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Inspection visit to the Nõlvaku care home at the Tartu Mental Health Care Centre

On 13 November 2020, advisers to the Chancellor of Justice inspected the activities and residents' living conditions in the Nõlvaku care home at the Tartu Mental Health Care Centre (hereinafter 'the care home').

The common rooms for shared activities on the second and third floor of the care home are cosy – homelike furniture items (such as a sideboard, soft armchairs) have been used, as well as photo wallpaper and an imitation fireplace. The rooms at the care home are clean and adjusted for the needs of people with challenged mobility – the floor of interior rooms has been levelled, corridors have handrails for keeping balance, the building has a lift. Every floor has a toilet equipped with a view to the needs of wheelchair users.

Information exchange among staff is well organised. Staff have a separate resting room. A nurse helps to take care of residents' health concerns. According to residents, the staff are helpful and friendly. Many residents praised the possibility to go to the sauna and also the delicious food.

The privacy of residents must be better ensured. Furnishings and bedroom size must comply with the requirements laid down by legislation.

People should be assisted with going outdoors. Those mostly confined to bed also need diversity in spending time and should be offered assistance with this. The care home must consider the possibility to hire more people and start using the assistance call system.

Care plans must also reflect a person's need for a healthcare service. Care plans must be regularly reviewed and amended as appropriate. Turning bedridden residents and other scheduled procedures must be documented immediately after the event. The management together with the team must analyse extraordinary incidents and agree on operating procedures in the event of – or preventing – their recurrence.

Administering non-prescription medication should be recorded in writing in more detail and proper storage of medicines ensured. The care home might consider finding rooms which are more suitable for a nurse's work.

The Chancellor's advisers together with a healthcare expert carried out a tour of the care home rooms, examined documents and interviewed staff and residents.

1. Living conditions

The care home is a three-storey building with a lift. The first floor has 15 beds, the second floor 14 and the third floor 19. At the time of the inspection visit, all beds were occupied. People are accommodated in double- to triple-occupancy bedrooms. On the basement floor of the care home is a sauna, staff resting room and a storage room which simultaneously serves as the medical nurse's office. The building is surrounded by a well-maintained fenced yard area.

The bedroom furnishings include, for instance, personal mementos, textile curtains, patchwork quilts and flowers, which make them more cosy. Eating rooms and rooms for shared activities on the second and third floor have been renovated and furnished according to people's needs and tastes – for instance, they included retro-style furniture, patterned wallpaper, photo collage, an imitation fireplace.

Toilets and washrooms are located in the corridors. To support people's mobility and prevent falling, handrails have been installed on the walls in corridors and washrooms. Every floor also has a toilet adjusted for wheelchair users. Sanitary rooms and bedrooms were clean and could be locked from the inside.

Many residents use diapers and commode chairs. To ensure privacy, screens or curtains must be used in multiple-occupancy bedrooms.[1] It is important to ensure privacy in performing hygiene procedure (e.g. changing diapers and a urine bag, bandaging) even if a person themselves does not ask for a screen or curtain (see also the general care service quality guidelines).[2]

Common rooms and bedrooms were clean. In general, residents' bedrooms had been furnished according to requirements. However, spot lighting was lacking from several beds although this is required. In some rooms, the mandatory furnishings and fittings had been placed so that it was impossible for residents to use them. For instance, a table was pushed against the wardrobe door, or both spot lights on the wall in the room were next to one bed while the other bed had no spot lighting at all. Bedrooms are of different sizes; some rooms felt cramped. For example, the size of the three-person bedroom on the second floor does not comply with the minimum requirements[3].

As a rule, care home residents should be accommodated in single- or double-occupancy rooms. A bedroom for people requiring significant external assistance and suffering from profound multiple disability may also be quadruple-occupancy. When furnishing the room, it should be observed that positioning of furniture should enable nursing care providers access to a bed from both sides if necessary. Residents should also be able to use the furniture and furnishings and fittings in a room.

