inserted.
- A patient using the toilet chair was unable to stand up from the chair on her own and could not reach the signalling device to call assistance. She was forced to stay in the chair longer than necessary, which she found frustrating.

The treatment facility should work systematically with patients' bladder voiding regime and take into consideration their individual emptying habits and needs. The treatment facility must set an individualised bladder voiding regime for patients and encourage independent emptying in conditions that suit the patient. The staff should use incontinence aids only in necessary cases where they are properly

indicated. Especially catheters are a potential source of infection and, in addition, their prolonged use reduces the ability to restore normal urination. The use of urinary catheters must be properly documented. If a patient using incontinence aids requests assistance, the staff should assist him or her and raise him or her to the toilet, or help the patient walk to the toilet or provide a bed pan or urine bottle. Incontinence aid is not a reason for abandoning work with the patient's bladder voiding regime.

Recommendations:

- **Adopt maintaining or improving patients' independent emptying as one of the objectives of hospitalisation.**
- **Use incontinence aids (diapers) only in necessary cases.**
- **Consider very carefully the indication of urinary catheters and duly document the related nursing tasks.**

16) Medical and nursing records

Medical records are an important element of care. They are a place for sharing knowledge about a patient and his or her medical condition, a tool for planning and individualising care. As such they must be kept demonstrably, truly and legibly and must be continuously updated – records must be made without unnecessary delay.[65] Where this is not observed, the patient's health and, in extreme cases, life may be at risk.

The records must be kept in such a way as to provide sufficient information about the patient's medical condition for all team members who peruse the records. Failure to maintain medical records up-to-date can sooner or later have implications in the quality of the care provided. Where records are kept improperly and unsystematically, the risk of errors increases, and patient's health may be compromised.

Findings from the visits:

- A blank Barthel ADL Index was found in the records of a patient despite the fact that the patient had been admitted to the facility about two weeks earlier. The documentation did not specify any reason why the index had been left blank.
- The records in a patient's daily report were illegible.
- Dressing records were missing for a patient after the amputation of a lower limb. Only a brief note of the amputation was contained in the document "Care plan for patients with decubitus ulcers and other cutaneous defects".

> "Poorly kept records may endanger patient's health"

65 Section 54 (2) of the Healthcare Services Act.

- Some information was available in the nurses' reports, despite the fact that such reports do not form part of medical records and as such they should not contain information about the medical condition of patients.
- The physician's record about a patient was completely omitted. Although the patient had a decubitus ulcer at the time of the physician's visit, the physician's description was missing. Only the nurse's record contained the information.
- A patient was admitted after a fall with fracture of the right upper limb; according to the records, the hospitalisation was necessitated by the need for nursing care on grounds of long-term adverse medical condition. In the patient's records, the physician did not describe the state of the fracture and did not indicate rehabilitation.

The nursing anamnesis on admission must contain an evaluation of the biological, psychological and social needs that changed as a result of the medical condition. This is the only way of determining the objective of the hospitalisation and its key regime aspects.

For in-patient care exceeding 7 days, the medical records should also include a summary (epicrisis) of the course of treatment and further treatment plan.[66] Only in this way is it possible to evaluate success of the chosen approach and, if appropriate, change the course of treatment during hospitalisation.

In some cases the medical staff simplified their work by making the nursing tasks entries beforehand. This is at variance with the law (medical records must be true[67]), and even more importantly, puts the patient at risk. If a task is recorded in advance, the staff may forget to actually perform the task or perform the task twice (in two subsequent shifts).

Recommendations:

- Keep medical records in such a way that they serve as a relevant basic document for further care.
- Introduce evaluations of psychological and social needs of patients upon admission and note them in the records.
- Keep the epicrisis and plan of further therapy.
- Record data about nursing tasks only after the tasks have been actually performed.

66 Section 2(c) of the Decree on medical records.

67 Section 54 (2) of the Healthcare Services Act.

17) Ordering, preparation and administration of drugs

The law requires that records of the prescription of medicinal products (including dosing and the number of packages prescribed) and their subsequent administration (again, including quantities) shall be included in patients' medical records.[68] However, details of the method of ordering, preparation and administration of drugs are not provided for by the law; it is accordingly for the facility to establish a safe system. During the visits, the Defender's employees encountered errors in orders, administration and storage of drugs. In view of these shortcomings, I recommend placing emphasis especially on the below areas.

Ordering of drugs

Drugs are to be ordered exclusively by physicians, including standard commercial drugs. Orders must be accurate and complete, including form, dilution method, etc. Copying (for example, into the reports book, from sheet to sheet, etc.) may cause errors in orders, unlike using the original order in the daily report, which is a way of minimising errors. It is also appropriate to adjust the system of orders in such a way as to make clear who ordered which drug and when. The order of an irregularly administered drug should also provide information about the maximum daily dose of the prescribed drug and the minimum administration intervals. After the drug has been administered, information should be provided about the time of administration, situation preceding administration and effect.

