Commissioners for Human Rights of Poland answers to the Guiding Questions for the focus areas of the IX Session of the Open-ended Working Group on Ageing

AUTONOMY AND INDEPENDENCE

1) **In your country/region, how is the right to autonomy and independence of older persons defined in legal and policy frameworks?**

In the Polish legislation, the right to autonomy and independence of older persons is not defined. Only in the *Long-Term Senior Policy Guidelines for the period 2014-2020*, autonomy is mentioned as one of the objectives of strengthened healthcare for older persons. Their independence is indicated as an objective to be pursued by educational activities addressed to seniors. This document, introduced in 2013 by a resolution of the Council of Ministers, does not indicate activities or tasks necessary to achieve the set objectives.

In individual cases, the right to autonomy and independence of older persons can be derived from scattered regulations contained in acts of the Parliament and relating e.g. to patient rights.

One of the basic rights of the patient and the main obligations of the doctor is medical procedure performance solely with the patient's informed consent. Every patient (who is of legal age and is not incapacitated) may refuse or withdraw such consent. Patient's consent should be preceded by the provision to him/her, by a competent person, of information on his/her health condition, diagnosis, proposed and possible diagnostic and treatment methods, foreseeable results of their delivery or non-delivery, expected treatment effects and prognosis. Medical procedure performance without the patient's consent required by the law in the given circumstances is a crime.

2) **What other rights are essential for the enjoyment of the right to autonomy and independence by older persons, or affected by the non-enjoyment of this right?**

3) **studies and data are available? What are the key issues and challenges facing older persons in your country/region regarding autonomy and independence? What**

A) The right to autonomy and independence in institutional care:

Since 2008, the Commissioner for Human Rights has also held the role of the National Mechanism for the Prevention of Torture and Inhuman Treatment. In 2017, the Commissioner published a report on inspection visits paid within the Mechanism to 150 social care homes i.e. institutions that provide 24-hour care (not only for older persons). Among the challenges identified during the visits, the following problems should be mentioned:

1. Residents' restricted possibility to leave the care institution's premises. In the visited homes, the restrictions had different forms: from discouragement by the staff members, through solutions such as the possibility to leave solely within the administrative staff office hours, or issuing passes to leave, to locking the building's doors. It should be emphasized that the current legislation

contains no provisions that permit the introduction of restrictions regarding residents' possibility to leave the care institutions' buildings and premises.

2. Violation of the right to intimacy during personal hygiene procedures performed with regard to care home residents. Irregularities in this area concerned the procedures' performance in multi-bed rooms in the presence of other residents, without ensuring a privacy curtain to cover the person undergoing the care procedures, as well as situations in which residents in their rooms had to be naked while waiting for a bath.

3. Inspecting residents' belongings: in some of the institutions, staff members inspect the residents' belongings, items bought by them, parcels sent to them, bags and sometimes even the pockets of their clothes; this makes the residents feel humiliated and ashamed.

4. Engaging residents in staff work for the home or for other residents, including, in particular, requesting residents' assistance in carrying out personal hygiene procedures for other residents (bathing, diaper change, disposal of used diapers), in restraining other residents if so done, in dispensing pharmaceutical products to other residents.

5. Violation of residents' right to information on pharmaceutical products administered to them: the inspectors had objections regarding residents' lack of knowledge about medicines administered to them including, primarily, lack of awareness of medicines administered to them, crushed or diluted in meals, without their consent in cases when they refused to take them consciously. There were also objections as to the practice of administering evening doses of medicines, including psychotropic drugs and sleeping pills, already at 6 p.m. (which is easier for the staff).

6. Use of "disciplinary sanctions" in relation to some residents. The list of such sanctions used in care institutions is very long, and contains inter alia: moving the resident to another room, including a lower standard room; placement in a room with persons with a higher degree of intellectual disability; warning; reprimand or warning registered in the resident's files; reprimanding the resident in the presence of others; restricting the resident's freedom to freely spend his/her money; temporarily suspending the resident's right to participate in excursions, integration events or other activities organized by the home; not giving cigarettes to the resident at usual time; blocking the possibility to buy a telephone card or to do shopping in the home's shopping point; blocking the possibility to go to a shop; blocking access to sweets or coffee; prohibition to drink coffee or to smoke; seeking the resident's transfer to another institution; refusing the possibility for the resident to stay in the care home for any longer; restricting the right to leave the home's premises; prohibiting visits to the family home; prohibition to eat meals in the canteen and necessity to have meals in the bedroom; requirement for the resident to wear pyjamas throughout the day if he/she has left the home without consent; prohibition to meet with other persons in the bedroom; prohibition to leave the bedroom; prohibition to have guests in the bedroom; closing the resident in the bathroom; making the resident stand in the corner of the room; asking the resident to do cleaning work; physical exercise;

prohibition to watch television, prohibition to use a computer.

B) The right to autonomy and independence of older patients

As regards patient's consent to medical procedures, the Polish legislative system should be considered sufficiently developed. Yet, it is not free of defects. The existing regulations do not provide for the binding effect of statements of consent/lack of consent to procedures that may be performed in more distant future, called *pro futuro* statements (in such cases, decisions are taken by courts in individual cases separately). The legislation also fails to regulate the issue of proceedings before a guardianship court with regard to consent to medical procedure concerning an unconscious patient who does not have any legal representative. It would be advisable to introduce a regulation allowing the court to appoint, ex officio, a proxy for a patient who is unconscious and does not have a legal representative.