The Chancellor asks to take appropriate measures to better ensure privacy of care home residents. Refurbishment of common rooms on the first floor similarly to the second and third floor should

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[1] A textbook-handbook *Hoolides ja hoolitsedes* (Caring and providing care) also draws the attention of carers to respect for the privacy of a person under their care and use of screens or curtains while carrying out intimate and hygiene procedures. (M. Jaanisk et al. Hoolides ja hoolitsedes. Õpik-käsiraamat hooldustöötajatele. Tartu Tervishoiu Kõrgkool. [Caring and providing care. A textbook-handbook for care workers. Tartu Health Care College] Kirjastus Argo, 2015.)
See also the Chancellor of Justice circular to general care service providers of 11 July 2017 (para. 5.2).

[3] The room with the size of 13.521 m^2 had three beds during the inspection visit. According to applicable requirements, the size of a triple-occupancy room should be at least 18 m^2.

be considered. Bedroom furnishings and size must comply with the requirements laid down by legislation.

2. Staff and security

During the daytime (between 8–20), two carers are on duty on the first and second floor, and one carer on the third floor. If necessary, staff from different floors help each other. At night (between 20–8) there is one carer on each of the first and second floors. There is no carer at night on the third floor but video surveillance is used there and carers on night duty constantly monitor the video feed. During the daytime, a food distributor and cleaner are also on duty. On working days, the care manager and nurse are also present in the care home (between 8–16). On working days (10–16), one activity supervisor is on duty for three floors, organising shared activities and walks.

According to explanations by staff, the third floor accommodates people who do not need constant assistance at night; no people with challenged mobility are accommodated there. Those with increased need for assistance and bedridden residents are accommodated on the first and second floors. Carers are not assigned to a specific floor. Usually it is agreed in the morning who will be on which floor during the upcoming shift. According to the staff, work on the first and second floor is physically more challenging, on the other hand staff experience more mental strain while taking care of third-floor residents.

The care home has a call system but it is not used. This means that people have to call for assistance by shouting or asking fellow residents to do it. The situation is worst for the third-floor residents since in the evenings and at night there is permanently no staff there. The security camera monitored by the first- and second-floor carers does not include an audio feed, which makes shouting for help useless.[4] The staff explained that, due to memory problems and dementia, it would be complicated for many residents to use the assistance call equipment and many false alarms would be triggered.

Residents mentioned that, as a rule, carers do hear shouting. However, some residents, mostly those who are bedridden, expressed the wish to have staff call equipment at hand.

The Chancellor has repeatedly emphasised[5] that shouting or relying on fellow residents being able to call for assistance fails to ensure that a person obtains quick assistance if needed. Shouting may be exhausting or degrading for some people and since many residents share a room, shouting also disturbs the peace of room-mates.

One of the objectives of the general care service is to ensure a safe environment for people (§ 20(1) Social Welfare Act). Inter alia, this means that residents' concerns are noticed in time and are resolved as soon as possible. A person in need of assistance should not be dependent on their fellow residents being able to call for assistance. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has also emphasised[6] the importance of an effective assistance call system, in particular for bedridden people. Certainly, installation of a call system should take into account that it should not replace attentiveness by

[4] See e.g. also the Chancellor's inspection visit of 6 November 2019 to the care home of OÜ Häcke at Kohtla-Järve (para. 2); the inspection visit of 9 March 2018 to Polli Care Home (para. 1); the inspection visit of 17 April 2019 to Tapa Home (para. 1).
[5] See e.g. the Chancellor's inspection visit of 21 November 2019 to Tammiste Care Home (para. 2); the inspection visit of 29 March 2019 to Pärnu-Jaagupi Care Home (para. 1); the inspection visit of 6 November 2019 to OÜ Häcke care home at Kohtla-Järve (para. 2).
[6] CPT report, para. 94.

staff because a care home always has people whose health condition does not enable them to use technical equipment (e.g. due to paralysis or memory problems).

Although the staff affirm that people with better coping ability have been accommodated on the third floor, these are still people in need of assistance. Interviews with residents and documents revealed that people on the third floor have memory problems, some need assistance with hygiene procedures (e.g. with using a commode chair) and some people's behaviour may disturb others (aggression, wandering around), which in turn causes conflicts between residents. Situations have occurred where a third-floor resident's need for assistance was noticed only in the morning. A form for recording significant events during a 24-hour period contains a separate field for remarks about rounds of the building made by carers at night, but this field was not filled out on most forms (including concerning third-floor residents).

