OPCAT Aged Care Monitoring

Chief Ombudsman's Observations 2021-2024

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OPCAT Aged Care Monitoring
Chief Ombudsman's Observations
2021-2024

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Foreword

As Chief Ombudsman | Kaitiaki Mana Tāngata, I carry out a range of roles that contribute to safeguarding people's rights. One of my key roles is that of National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA).[1]

In this role, I examine the treatment and conditions of people who are held in secure places – ie, where they are not free to leave when they wish to do so.[2] These places include prisons, courts, health and disability places of detention, and places of immigration detention.



In relation to aged residential care, my jurisdiction is limited to examining the conditions of those in secure dementia and psychogeriatric units[3] and how these residents in particular are treated, from a human rights perspective. These residents are at a heightened risk of ill-treatment, as a consequence of being in secure care, and depend on others to respect their basic rights.

My NPM role is a preventive one. It involves visiting facilities to identify any risks, poor practices or systemic problems, and making recommendations for improvement where I think necessary. I also endeavour to identify examples of positive practice. Ultimately, my role helps to ensure that residents who are not free to leave these facilities are treated humanely and their human rights are respected.

I have published *Expectations for the treatment and conditions of residents of secure aged care facilities* (My Expectations).[4] My role helps to ensure New Zealand adheres to international human rights standards, and these Expectations are based on international and domestic human rights law and guidance.

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1 For the purposes of section 26 of COTA, I am, as Ombudsman, designated a National Preventive Mechanism (NPM) to examine and monitor the treatment of persons in various places, including in health and disability places of detention. "Designation of National Preventive Mechanisms" (22 June 2023) *New Zealand Gazette* No 2023-go-2676. Read more about my aged care monitoring role online at **https://www.ombudsman.parliament.nz/what-ombudsman-can-help/aged-care-monitoring**

'Torture' may be a confronting term to people in the aged care sector. However, it is a term found in both COTA and the international convention which COTA ratifies (the 'Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment'. More information about the Convention and its Optional Protocol can be found on the Ministry of Justice website at: **https://www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/human-rights/international-human-rights/cat/**

2 COTA refers to such facilities as 'places of detention' and the residents as 'detainees'.

3 There are four levels of care provided at aged residential care facilities: Rest Home, Hospital, Rest Home Dementia and Psychogeriatric Specialist Hospital Care. People with a diagnosis of dementia may receive any of these levels of care. Only dementia units and psychogeriatric units are secure.

4 Office of the Ombudsman. *Expectations for the treatment and conditions of residents of secure aged care facilities*. (10 April 2024) Wellington. Available online at **https://www.ombudsman.parliament.nz/resources/expectations-conditions-and-treatment-residents-health-and-disability-places-detention**

I have also published two thematic reports on the care provided to residents during the height of the COVID-19 pandemic – **one in 2020** and **one in 2021**.[5]

I am pleased to now be able to provide an update on my monitoring of the secure aged care sector (**the Sector**) since the pandemic.

Between 1 July 2021 and 30 June 2024, my team of OPCAT[6] inspectors visited 148 facilities out of the 269 within my designation that provide secure aged residential care.[7] There were 125 'drop-in' visits[8] and 23 inspections. A written summary of observations was provided to facility management following a drop-in visit and a more detailed report, with my recommendations, provided following an inspection. To date these reports have not been published, but consideration may be given in the future to publishing some of these reports where it meets my preventative purpose.



This report identifies some themes that emerged from the information obtained, although it is not an exhaustive list of all matters observed.

I share examples of good practice and areas where there was room for improvement. I also share what some facilities have told me they have changed in response to my visits. I hope that the Sector finds this a useful resource. It illustrates what my inspectors may comment on when they visit and will enable facilities to learn from each other.

The COVID-19 pandemic placed huge challenges on residents, staff, and whānau, with many restrictions being imposed in secure aged care facilities. While I observed some residual restrictions still being applied (eg, on visiting times, activities, outings), it was pleasing to see that they have decreased over time.

As OPCAT Aged Care monitoring continues, my office will continue to build on the knowledge gained through visits when looking at how the responsible government agencies, as well as individual facilities and providers, are ensuring residents who cannot freely leave experience appropriate conditions and treatment.

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5 I have also discussed some of my observations and concerns around these inspections in my submissions to the United Nations Committee against Torture last year. These submissions can be found at: **https://www.ombudsman.parliament.nz/resources/submission-77th-session-committee-against-torture**.