Recommendations:

- Administer drugs to patients only on the basis of an accurate and complete physician's order.
- Keep records of the time of administration, situation preceding administration and subsequent effect in irregularly administered drugs.

68 Section 1 (2)(e) of the Decree on medical records.

Administration and serving of drugs

A general nurse should distribute drugs to patients immediately after preparing them from the original package, at the time for which the drugs were ordered by the physician. Drugs should be administered by a healthcare assistant or attendant only under the supervision of a general nurse and access to drugs should be permitted only to persons authorised to handle them. A drug should be deleted from the daily report only after it has been actually administered to the patient. Drugs administered to patients must be checked on a regular basis to ensure the expiry period has not elapsed. After administering drugs, it is also important to check that the patient has actually used the drugs rather than e.g. dropping them into the bed.

Recommendations:

- **Ensure that only authorised personnel administer drugs to patients. Set the drug administration procedure so as to minimise the risk of errors.**
- **Ensure that only authorised personnel have access to drugs.**
- **Regularly check the expiry dates of drugs.**

18) Evaluation of pain

Illness is often accompanied by pain, which has a strong effect on patients' quality of life and should therefore be regularly monitored, evaluated and, as far as possible, minimised.

I consider it important to continuously monitor whether and how (in terms of character and intensity) a patient perceives pain and how pain is influenced by the chosen treatment procedure. The method of detecting, documenting and evaluating pain should be regulated by an internal rule and due account should be taken of pain in practice.

Findings from the visits:

- Pain was not systematically evaluated in a facility and did not receive a special section in the records.
- It followed from a patient's medical records that after a nurse repeatedly noted great pains in the records, the physician ordered analgesics as late as the third day after the last record.

Many patients regularly use analgesics, including opiates. In that case, I consider it important to regularly evaluate the effect of such pharmaceuticals and to properly keep records of their use.

Findings from the visits:

- The documentation did not contain information whether the administration of an analgesic was effective and the patient was relieved.
- In some cases analgesics were ordered incompletely, without the minimum administration intervals to be observed by the nurse. Quite to the contrary, in one case Morphin s. c. was ordered for administration every 12 hours but was in fact administered at 6:00 a.m. and 8:00 p.m. – in 14-hour intervals.

Recommendations:

- Introduce a standard evaluation of pain and record the character and intensity of pain.
- Keep proper records about the administration of analgesics including their effect on the patient.

19) Depression

Old age tends to be accompanied by feelings of loneliness, loss of interest on the part of the person's children, loss of partner, home, health and social status, which all may cause depression in patients. Depression also often accompanies dementia. Therefore, staff in treatment facilities for long-term patients should also address the symptoms and treatment of depression. Depression may strongly influence fulfilment of a patient's individual plan and the total duration of his/her stay in the facility. It is hence important that the physician detects depression in time, invites a specialist if needed and subsequently takes account of the disease in fulfilling the patient's individual plan.

Recommendations:

- Concentrate on early detection of symptoms of depression.
- Take depression into account in fulfilment of the patient's individual plan.

20) Cutaneous defects, decubitus ulcers

Some clients in the facilities visited had limited mobility and were bedridden for most of the time. Consequently, treating and, even more importantly, preventing cutaneous defects and decubitus ulcers

are an inseparable part of patient care in treatment facilities for long-term patients. One of the basic preventive measures is positioning.

Findings from the visits:

- Many patients in the facilities spent several hours in the same position. Records were not kept about positioning that would show when and how the patient's position was changed.

It followed from the visits to the facilities that the records on the prevention of decubitus ulcers and their treatment were often kept poorly. The records lacked information, to various degrees, about the positioning of patients and dressing, as well as information about the level and state of decubitus ulcers in individual patients. Photographic documentation of the state of decubitus ulcers was neglected.[69] The records did not reflect the care actually provided by the facility. A logical counter-argument was that the staff preferred patient care to paperwork. However, with records kept in this manner, the care of decubitus ulcers and their prevention were unsystematic and intuitive.

Recommendations:

- **Systematically position patients with decubitus ulcers and those at risk of decubitus ulcers.**
- **Record tasks related to the treatment of decubitus ulcers (information about the frequency of dressing and state of the patient's decubitus ulcers including photographic documentation) in the medical records.**
- **Keep appropriate records of positioning.**

21) Care of a patient with dementia

In all the facilities visited the patients included people suffering from a form of dementia. Given that the number of people suffering from this disease has increased in recent years,[70] I consider that treatment facilities for long-term patients should be prepared for the specificities associated with care for these patients. Timely diagnosis and adjusting care to the specific needs of patients suffering from the disease are of particular importance (see also chapter 3.1).

69 Only the decubitus ulcer and its treatment are to be photographed, rather than the whole patient, and the photograph is part of the patient's medical records.

