**Summary of Case Report № AJB-2479/2018 of the OPCAT Visit to the South-Borsod Joint Social Institution**

(May 22-23, 2018)

On May 22-23, 2018, the OPCAT National Preventive Mechanism (hereinafter the "NPM") Department paid a visit to the South-Borsod Joint Social Institution (hereinafter the "Institution").

The Institution is located in three buildings. The offices of management and finance are in building "A", the residents live in buildings "B" and "C". In buildings "B" and "C", there live 120-120 residents, most of them with psychosocial disabilities. The residents' distribution by gender was 50-50 percent in each building.

From the residents living in the Institution, the legal capacity of 23 persons was not restricted but one of them was helped by an advocate in decision-making. According to the data of the Institution, 101 residents were legally incompetent (or had "precluded competency" by the terminology of the former Act on the Civil Code), 112 residents were under guardianship with restricted legal capacity (or "limited competency" by the terminology of the former Act on the Civil Code) in certain types of matters.

Only natural deaths occurred in the Institution. Amongst the causes of death, the number of tumorous conditions has increased but brain haemorrhage, pneumonia and marasmus were also frequent causes of death. In March 2018, 4, in April, 3, while in May, 2 deaths occurred until the time of the visit.

A manager, 46 nurse-carers (including two nurses who were heads of division), 4 social workers, a social administrator, 2 animators and 3 developer-helpers were working in the Institution at the time of the visit. One of the nurse-carers was on maternity leave and she was substituted by another colleague. The number of the workers in nurse-carer position, also taking into account the nursing assistants who promised to obtain the professional qualification, did not reach the norm of staff headcount defined in Annex 2 of Minister of Health, Social and Family Affairs Decree 1/2000 (I. 7.) SzCsM for residential institutions providing personal care.

7-8 residents live in the 40 square metres rooms, in buildings "B" and "C", both on the female and male sides. Each level on both sides is provided with two toilets and a bathroom with a bathtub and a shower.

In the Institution, the statutory requirement of living space per capita was not met in the 8-bed rooms. The number of the available toilets and bathing or showering facilities did not reach the statutory requirement (8 toilets and 8 showers or bathtubs serve 120 residents). Contrary to the statutory requirement, more than 4 persons were placed in the rooms. The living space per capita and the lack of toilets and showers defined in the law caused an impropriety related to the residents' right to human dignity, stipulated in Article II of the Fundamental Law, and related to the principle of legal certainty arising from the rule of law, stipulated in Article B) of the Fundamental Law.

There were no rooms for placing married couples or couples together. There was a 7-square metre conjugal room in building "C" with two divans placed next to each other. With regard to the long-term relationships with shared finances, the lack of rooms providing a joint placement of couples caused an impropriety related to the right to respect of the private and family life, stipulated in Article VI of the Fundamental Law.

The Institution provided the residents' meals from its own kitchen. The residents were given meals 5 times a day: breakfast, a snack in the morning and in the afternoon, lunch, dinner.

The planning of the diet met the statutory requirements; the variety index of the basic menu was 100%. Animal source proteins were ensured by the main meals. Three times a week, on Monday, Tuesday and Thursday, both the lunch and the dinner were hot meals. The residents were given fruits, mostly as compote, and/or vegetables every day. The visit did not find any improprieties in connection with the technology of the preparation of pulpy and liquid food,

taking into account that the residents eating the diet menu were satisfied with the food, keeping in mind that the primary objective is to ensure the adequate nutrition for the residents.

The residents' medical support in the Institution was ensured by a general practitioner being present two times a week, on Tuesday and Thursday. If it is required by a resident's condition, the physician visits the Institution outside consultation hours too.

The psychiatrist visits the Institution once a week. On the one hand, he examines the residents indicated by the nurses, on the other hand, he monitors the patients' psychiatric condition even when no problems occur. The condition of every resident is reviewed at least once a year. The psychiatrist conducts therapy talks with the residents. The visit has not found any fundamental right related improprieties in connection with the medical care.

Maintaining the blood sugar level of the residents suffering from diabetes caused a problem, probably because of the non- observance of diets. It is unacceptable that the control of the blood sugar level of the residents suffering from diabetes is not ensured due to dietetic reasons. The omission of ensuring the proper nutrition for the patients requiring diet menus and the lack of controlling diets caused an impropriety related to the right to human life and dignity, stipulated in Article II of the Fundamental Law.

The incomplete documentation of the chemical restrictive measures endangered the residents' right to the freedom of movement, which means the substance of personal liberty.

The few documentations on physical restrictive measures (the Institution provided documentation only for one case), taking into account the report on applying the restrictive measures in the abovementioned case, indicated that documentation is not always prepared when physical restriction is applied. This practice caused an impropriety related to the residents' right to human dignity, stipulated in Article II of the Fundamental Law.

For lack of a complaint box, the residents or their relatives could not anonymously lodge their complaints about the circumstances in the Institution, which caused an impropriety related to the right to complain, stipulated in Article XXV of the Fundamental Law.