The general care service is intended for people who are unable to cope independently at home (§ 20(1) Social Welfare Act) and therefore need assistance. Many residents have various health problems that need swift intervention in the event of deterioration. For this reason, it is important that the staff should be as close to residents as possible. For a staff member located in a unit separated from their main place of work (e.g. on another floor, in another building), it is complicated to be responsible for safety of residents.

According to the staff, they generally feel safe. Nevertheless, there have been incidents of insults against staff, but physical assaults against staff are a rare occurrence.

It is commendable that all the extraordinary incidents documented in the care home were thoroughly described on separate forms and combined into a single register. The register revealed that the majority of extraordinary incidents involved falls by residents. Some falls have happened in the room for shared activities while a carer was away assisting another person in their room. Third-floor residents have also fallen while no carer was currently present on the floor. In some instances, residents have been violent, and on one form it was noted that a person had been locked in their room to calm down.

Most incident descriptions included a carer's comment that the situation could only be avoided by the presence of larger staff numbers. It is impossible for one worker to supervise people in a room for shared activities and simultaneously provide assistance in a bedroom. It is also impossible to be simultaneously on several floors. The documents did not indicate whether the management of the care home have drawn any conclusions from these observations.

There were also descriptions of some violent incidents which would have required immediate attention and resolution. However, examination of the care home documents left doubt as to whether this had been done. For instance, an incident had been documented where a resident attacked their room-mate. Carers intervened and noted on the extraordinary incident form that the assailant needs a separate bedroom due to dangerous behaviour caused by their illness. At the time of the inspection visit, residents were accommodated in double- to triple-occupancy bedrooms.

Ensuring a safe environment (§ 20)1) Social Welfare Act) also means that a care home resident is protected against assaults by other residents. For example, in a court case concerning the 24-hour special care service, the court reached the conclusion that a care home must protect a person from aggressive behaviour by another resident, and awarded non-pecuniary damages to the victim from the service provider.

The condition of each resident and significant events related to them are documented on a special form. Examination of the forms revealed that the care home has several people whose behaviour may turn violent and who have caused staff physical pain (scratched or hit them) or other inconvenience (e.g. spat at them). Not all such cases might end up in the extraordinary incident register since they are not deemed to be sufficiently serious. However, analysis of staff workload and safety should also take into account less serious day-to-day incidents.

The Chancellor has repeatedly drawn the attention of social welfare institutions to the fact that the law does not lay down a possibility to restrict the freedom of movement of people receiving the general care service[7]. Naturally, people with extremely challenging behaviour may also end up at a care home (e.g. those with a dementia diagnosis), but a welfare institution must provide a safe environment lawfully and safely for all its residents.

The Chancellor asks the care home to consider starting to use assistance call equipment so that residents would be able to notify their need for assistance quickly and with dignity. The care home should also consider increasing staff numbers to ensure the safety of residents on all floors as well as that of staff. The management together with the team must analyse extraordinary incidents and agree on operating procedures in the event of – or to prevent – their recurrence. People's freedom of movement may not be restricted without a legal basis.

3. Recreational opportunities

Organising active and meaningful recreational activities at the care home is mostly the responsibility of the activity supervisor. The activity supervisor is present at the care home for four hours on working days (two hours in the morning and two hours in the afternoon). The activity supervisor reaches every floor for two hours three times a week. If a sauna day is scheduled for residents on a floor then on that day no activities are organised for them,

A weekly schedule of activities is drawn up for residents on each floor. Activities have been described with general titles (e.g. mobility activity, memory training) and determining their more specific substance is the duty of the activity supervisor. According to the staff, residents read and discuss news, watch films, listen to music and draw together with the activity supervisor. People are also involved in handicrafts. The activity supervisor also assists people with going outdoors if the weather is nice.