70 According to the 2016 Report on Dementia published by the Czech Alzheimer Society, there was probably almost 156 thousand people with dementia in the Czech Republic in 2015 (105 thousand women and 51 thousand men).

Timely diagnosis together with appropriate treatment can help limit progression of the disease, prolonging patient's self-reliance and good quality of the patient's life[71] A patient who knows his or her diagnosis in time has also time to make decisions on his or her future (choosing a social service where s/he wishes to reside in the future, or appointing a person to make decisions for the patient in situations where the patient is no longer capable of making autonomous decisions).

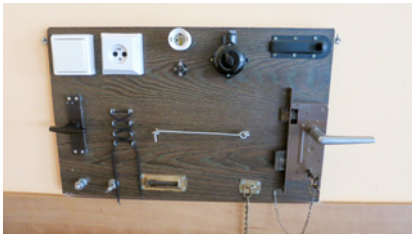
Recommendation:

- **Carry out comprehensive diagnostic cognitive tests.**

22) Rehabilitation, ergotherapy, activation

For some long-term patients, the care provided is centred around rehabilitation (including ergotherapy) and activation. The roles of rehabilitation and activation are to help improve the patient's medical condition, develop or preserve existing abilities and promote self-reliance so as to maximise the patient's participation in normal activities.

Ergotherapeutic room



Tool for training patients' fine motor skills

A rehabilitation plan should be set up for every patient upon admission

71 HOLMEROVÁ, Iva. Úvodní stručná informace o problematice demence (Brief Introduction to the Issues Concerning Dementia). In: Ochrana práv seniorů v instituci s důrazem na osoby s demencí (Protection of Rights of the Elderly in Institutions, Focusing in Particular on Persons with Dementia). Brno: Office of the Public Defender of Rights, 2014, pp. 6-13. ISBN 978-80-87949-03-0.

Findings from the visits:

- The therapy provided was not individualised; it did not take account of the patients' needs
- Therapy was not performed, activation did not take place, or took place only for mobile patients.
- Patient rehabilitation took only several minutes per day. Patients demanded a more intense rehabilitation, which could not be provided due to a lack of staff.
- No social activities were available in the facility.
- The patients spent all day in nightwear.
- Watching television was classified as activation and was the only activation element present in the facility.
- Patients requiring constant assistance were not regularly accompanied outside the building, into the park within the premises. A patient stated she had not been outside the building for a whole year.
- The rehabilitation plan was set up with a delay (about 3 weeks after the patient was admitted to the facility) and was performed only sporadically.

Given that psychological well-being and physical health are closely related, treatment facilities must provide patient-oriented care. In order for care to attain its objective, it must be individualised and reflect patients' health and needs. The facility should not omit various types of therapies and should pay proper attention to activation – otherwise the care provided will not be comprehensive.

Activation should be performed systematically in order to attain its objective, i.e. improve or preserve the patient's self-reliance and ability to manage everyday activities.

Findings from the visits:

- Patients were activated on the basis of the activation plan. The plan consisted of a brief evaluation of the user's existing condition, a short-term plan and a long-term plan. Neither of the short-term plan and long-term plan indicated any fulfilment deadlines, and the plans did not specify which persons should participate in the fulfilment and how, and whether the plan should be evaluated or updated. Activities such as watching TV and receiving family members visiting the patient were classified as activation by the facility.

Activation plan is an important tool. It is based on the patient's needs, takes account of the patient's capabilities and systematically guides the patient through activation during the entire course of his or her hospitalisation in the facility. It sets objectives that the specific patient is able to attain through appropriate means (activities). However, it is important that it also determines the persons who will participate in the patient's activation and regularly evaluate the fulfilment of the plan. As mentioned above, patient activation is an integral part of the care provided; therefore, the activation plan should not be prepared only formally, but should rather serve as a truly effective tool.

Recommendations:

- **Use available therapies, increase activation of patients and encourage self-reliance training.**

- Reflect patients' individual needs and abilities; take efforts to activate even those patients who do not take part in collective ergotherapy.
- Develop activation plans in such a way as to make clear how specifically and in what period of time a patient's activation should take place and who should deliver the activation process.
- Even patients who need assistance with leaving the building should have the possibility to spend time outside.

23) Care for terminal patients, palliative care

Poor availability of palliative care is one of the factors undermining the fundamental rights of dying persons in the Council of Europe member states.[72] Given that almost 10 % of the population of the Czech Republic die in treatment facilities for long-term patients, the Defender's employees dealt also with this topic during their visits.