6 The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) provides for both national and international preventive mechanisms. The United Nations Subcommittee on the Prevention of Torture (UNSPT) is the international preventive mechanism. Members of the UNSPT last visited New Zealand places of detention in 2013. Their report can be found at: **https://digitallibrary.un.org/record/767897?ln=en**

The UNSPT have **announced** they intend to visit New Zealand in 2025. They may choose to inspect aged residential care facilities during this trip.

7 This number was obtained from the Ministry of Health, and was current as at 28 January 2025. Regularly updated data is available online at **https://www.health.govt.nz/your-health/certified-providers/aged-care**

8 The difference between a 'drop-in' and an inspection is explained in the Visit Methodology section of this report.

This broad view will be necessary as the aged residential care system currently has a number of systemic features which have the potential to affect the conditions and treatment of residents who cannot freely leave the facility in which they live.

The systemic features I discuss in this report include:



- A lack of centralised oversight of whether there is appropriate legal authority for residents to be deprived of their liberty and an over-reliance on individual providers to ensure this is the case.
- Inequities in the material conditions and standard of care experienced by residents.
- Occasions of substitute, rather than supported, decision-making in the care provided to those detained in aged care.
- A need for facilities to provide a familiar 'home-like' experience to residents of varied ethnic and cultural backgrounds.
- An over-reliance on whānau to provide advocacy and support for residents in secure aged care, and a lack of access to independent advocacy services who proactively visit these residents.
- No nationally-mandated training in dementia for staff who work in secure aged care units.
- Variation in staffing levels and staffing mix across facilities.

Parliament's Health Select Committee is conducting an inquiry into the aged care sector's current and future capacity to provide support services for people experiencing neurological cognitive disorders.[9] A Health New Zealand | Te Whatu Ora review of the funding and service models for the aged care sector is also currently underway. I encourage those currently considering these matters to ensure that human rights remain a key consideration when designing appropriate services for residents.[10]

My inspectors and I are always mindful that when we visit a secure aged care facility, we are stepping into the home of its residents. I thank them for their hospitality. I am also grateful to everyone who shared their experiences. This includes residents and their whānau, as well as facility staff and managers. Their openness and insights are highly appreciated.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

9 The terms of reference for this inquiry can be found at: **https://www.parliament.nz/en/pb/sc/make-a-submission/document/54SCHEA_SCF_68DED697-E85E-4888-DE1A-08DC7A1062A5/inquiry-into-the-aged-care-sectors-current-and-future**

10 I appeared before the Select Committee on 11 December 2024 in relation to their inquiry. My written submissions can be found at: **https://www.parliament.nz/en/pb/sc/submissions-and-advice/document/54SCHEA_EVI_68ded697-e85e-4888-de1a-08dc7a1062a5_HEA1927/office-of-the-ombudsman.**

Introduction

This report summarises some of the insights I have gained from visits to secure aged care facilities between 1 July 2021 and 30 June 2024.

I have structured my observations under a number of themes. Each theme includes a summary of what I observed and areas for improvement. I have chosen not to name individual facilities in this report.

By way of introduction, I first highlight some overarching observations about the secure aged care sector (**the Sector**) and provide some relevant context to the matters outlined later in this report.



Terms used in this report

In this report, I use the term **'residents'** to refer to people who live in secure aged care facilities and are unable to freely leave.

There may be more than one unit at a facility site, only one of which may be secure. Where this is the case, I use the term **'unit'** to describe a specific secure unit I am visiting – eg, the dementia unit.

There are also many circumstances where a single 'provider' owns or manages more than one facility. Some facilities are owned by corporate entities; some are in single-ownership. With each facility providing secure aged care services, there is the potential for confusion of terminology. Hence, I refer to **'facility'** rather than 'provider' when speaking of the place visited.

Context in which independent monitoring of secure aged care facilities occurs

The NPM Role

New Zealand has international human rights obligations under the United Nations Optional Protocol to the Convention against Torture (OPCAT) to prevent torture and other cruel, inhuman or degrading treatment and punishment. As part of OPCAT, there is a requirement for New Zealand to have an independent inspection programme of places of detention (where people are not free to leave at will).

Ombudsmen have been designated by the Minister of Justice to carry out OPCAT inspections of health and disability facilities, including privately-run aged care facilities. The preventive purpose of these inspections is to provide independent assurance that the treatment and conditions in these facilities are appropriate, and to provide recommendations for improvement. The focus of these inspections is human rights based.