Activities are organised in the room for shared activities, so that bedridden residents are mostly not included. During interviews people mentioned that they liked joint film viewings and board games. At the same time, bedridden residents mostly spend time by reading newspapers or listening to the radio in bed. Those who wish can go for a walk in the yard of the care home, but people with challenged mobility are assisted to go outdoors only during a warmer season.

The CPT has noted that hospital patients should have easy access to their overcoats and footwear.[8] An institution must also have a sufficient number of staff who can accompany patients on a walk

[7] See e.g. the Chancellor's circular to general care service providers of 11 July 2017 (para. 5.2); the Chancellor's inspection visit of 31 August 2018 to Aa Care Home of the non-profit association Vahtra Hooldemaja (para. 1); the inspection visit of 5 June 2020 to Taheva Sanatorium Foundation (para. 2). See also E. Lillemaa, M. Sults. Vabatahtlikkuse põhimõte üldhooldusteenuse osutamisel. [The principle of voluntariness in providing the general care service] Journal *Sotsiaaltöö* 4/2017.

[8] CPT's 2012 visit to Croatia (para. 96); CPT's 2016 visit to Latvia (para. 111).

if necessary[9]. According to CPT assessment[10], staff shortage cannot be used as justification for denying patients/clients outdoor access. Wheelchair users should have equal opportunities with others to go outdoors every day (see the CPT opinion[11]). The Chancellor has repeatedly said[12] that a social welfare institution might proceed from the same recommendation and provide people the necessary assistance to go outdoors.

If insufficient attention is paid to offering residents meaningful recreational activities and activating them, they may become passive about their life and well-being. Hobby activities help people maintain and improve their functional abilities.[13] The CPT is of the opinion[14] that therapeutic and developmental activities must be ensured for all care home residents. People must be offered activities in line with their specific nature and need for assistance and more therapists should be involved where appropriate[15]. According to the CPT assessment[16], people should be able to participate in one organised activity every day.

The care home residents include several people with challenged mobility who are not included in shared activities and with whom no systematic physical exercises are carried out. The expert involved in the inspection visit noted that regular physical exercises and activity therapy are extremely necessary: this helps to maintain the mobility of joints and muscle strength.

The Chancellor asks to ensure that all care home residents are enabled meaningful recreational activities. People with challenged mobility should be assisted with going outdoors and to the room for shared activities. Increasing the number of staff organising hobby activities could be considered.

4. Care, documenting care, and exchange of information

The care home has many people with challenged mobility as well as bedridden residents. Many use diapers and need assistance with washing and getting dressed, and some also with eating. The majority of people have memory problems. According to residents, the staff attitude to them is friendly and helpful. People also pointed out that carers have very much work and they do not want to bother them with every concern or wish.

People wear personal clothing. If a care home resident needs clothes, the care home gives them clothes for personal use. Bedridden residents have special mattresses which should prevent bedsores. A hoist is available for lifting people needing assistance, but according to staff it does not fit into every room.

Washing takes place once a week in the care home sauna. People who do not need assistance with washing can use the shower room on each floor at a time that suits them. According to the table

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[9] CPT's 2014 visit to Georgia (para. 148).
[10] See paras 125–126.
[11] See para. 183.
[12] See the Chancellor's inspection visit of 11–12 June 2018 to Hellenurme Home of the South-Estonian Care Centre Ltd (pages 5-6); the inspection visit of 5 June 2018 to the general care department of Kallavere Hospital (page 4); See also the Chancellor's annual report 2018/2019.
[13] M. Jaanisk et al. Hoolides ja hoolitsedes. Õpik-käsiraamat hooldustöötajatele. Tartu Tervishoiu Kõrgkool. [Caring and providing care. A textbook-handbook for care workers. Tartu Health Care College] Kirjastus Argo, 2015, page 51.
[14] See paras 156, 160.
[15] See e.g. CPT's 2014 visit to Denmark (para. 138).
[16] See para. 18.

for care procedures, diapers are changed at least twice a day, but the staff affirmed that this is done even more frequently if necessary. Water cups were available by the bedside of bedridden persons. According to the residents, carers constantly check that there is water in the cup.