> "Every tenth person in the Czech Republic dies in a treatment facility for long-term patients"

The statistics obtained during the visits show that about one patient per week dies in the facilities. Although a large part of these deaths are not sudden, patients in the facilities often do not receive palliative care in accordance with the Standards of Palliative Care[73]. I recommend in particular the following:

a) Create plans for palliative care
Palliative care must be active; it must seek to foresee new problems that could occur as the disease progresses, prevent them as far as possible or at least take them into consideration. Systematic and continuous planning of palliative care can avoid unnecessary crises and patient transfers.

b) Communicate enough with the patient and his relatives.
The physician is responsible for developing the palliative care plan. Here too, however, the patient is a subject and not object of care, and whenever possible, the patient should be engaged in the preparation of the plan. What more can we do for a dying patient than try and make the terminal part of his life as close to his preferences as possible. An appropriate form of communication about the approaching end is one of the important elements of palliative care.

c) Train staff in palliative care
All members of a team caring for a dying patient should be supported in continuous training.

72 Council of Europe Recommendation of 25 June 1999 on protection of the human rights and dignity of the terminally ill and the dying.

73 Standards of palliative care published by the Czech Society of Palliative medicine in 2013.

In my opinion, in order to respect the rights of the patient and his or her relatives, it is important that the facility actively informs the persons specified in the patient's medical records or the patient's relatives about the patient's medical condition. If the above persons are not informed about worsening of the patient's health, they cannot participate[74] in decisions on further care, and if the patient dies, they cannot part with the patient.

Recommendations:

- **Provide standardised palliative care.**
- **Inform the patient's relatives about worsened health and enable them to stay with the patient even outside visiting hours.**

24) Social work

As a rule, long-term poor health and the related hospitalisation impact the patient's social status. Disease can deprive the patient of his or her self-reliance and capacity to cover his or her financial needs and the needs of the family; the patient can be threatened by social exclusion. For this reason, the legislation anticipates that the healthcare team in facilities for follow-up care and long-term in-patient care should include a medical/social worker.[75]

74 Section 34 (7) of the Healthcare Services Act.

75 Paragraph 18 of Annex 3 to the Decree on minimum requirements for personnel in healthcare services.

Professional qualification of a medical/social worker

The minimum qualification criteria for medical/social workers are stipulated by the law[76] As with other members of staff, the work of a medical/social worker may not be substituted for by persons lacking the required professional qualification.

Findings from the visits:

- In one of the facilities, social work is carried out by the assistant to the head of the facility, a ward nurse, field healthcare nurse and the head of the facility. Only the head of the facility meets the professional qualification criteria for a medical/social worker. In her own words, and the same is noted in the records, the head of the facility attends to this agenda only very little due to her workload.

Recommendation:

- Hire a worker qualified for the performance of social work.

Ensure availability of social work

The facilities often had a lack of medical/social workers given the total number of patients in the facility. During the visits, the medical/social workers admitted that with over fifty patients per worker, it was very difficult to maintain everyday contact with all of them. It is all the more important that the patients know the medical/social worker and understand how, where and with what matters they can address the worker, i.e. to make the worker accessible for patients.

Special attention (in addition to the above) should be paid to particularly vulnerable patients and patients to whom social work should be offered even if they do not actively ask for it. This includes, for example, geriatric patients, patients with dementia, homeless patients, those with physical or mental handicaps occurring as a result of the disease, oncological patients, etc. In a facility that had defined these groups in advance, the personnel were able to classify patients in time (often upon admission). They were able to deliver a prompt medical and social care through a special social inquiry and proposal for further procedure. All this subject to the patient's consent.

Findings from the visits:

- Social inquiry on the patient's admission was carried out by a physician. It was not ascertained that the patient's social situation would be systematically examined and addressed by a medical/social worker after admission. No special records were kept regarding social work in the facility. Although the facility is in contact with the patient's relatives immediately after admission, this is mainly to negotiate the donation agreement.

76 Act No. 96/2004 Coll., on the conditions for acquiring and recognising qualifications for performing paramedical healthcare professions and for performing activities related to the provision of medical care and on amendment to some related laws, as amended.

- The social worker was on a 3-week leave at the time of the visit. Social work was not performed in the facility during her leave.

Recommendation:

- **Perform social work in accordance with the patients' needs, during the entire hospitalisation.**

Social work standards

No legally binding standards of social work are in place in medical facilities. This is in spite of the fact that the Healthcare Services Act stipulates certain duties of healthcare services providers that cannot be met if social work is not performed.

For example, a healthcare services provider is obliged to inform patients about other healthcare services and other possible social services that can improve the patients' medical condition.[77] If a patient's medical condition is such that the patient needs another person's assistance and further care is not provided, the healthcare services provider shall provide this information in due time to the municipal authority of a municipality with extended competence according to the location of the patient's permanent residence.[78]

The medical/social worker should also help patients with financial security for the time after release from the facility (for example, assist the patient in applying for the allowance for care). The competent regional branch of the Labour Office of the Czech Republic can newly carry out on site inquiry for the purposes of proceedings on allowance for care already during hospitalisation,[79] which significantly speeds up the allowance administration process, although only provided that the patient is advised of this option and, if necessary, the medical/social worker assists him/her in lodging the application.