4) **What steps have been taken to ensure older persons' enjoyment of their right to autonomy and independence?**

5) **What mechanisms are necessary, or already in place, for older persons to seek redress for the denial of autonomy and independence?**

Mechanisms are needed to increase older persons' and their guardians' awareness of seniors' rights and, in particular, their exercise in practice.

The currently existing system of appeal possibilities, including proceedings before a court, proceedings before other law institutions, submission of complaints to the Commissioner for Human Rights or to the Patient Ombudsman, does not sufficiently meet the need to report cases of abuse or irregularities in order to solve them quickly or to prevent further limitation of older persons' independence. Such system should take into account the fact that persons who require care provision by carers, either at their own home or in an institution, are dependent on their carers which involves certain psychological and physical aspects.

LONG-TERM CARE AND PALLIATIVE CARE

1) **In your country/region, how is long-term care for older persons defined and provided for in legal and policy frameworks? What types of support and services are covered?**

2) **What are the specific challenges faced by older persons in accessing long-term care?**

The problem of insufficient care provision to senior persons and of deficit of care and nursing services for persons who are ill and dependent on others remains unsolved. The Polish system of health care and assistance for older persons is inefficient and unadjusted to the rapid demographic change i.e. the increase in the number of older citizens. Activities undertaken in this area are not sufficient, consistent, efficient or effective. They are therefore unable to meet the new challenges in the area of coordinated holistic medical care for seniors. The main shortcomings of the system include: evident lack of strategies and action plans at the local and national levels (the Ministry of Family, Labour and Social Policy is currently drafting a project entitled *Social policy for older persons: solidarity, security, participation,* but the draft does not indicate the additional sources of funding of the identified measures. There is a lack of coordination of support provided at the local level, an insufficient number of doctors - specialists in geriatrics, of geriatric wards and outpatient clinics, a lack of new methods of diagnosing dementia-related diseases (the expert draft of the National Plan to Address Alzheimer's Disease was not approved, not elaborated by authorities therefore there is no such an action plan at the national level), doctors have no possibilities to provide sufficient care to the elderly. There is also a lack of efficient geriatric medical care system and implementation of geriatric approach standards (to meet the needs of older patients in a commonly available, high-quality, accessible and comprehensive way), lack of sufficient funding and of support instruments for persons who are carers of senior persons.

3) **What measures have been taken/are necessary to ensure high-quality and sustainable long-term care systems for older persons.**

Firstly, it is necessary to implement a comprehensive policy for older persons, to ensure adequate funding and to coordinate activities taken within care provision either at the person’s place of residence or at an institution. Notably, the Commissioner strongly supports the idea of shifting from institutional care to properly-coordinated care at home.

4) What other rights are essential for the enjoyment of the right to long-term care by older persons, or affected by the non-enjoyment of this right?

Since 2008, the Commissioner for Human Rights has also held the role of the National Mechanism for the Prevention of Torture and Inhuman Treatment. In 2017, the Commissioner published a report on inspection visits paid within the Mechanism to 150 social care homes i.e. institutions that provide 24-hour care (not only for older persons). Among the challenges identified during the visits, there are problems concerning autonomy and independence of older persons, as described in the relevant section above.

5) In your country/region, how is palliative care defined in legal and policy frameworks?

The relevant regulation of the Minister of Health of 2013 defines palliative and hospice care as comprehensive, full-scope care and symptomatic treatment of patients suffering from diseases that are incurable, not subject to causal treatment, progressive and causing restrictions in patient's life. The care aims to improve patient's quality of life, prevent or alleviate pain and other somatic symptoms, mitigate psychological, spiritual and social suffering. Palliative care services are guaranteed to patients with cancer and other diseases that are incurable, progressive and cause restrictions in patient's life; the diseases are specified in article 3 of Attachment 1 to the ministerial regulation.

6) What are the specific needs and challenges facing older persons regarding end-of-life care? Are there studies, data and evidence available?

Reports of the Supreme Audit Office identify e.g. the following problems:

- there is no uniform system of geriatric medical care provision to senior patients in Poland.

- high prices of seniors' stay in public-sector residential care homes lead to increased interest in the offer of private-sector homes where stay is cheaper. However, there is a growing number of facilities that provide 24-hour care without the required permit issued by the head of regional (i.e. voivodeship) administration; and there are no legal instruments to control such facilities.

Also data collected in the national-level survey *POLsenior* carried out in 2010 indicates that older persons experience problems in various areas. The Act on Older Persons, adopted in 2015, requires the government to present annual information on the situation of older people in the country (based on statistics gathered by public-sector institutions).

7) To what extent is palliative care available to all older persons on a non-discriminatory basis?

The availability of palliative care in Poland is relatively high, despite some so-called white spots. Due to insufficient number of hospice facilities and shortage of funds allocated by the National Health Fund to palliative care, access to it is not full and there is no possibility to select a specific hospice. Not all persons in need of palliative care receive it without delay at a place that best meets their needs and preferences. Although the level of funding for palliative and hospice care services is increasing, patients not always receive care that is fully adjusted to their needs. Palliative and hospice care services are not accessible to all those in need but to patients diagnosed with certain diseases. There is a lack of so-called hospital support teams that would offer consultations in palliative medicine, facilitate transfer from the hospital to a care facility optimal for the patient, educate families and medical personnel. In addition to the publicly-funded system (the National Health Fund), there are hospices and care services financially supported e.g. by churches and religious associations, foundations and non-governmental organizations.