It is the carers' duty to monitor and document the condition of residents. With regard to each resident, notes are made every day on their individual form concerning essential circumstances about that person. On each floor, a summary of events during the shift is drawn up, and a general overview also given about all the floors. This is discussed during the daily morning meeting. Current reports are drawn up in handwritten form. Also attending the morning meeting is a nurse who is informed if a resident needs the attention of a medical professional.

Apart from this, carers fill out tables about care provided to a resident (washing, changing clothes, eating, changing diapers, etc.). The results of measuring blood pressure and temperature, as well as changing the position of bedridden residents are all recorded. If necessary, carers fill out an extraordinary incident form. This means that the carers' day-to-day documentation burden is rather heavy.

Documents revealed that tables on provision of care and turning bedridden residents are not filled out immediately. For example, the morning/daytime procedures (e.g. turning bedridden residents) for the date when the inspection visit took place had not been entered in the table. Although tables might be filled out retrospectively, this involves the risk that some entries may be erroneous. Essential procedures should be recorded immediately after they take place, especially if they need to be carried out regularly. For instance, changing the position of bedridden residents at specific intervals should be monitored. If a table on changing position is filled out retrospectively, it is impossible to be convinced whether turning indeed took place at a required interval.

To avoid bedsores, a person's position also has to be changed in the evening and at night, i.e. when only one carer is on duty on the floor of bedridden residents. It may be difficult for a carer alone to turn a person, and also for a person themselves it is more convenient and safer if they are assisted by two people simultaneously[17]. The healthcare expert participating in the inspection visit noted that prevention and treatment of bedsores must comply with treatment guidelines, and it should be observed that turning takes places often enough. The tables that had been filled out showed that at night bedridden residents were turned less often than prescribed by treatment guidelines.

The daily entries describing the condition of care home residents were rather scant and some of them did not reflect a person's condition objectively but rather reflected a carer's personal judgment. For instance, daily entries contained some remarks such as: "spoilt", "faking pain", "whiny", "disturbing", "doing well". It remained unclear what such assessments were based on and for what purpose this information is collected.

Everyone receiving the general care service has a personal care plan. The care manager is responsible for drawing up and reviewing the care plan; carers and the activity supervisor can also make proposals in this regard. Prior to drawing up a care plan, a thorough description of the condition of a new resident is prepared. It is positive that, inter alia, a person's interests and lifestyle before arrival in the care home have been described. A care plan is clearly structured, it records the need for assistance, the purpose of care and planned activities along with the person responsible. It is commendable that a care plan also lists the measures which help people

[17] M. Jaanisk et al. Hoolides ja hoolitsedes. Õpik-käsiraamat hooldustöötajatele. Tartu Tervishoiu Kõrgkool. [Caring and providing care. A textbook-handbook for care workers. Tartu Health Care College] Kirjastus Argo, 2015, page 38.

participate in dynamic activities (e.g. physical exercise, walking outdoors, hobby groups). If possible, a resident themselves is involved in drawing up the care plan, in which case the care plan has been signed by them.

The care plans did not reflect the need for healthcare services. However, this is necessary to plan visits to specialist doctors by people with chronic illnesses. The law does not lay down a form for a care plan but prescribes that in drawing up a plan the need for care and health services must be assessed, and this should be done by an appropriately qualified healthcare professional (§ 21(3) Social Welfare Act).

The care plan must be reviewed and the client's condition assessed at least once every six months (§ 21(5) Social Welfare Act). Periodic assessment enables monitoring whether objectives set were achieved and planned activities carried out. Whether planned activities may continue or need changing should also be assessed.

Some care plans lacked a conclusion about the results of a resident's periodic review. Care plans submitted after the inspection visit contained scant remarks about the change of condition of a resident. No modifications in a care plan had been made even where the person's health condition had significantly deteriorated. For instance, in the case of a person whose condition no longer allowed walking, the care plan noted walks as one of the activities; or else a care plan lacked information about a person's violent behaviour.

Care plans for many people included regular outdoor walks accompanied by staff. However, the inspection revealed that carers and the activity supervisor have no time to walk with everyone needing assistance. Thus, in view of staffing levels, the planned activities are not feasible – at least in respect of some people. Such remarks should also be reflected in the periodic review of a care plan and analysed with the team.