Given the obvious fragmentation of the medical/social worker's tasks, I recommend that the management of every facility set up a system to be followed by the worker in performing social work in order to ensure fulfilment of all the above duties. The management should also continuously monitor whether the system is observed.

Recommendation:

- **Set up a system to be followed by the medical/social worker in performing social work.**

77 Section 46 (1)(c) of the Healthcare Services Act.

78 Section 47 (2) of the Healthcare Services Act.

79 Section 25 (1) of Act No. 108/2006 Coll., on social services, as amended.

Information sharing between the medical/social worker and other members of staff

The management of the facility should appropriately set up the co-operation between the medical/social worker and the remaining team members, during the entire hospitalisation. For example, the medical/social worker could regularly take part in team conferences. I consider it very important to share information about patients because the medical and social aspects of a patient's disease may be closely related and may interact.

Findings from the visits:

- A ward nurse stated that they did not examine social history of all patients but only those who were identified by the ward staff as patients at risk. Social work consisted primarily in looking for a follow-up facility. Another ward nurse explained that the medical/social workers independently obtained the required information about every patient from the application for hospitalisation which included the basic social information; the ward staff did not advise the medical/social workers about patients they should focus on.
- The nursing staff did not work with the social records and with the information they contain. The staff interviewed were not able to find social records in the computer network and, therefore, they could not work with the comprehensive needs of patients.

Recommendation:

- **Set rules for information sharing between the medical/social worker and other members of staff.**

Keeping records of social work

Appropriately kept records about the interventions of the medical/social worker make work easier especially for the worker him/herself. However, it can be equally helpful also for other members of the team attending to the patient. As a typical example, the patient's psychological condition has suddenly worsened, which is accompanied by e.g. refusing food. If the medical records include entries made by a medical/social worker, it is easy to find out whether the worsening originated in the patient's social circumstances.

Findings from the visits:

- A medical/social worker kept records in the form of "social worker's entries". She inserted the entries in the nursing records. According to the social worker, the entries were updated during hospitalisation by inserting a new entry or supplementing new information. Nevertheless, the entries in the records did not indicate any continuous social work.
- The social worker's entry contained the conclusion from social inquiry, which is either a laconic description of the patient's social situation (divorced, married, family, children), or contained a note that the social inquiry had not been performed, often with a note that the family had

not been contacted. The social worker stated that this was the case when the patient was not capable of communicating (for example, patients in an advanced stage of dementia). At the same time, there is no entry showing that the worker attempted to examine the social situation using other methods (from the family, from some other medical facility, etc.). The social assistance plan contained in the entry was in fact identical with the social work objective. There was no social assistance plan that would reflect the patient's individual needs and, simultaneously, define realistic steps towards attainment of the objective.

Recommendation:

- **Keep records providing sufficient information about social work with the patient.**

25) Personnel in care

Numbers of personnel on duty

A decree[80] sets the minimum numbers of personnel for in-patient care, as well as the duty for the facility to increase the numbers so as to ensure a high quality and safety of healthcare for patients. This requirement is often neglected. A sufficient number of qualified staff is a basic prerequisite for provision of high-quality care in the long term.

A lack of staff necessarily results in automation of care – the staff perform their tasks across the board, in a set regime based on operational requirements and not the needs of patients. The staff on duty enter the room, hastily check all patients' infusions, gives them drinks, check incontinence aids, cleanliness of beds and positioning and leave. This deprives the care provided of all individualisation.

> "Sufficient professional staffing is the basic requirement for good care"

With a lack of personnel, it is also difficult to activate patients, to prepare them for life outside the medical facility. This is obvious, for example, in the area of hygiene. The staff often do not have the time to check whether a patient can wash him/herself and do not have the time to assist the patient or provide advice.

The number of staff on night shifts is a specific matter. Obviously, patients sleep most of the time and require less attention than during the day. Nevertheless, care should be adapted to patients and their needs also at night. The bladder voiding regime is an example. As part of activation, the staff should accompany patients who go to the toilet, or toilet chair, during the night. In practice, however, the staff on duty lacks time or physical strength and, therefore, patients receive diapers.

80 Decree on minimum requirements for personnel in healthcare services.

Findings from the visits:

- There were usually 15 to 20 patients per nurse on the night shift.

Recommendation:

- Ensure sufficient numbers of nursing staff for all shifts.

Multidisciplinarity of the caregiving team

Patients in long-term care are attended to by a team of very diverse professions (physician, nursing staff, medical/social worker, physiotherapist, nutritional therapist and, in some cases, priest). If we add the fact that most patients are elderly people requiring care by not one but several specialised physicians, I consider it important that the facility set a method for these specialists to communicate among themselves, share knowledge about individual patients and converge their professional perspectives in order to achieve a proper standard of comprehensive care for every patient.[81]

81 Section 28 (2) of the Healthcare Services Act.

I am convinced that regular multidisciplinary conferences are a suitable way of achieving the above objective. They could avoid frustration of some of the workers who do not feel to be full members of the team.

During the visits, the Defender's employees witnessed a situation in which a patient was being transported for psychiatric examination. The facilities should avoid such situations, as far as possible. If a patient is in need of psychiatric care, it is appropriate to provide it directly in the treatment facility in the form of a council of psychiatrists. Transportation and transfers are very stressful for the fragile geriatric patients, and the same holds true for many patients with other symptoms typical for patients of treatment facilities.

Recommendation:

- Approach patients comprehensively, work as a team.

Engage a geriatrician in patient care

Although anyone can become a patient of a treatment facility for long-term patients, in practice these facilities hospitalise mainly elderly patients. Therefore, I recommend considering also the involvement of a geriatrician – an expert acquainted with the specific issues relating to care for geriatric patients can be a very useful member of the medical team.

Recommendation:

- Consider the engagement of a geriatrician in patient care.

26) Employee care

A provider has the duty to provide patients with healthcare services at a proper professional level and in a safe environment.

Findings from the visits:

- The Defender's employees ascertained from the roster in one of the facilities visited that some general nurses had only one day off in the period of one month (not counting the time off after a worked night shift).

I consider that overburdening some workers in the long term without sufficient rest is a violation of this duty because it is only a matter of time before an overburdened worker makes a professional error (due to a loss of concentration).

A social services provider has the duty to ensure that employees receive support from an independent qualified expert (supervisor). Although there is no analogy to this in the legislation applicable to healthcare services, nothing prevents providers from offering such service to their employees. This is due to the high emotional demands associated with care for long-term patients combined with the high mortality of patients.

Recommendations:

- Plan services so as to avoid overburdening of individual workers.
- Offer support by an independent qualified expert to employees.

Summary of recommendations

Patient rooms

- Decrease the capacity of rooms.
- Adapt the rooms' capacity to their size.
- The room must be a safe and dignified environment for a patient; it must provide at least a basic degree of privacy.
- Comply with compulsory room furnishing specified by the Decree on Requirements for Minimum Technical and Material Equipment of Medical Facilities.
- Furnish the room with a necessary amount of furniture; if the furniture is movable, it must be secured against movement.
- Provide patients with lockable space for storing personal belongings in the room and ensure, if possible, having regard to the patients' individual abilities, that the patients have keys.
- Provide reachable and functional signalling devices for every patient.
- Ensure immediate reaction of the staff to the use of a signalling device.
- Make visits to patients who cannot use the signalling device so often that they will not be left without assistance in case of complications and to ensure their bladder voiding regimen is not disrupted.
- Make the environment of the room more pleasant through inter alia personal belongings of the patients.
- Pay attention to the field of view of bedridden patients and use all available means to their motivation.

Environment of a treatment facility

- Provide sufficient number of barrier-free lavatories and bathrooms allowing horizontal showering of bedridden patients.
- Provide toilet paper, soap and towels for patients at the lavatories. Provide toilet paper in the toilet stalls.

- Equip bathrooms with curtains or other means for ensuring privacy.
- Separate lavatories for men and women.
- Provide means of safe locking of lavatories (with the possibility of them being opened from the outside) or, at least a suitable means of indicating occupancy of a lavatory.
- Equip lavatories with reachable and functional signalling device.
- Support the patients' ability to orient themselves in space and time through appropriate tools.
- Establish day rooms for patients.
- Provide a place for dignified dining.
- Implement a system of limiting access which will not restrict patients and other persons for which it is not desirable in free movement.

Rights of a person as a patient

- Do not admit patients for hospitalisation on condition of their financial participation.
- Donations from a patient may be requested and received only after the patient has been discharged.
- Make the internal regulations and rules for addressing complaints accessible to patients.
- Draw up a list of healthcare services whose provision at the facility requires written consent.
- Request consent of the patient (or consent of some other authorised person, if applicable) with provision of healthcare services every time a medical professional proposes an act that is subject to consent.
- Properly fill in individual fields of the form for granting consent to hospitalisation, so it is evident and conclusive what the patient agrees or disagrees with.
- Require consent to hospitalisation also for patients who arrive in the treatment facility from an acute care department of the hospital under which the treatment facility for long-term patients belongs and document the consent.
- Educate the staff in the area of declarations in anticipation of incapacity and living will.
- Respect legal regulation of granting consent to provision of healthcare services to patients with limited legal capacity.

- Determine and record the extent of limitation of the patient's legal capacity.
- Inform all members of staff who come into contact with the patient in question about his or her limited legal capacity (including the extent of the limitation).
- Protect the patients' privacy and, unless circumstances do not allow, not to disclose sensitive personal information regarding their medical condition in the presence of other patients.
- Offer walking patients the possibility of a private physician-patient conversation.
- Leave the choice of people who can be informed of the patient's state completely up to the patients, and not limit the number of such people and the manner of providing information.