The Chancellor asks the care home to ensure that care plans also reflect people's need for healthcare services. Care plans must be reviewed with the required regularity and relevant modifications made. The staffing level must enable carrying out the activities described in a care plan. The description of residents' condition in documents must refrain from judgements open to various interpretations. Turning bedridden residents and other procedures scheduled at specific intervals must be documented immediately after being carried out.

5. Staff numbers

Residents' coping and decent life depends to a large extent on staff directly dealing with them. A care home must create a safe environment for everyone and ensure they cope. The staff must carry out care procedures prescribed by the care plan and provide all-round assistance to people. For this, a care home must have enough staff. The law does not lay down the minimum staff number for a general care home. In determining the staffing level, factors to be taken into account include the number of service places in a care home, residents' need for assistance as well as the specific nature of the buildings, the grounds, and other specifics of the institution.

It is also important that people with increased challenged mobility should be offered activities within their ability range. Such residents should not stay only indoors month after month – they should be given an opportunity to spend time outdoors in the fresh air. A person's increased need for assistance must be taken into account in planning the composition of staff and their working duties, so that staff shortage does not impede dealing with residents.

The care home lacks an effective staff call system, so that the speed of obtaining assistance depends on the attentiveness of the staff. Residents include several bedridden people and those with challenged mobility who need assistance with eating, washing, changing diapers, changing position, and the like. Many care home residents are suffering from memory problems, a dementia diagnosis and behavioural problems caused by illness and thus need individual attention.

Staff numbers must be sufficient so that no resident is left without assistance (e.g. hygiene procedures not being carried out in time or medication not administered). According to the CPT assessment, staff shortage may also increase the risk of ill-treatment and place staff in a situation where they are forced to apply inappropriate measures (including restricting freedom of movement) in respect of irritated people.

The dedication of carers in providing care to people is worthy of recognition. At the same time, information collected during the inspection allows the conclusion that the care home lacks sufficient staff to ensure a 24-hour safe environment, to fulfil the objectives set in care plans and carefully document care procedures and changes in residents' health condition.

The Chancellor asks that the possibility of hiring more people at the care home be considered.

6. Handling medication, and nursing care

The care home employs one nurse who is on duty on working days (8–16)[18]. The nurse's office is located in the basement of the care home, in the same room where equipment necessary for care procedures and other stocks of the institution are kept.

The nurse's task is to distribute medicines into the drug dispenser for residents, monitor people's health and carry out medical procedures. The nurse also organises visits to general practitioners and specialist doctors and vaccinates the residents. Medicines are administered by carers.

The nurse documents her activities on a patient's electronic health card. The health cards examined indicated that the nurse had made entries regularly, and important changes in a patient's condition were reflected on the cards. The health card also contains a record of a person's visit to a general practitioner or a specialist doctor, the nurse's recommendations concerning care procedures, the procedures carried out by the nurse, and remarks by attending doctors. The documents inspected allow the conclusion that the nurse notices residents' health concerns at an early stage and organises the necessary treatment.

Information exchange between the care home staff and the nurse takes place mainly orally. The nurse participates in morning meetings and also has access to aggregate summaries prepared after each shift. During interviews, residents affirmed that they could always express their grievances to the nurse whenever needed.

Prescription medication is kept in packs and drawers marked with a person's name. Medicine drawers are not lockable. Since the nurse's workroom simultaneously serves the function of a storage facility, access by third parties to medicines is not precluded. Such an arrangement contravenes the general requirements for handling medicines. Nor is the nurse's workroom adjusted for counselling patients or for performing procedures. The law does not require setting

[18] Nursing care is provided by the company Azeltor OÜ which has entered into a contract with the Estonian Health Insurance Fund for provision of nursing care services in a general care home.

up a separate workroom for a home nursing service provider because, as a rule, a nurse carries out procedures outside their workroom (e.g. at a patient's home). Nursing care in a general care home means essentially a nurse's presence at a care home, constant cooperation with other staff, and communication with patients. For this reason, the care home could consider finding a suitable room for the nurse's work as well as storing medicines. Many general care homes have provided a nurse with their own office.