Dignity and privacy of patients

- Ensure correct addressing of the patients and appropriate communication, not putting the patients into the position of a child, not using diminutives to address them.
- Ensure that each member of staff introduces him/herself at least when meeting the patients for the first time.
- Ensure proper designation of the caring staff.
- Encourage the patients' self-reliance and communicate with them during personal hygiene.
- Limit taking away of the patients' identity cards and insurance cards.
- Secure the cards that have been taken away against misuse.
- Make it possible for the patients' families to visit the patient also outside the visiting hours and actively inform the patient's relatives of such possibility.
- Ensure privacy and a dignified environment for visitors.
- Secure material conditions that would allow for the patients' privacy in their rooms during personal hygiene, using the toilet chair or while nursing (for example by providing and using screens); set the staff's tasks so that they can ensure patient privacy.
- Avoid violation of the patients' privacy by engaging a thoughtful approach (closing the doors, knocking before entering a room, covering people, looking away, asking other patients to leave the room); ensure consistency of the staff.
- Ensure that self-reliant patients can maintain personal hygiene on their own and in privacy.
- Transfer the patients to the showers dressed.

Freedom of movement, safety

- Use restraints only in urgent cases.
- Prepare individual plans to manage restlessness.
- Record the use of restraints in accordance with the requirements of the Decree on Medical Records.
- Keep central records of use of restraints.
- Avoid indications of restraints pro futuro and assigning medical competences to paramedical staff.
- Abandon the vague prescription of sedatives stating "in case of restlessness" and always formulate the ordering clearly and in a way that will exclude the possibility of various interpretations.
- State the maximum daily dose of the drugs and the interval of administration when ordering sedatives.
- Keep detailed records about administration of sedatives; indicate the time of administration, describe the situation preceding administration and effect.
- Regularly analyse the circumstances of administration of sedatives and take it into account in planning further care.
- Ensure fall prevention.
- Respect the principles of proper and safe use of bed rails (see the text).

Nursing care and healthcare

- Consistently perform malnutrition prevention tasks, in particular by monitoring the risk of malnutrition (throughout hospitalisation), respond appropriately when malnutrition is detected and continue to evaluate the patient's medical condition (have a defined workflow in place).
- Set up a system of records for food and drinks which will not contribute to the risk of error (for example, place the record sheets at the patient's bed).
- Make use of the nutritional therapist's expertise in comprehensive patient care.
- Consistently monitor fluid balance in individual cases (catheterised patients, patients with an ordered maximum fluid intake).

- Pay more attention to dining culture and understand it as part of comprehensive care, taking account of satisfaction of not just biological but also psychological and social needs and the interest in preserving and restoring self-reliance.
- Take a serene approach when providing a patient with eating assistance; keep eye contact, pay attention to non-verbal communication and patient's behaviour, support his/her self-reliance.;
- Actively encourage patients to sit during eating.
- Avoid blending all components of a meal together.
- Adopt maintaining or improving patients' independent emptying as one of the objectives of hospitalisation.
- Use incontinence aids (diapers) only in necessary cases.
- Consider very carefully the indication of urinary catheters and duly document the related nursing tasks.
- Keep medical records in such a way that they serve as a relevant basic document for further care.
- Introduce evaluations of psychological and social needs of patients upon admission and note them in the records.
- Keep the epicrisis and plan of further therapy.
- Record data about nursing tasks only after the tasks have been actually performed.
- Administer drugs to patients only on the basis of an accurate and complete physician's order.
- Keep records of the time of administration, situation preceding administration and subsequent effect in irregularly administered drugs.
- Ensure that only authorised personnel administer drugs to patients. Set the drug administration procedure so as to minimise the risk of errors.
- Ensure that only authorised personnel have access to drugs.
- Regularly check the expiry dates of drugs.
- Introduce a standard evaluation of pain and record the character and intensity of pain.

- Keep proper records about the administration of analgesics including their effect on the patient. Concentrate on early detection of symptoms of depression.
- Take depression into account in fulfilment of the patient's individual plan.
- Systematically position patients with decubitus ulcers and those at risk of decubitus ulcers.
- Record tasks related to the treatment of decubitus ulcers (information about the frequency of dressing and state of the patient's decubitus ulcers including photographic documentation) in the medical records.
- Keep appropriate records of positioning.
- Carry out comprehensive diagnostic cognitive tests.
- Use available therapies, increase activation of patients and encourage self-reliance training.
- Reflect patients' individual needs and abilities; take efforts to activate even those patients who do not take part in collective ergotherapy.
- Develop activation plans in such a way as to make clear how specifically and in what period of time a patient's activation should take place and who should deliver the activation process.
- Even patients who need assistance with leaving the building should have the possibility to spend time outside.
- Provide standardised palliative care.
- Inform the patient's relatives about worsened health and enable them to stay with the patient even outside visiting hours..

Social work

- Hire a worker qualified for the performance of social work.
- Perform social work in accordance with the patients' needs, during the entire hospitalisation.
- Set up a system to be followed by the medical/social worker in performing social work.
- Set rules for information sharing between the medical/social worker and other members of staff.
- Keep records providing sufficient information about social work with the patient..

Staff

- Ensure sufficient numbers of nursing staff for all shifts.
- Approach patients comprehensively, work as a team.
- Consider the engagement of a geriatrician in patient care
- Plan services so as to avoid overburdening of individual workers.
- Offer support by an independent qualified expert to employees.

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Annex – Acquiring the Patient's Consent

1) Consent to hospitalisation

The process of granting consent to hospitalisation depends on the patient's medical condition.

The process of granting consent to hospitalisation depends on the patient's medical condition.

Findings from the visits:

- In one of the facilities, the form "Advice and Consent to Hospitalisation" was signed by patients' family members without indicating the reasons for which the patient is unable to give consent him/herself. At the same time, the facility did not inform the competent court and did not initiate court proceedings for a ruling on permissibility of keeping the relevant person in a medical facility (hereinafter "detention proceedings"). Interviews with the staff showed that in the negotiations on placement in the facility, patients grant a power of attorney to their relatives to represent them in any acts related to the provision of services. Consequently, the facility automatically turns to the authorised representatives in the matter of granting informed consent and submits the form to them for signing.

Written consent to hospitalisation may also be granted by a patient with a cognitive deficit, although provided that the patient understands that s/he is in a hospital and agrees with staying there.

Findings from the visits:

- According to the medical examination on admission, the patient concerned was disoriented. The following entry was found in the records: "On admission, she is unable to identify the location and the hospital, does not know the year, will not answer the question when she was born." On the same day the same patient signed her consent to hospitalisation.

If the staff (physician) admit a patient with a cognitive deficit for hospitalisation, they must adapt the information provided to the patient's ability to understand and record the circumstances under which the consent was granted in the hospitalisation consent form, because a patient is deemed to be properly informed only if he or she understands the information provided.

In addition to the patient, the hospitalisation consent form should always be signed also by the physician who has provided information to the patient in accordance with the law.

If, due to a poor medical condition, a patient is unable to express his or her consent to hospitalisation in writing, s/he can do so in some other manner.[82]

82 Section 34 (6) of the Healthcare Services Act.

In that case, the healthcare worker records the unquestionable display of the patient's will in the medical records kept for the patient, indicates how the patient displayed his or her will and the medical reasons preventing the patient from the required form of manifestation; the record is to be signed by the healthcare worker and a witness.

If, due to a poor medical condition, a patient is unable to express his or her consent to the provision of medical services but is in a condition that requires urgent care, it is possible to hospitalise him or her without consent[83]

In that case, the provider is obliged to inform the court with local jurisdiction for the medical facility within 24 hours. The provider is obliged to inform also persons appointed by the patient in accordance with Section 33 of the Healthcare Services Act, and if there are no such persons, a related person, or a person living in a common household with the patient, or the patient's statutory representative, if they are known to the provider.

We recommend here that providers should regulate the procedure of notifying the court and other parties about the admission of patients for hospitalisation in an internal regulation.

2) Consent to provision of healthcare services

1. **If the patient's medical condition allows this, the consent shall be given by the patient him/herself.**

The Healthcare Services Act does not require written form for the consent to the provision of healthcare services. This does not apply to acts for which a special law[84], or the provider, requires written form (see chapter 4.3) Written or even implicit consent is sufficient in other cases (for example, when administering an injection[85]).

2. **If a special law (or the provider) requires consent in written form, but the patient is unable to express his or her consent in written form because of poor health, the patient may express his or her consent in some other manner.**

In that case, the same rule applies as that for consent to hospitalisation – a healthcare worker notes an unquestionable display of the patient's will in the patient's medical records. The worker indicates how the patient manifested his or her will and the medical reasons preventing him or her from the required manifestation; the record shall be signed by the medical worker and a witness.

3. **If a patient is unable to express his or her consent to the provision of healthcare services because of poor health, the consent of a person determined under Section 33 (1) of the Healthcare Services Act is required; if such person does not exist or cannot be contacted, the consent of the patient's wife/husband or registered partner is required, and if such person does not exist or cannot be contacted, the consent of a parent is required, and if such person does not exist or cannot be contacted, the consent of some other close person enjoying legal capacity, if such person is known.**

If no person exists who would meet the above criteria, and if the relevant services cannot be provided without consent, the provider is not authorised to provide the healthcare services.

83 Section 38 (1)(c) of the Healthcare Services Act.

84 For example, Act on Specific Healthcare Services.

85 Explanatory Memorandum on draft Act No. 372/2011 Coll., on healthcare services.

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