The expert participating in the inspection noted that a brief overview of the treatment scheme and the most essential health information for each resident could be drawn up so that it could be quickly presented to the ambulance if necessary. The treatment scheme marked on a drug dispenser should also reflect unequivocally clearly any changes in the scheme, and in the event of major changes the new treatment scheme might be written on the dispenser in the interests of clarity. If the doctor has decided to exclude a certain medicine from the treatment scheme, the particular medicine must be taken out of the person's medicine drawer in order to avoid mistakes.

Over-the-counter (OTC) medication (e.g. pain killers) is also kept on each floor which the carers administer to people to alleviate minor ailments. Administration of medication is documented in general terms on a person's individual health monitoring form, and sometimes also in the aggregate shift summary. The forms inspected sometimes lacked information about the precise name and amount of medication; for instance, it was only recorded that a pain killer had been administered to a person. The expert participating in the inspection noted that in the event of administering OTC medication it is important to note down the name of the medicine, the dosage, and the precise time of administration. Detailed documentation provides a good overview of a person's consumption of medication and helps to prevent over-dosage. This information also helps the nurse in monitoring a person's health condition.

The Chancellor acknowledges the nurse's work in monitoring and documenting the health of residents. Administration of OTC medication should be recorded more precisely. The care home must ensure proper storage of medicines. The care home might consider setting up rooms which are more suitable for the nurse's work.

7. Combating the spread of the coronavirus

To combat the spread of the coronavirus SARS-CoV-2, the Chancellor asks to comply with the recommendations given by the Health Board on implementing precautionary measures.

Staff have been trained to use personal protective equipment and an action plan has been agreed in the event of any of the residents getting infected or the risk of infection arising. The body temperature of all residents is not measured daily, while the body temperature of staff is checked every morning. Joint meetings have been suspended, information exchange takes place in writing. The staff wear protective masks. Two people at a time are allowed to be present in the staff resting room.

While implementing precautionary measures for protecting the health of residents and staff, it should be observed that soap is always available in every toilet. The healthcare expert involved in the inspection visit recommended using liquid soap for washing hands and avoid using shared towels. In general, this requirement is complied with.

To combat the spread of SARS-CoV-2, the care home has established visiting rules. Visiting residents is prohibited but exceptionally next of kin are allowed to visit someone who is dying.

Care home residents can communicate with their loved ones by telephone but, according to the staff, unfortunately most people with a dementia diagnosis lose the skill of using a telephone. It is also complicated for residents to focus on a video call, so this option for communication with next of kin has not been used. People can take parcels to their next of kin at the care home.

The Chancellor has noted[19] that, in the event of imposition of a visiting ban to combat the spread of the virus, the institution must ensure that people can communicate with their next of kin differently. Alternative means of communication (e.g. video calls) could be considered. Even if a care home resident does not actively participate in conversation, hearing their voice or seeing them via a video feed helps next of kin keep informed of their situation. The longer the restrictions on meetings with next of kin are maintained, the more alternative possibilities for communication should be offered. Information about options for communication should be easy to find for next of kin (e.g. on the institution's website) in order to encourage them to be in closer contact with residents.

Naturally, even by implementing all precautionary measures, the spread of the virus in a social welfare institution is not precluded. It is worth recognition that, during the inspection visit, the management of Nõlvaku care home analysed different risks based on information about the spread of the virus and decided to give people an opportunity to visit residents in a difficult condition and send parcels to residents.

8. Assessment by the healthcare expert

The opinion by the healthcare expert involved in the inspection visit is appended to this letter. With regard to the observations and recommendations contained in the healthcare expert's opinion, I ask the care home to formulate their position and submit it to the Chancellor of Justice together with replies to the observations in the letter.

I expect your opinion by 9 June 2021 at the latest.

Ülle Madise

Appendix: Healthcare expert's opinion

Copy: Social Insurance Board, Health Board, Agency of Medicines, Tartu City Government.

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[19] See para. 4.