Risk of mistreatment

Residents living in secure aged care facilities are reliant on those who care for them, and therefore may be exposed to many risks. These include risks of:



- Mistreatment or neglect.
- Physical, emotional, cultural, or spiritual needs being overlooked.
- Further loss of independence and the ability to make choices for themselves.
- Being prevented from doing things they have always regarded as routine when living at home.
- Becoming institutionalised and isolated. Losing contact with their wider community or the world outside their home.
- Being restrained in order to limit movement or decision-making capacity.

Placement in secure aged care facilities can lead to a perception from others that a person has lost the capacity to make all decisions about their daily life. This can result in an over-reliance on substitute – rather than supported – decision-making.[11]

Residents receiving psychogeriatric care can be particularly vulnerable and are even more likely to be seen as incapable of having their own views or making their own choices. These residents are also likely to experience more severe behavioural and psychological symptoms of dementia.[12] As a result, they are at increased risk of being subjected to excessive restrictions or restraint.

Restraint can come in many forms, including:

- Staff using their own body to limit residents' movement (**personal restraint**). For example, grabbing a resident by the arm.
- Staff using equipment to limit residents' movement (**physical restraint**). For example, intentionally placing furniture in front of a resident's seat to prevent them from leaving it.
- Staff using medication or a chemical substance to restrict residents' movement or decision-making capacity (**chemical restraint**).
- Staff intentionally restricting residents' access to their normal environment (**environmental restraint**). For example, locking the door to the garden to prevent residents from going outside.

11 Substitute decision-making is when someone else makes a decision for a person, including a decision they feel is in the person's best interests. Supported decision-making is when a person is helped to make their own decisions. This help could involve giving someone information in a way they can understand and enough time to understand that information so that they can make the decision.

12 Common behavioural and psychological symptoms of dementia include agitation, aggression, psychosis, depression and apathy.

Minimal safeguards

Other designations I monitor, such as prisons or mental health facilities, have a specific organisation to safeguard detainees' rights.

District Inspectors[13] are a support available to people receiving compulsory treatment in mental health facilities. Prisons have the **Office of the Inspectorate**.[14] However, there is no directly comparable safeguard for residents in secure aged care facilities.

All residential aged care facilities are audited for their compliance with the Ngā Paerewa Health and Disability Services Standard (**Ngā Paerewa**).[15] Ngā Paerewa includes criteria which are relevant to facilities respecting residents' rights. For example, consent processes, ensuring residents are free from neglect and abuse, compliance with legislative requirements, restraint, and complaints processes. These audits look at the entire facility, not just the secure unit, and it is usual practice for a sampling methodology to be used, where the treatment of a portion of residents within the facility is examined. [16]



In addition to facilities' internal complaints processes, specific complaints can be made to the local Health New Zealand Portfolio Manager or directly to the Health and Disability Commissioner (HDC). Within HDC, the Aged Care Commissioner also has responsibility for monitoring issues across the broader aged care sector.

However, these are very different roles from an independent agency who regularly visits each secure unit to identify and escalate any concerns with individual residents' placement in secure aged care facilities and how they are being treated.

13 Lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act).

14 A team of Inspectors who report directly to the Chief Executive of Corrections. The Inspectorate carries out, among others, prison inspections, investigates complaints from prisoners, investigates deaths in custody and carries out other investigations or monitoring activities where concerns are identified.

15 HealthCERT, a team within the Ministry of Health, designates Auditing Agencies to undertake these audits. For more information about the certification of health care services, see: **https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services**

16 Where issues are identified during the review of how this sample of residents have been treated, the audit may be expanded to consider whether these were one-off errors or indicative of a more systemic issue. HealthCERT can also undertake inspections of facilities if concerns are raised following an audit, a complaint made directly to HealthCERT, or if concerns are raised by Health New Zealand | Te Whatu Ora.

Whānau often relied upon

I identified that whānau[17] often end up in the position of having to act as an advocate for their loved one, but they are not always in the best position to do so.

When asked by my inspectors, the majority of whānau spoken to said that they trusted facility management to take their concerns seriously but some were still reluctant to complain. The reasons given for this differed. For some, their reluctance was out of concern about consequences for them or their loved one if they complained. Others said that they were worried that their loved one may be thought of as difficult and be asked to leave the current facility.[18] Other whānau were reluctant to complain because they felt their loved one's needs were difficult to meet and that the facility was doing the best they could to take care of them.

I identified that whānau can also be dependent on facility staff to set their expectations about what good treatment and care is. This includes the appropriate balance between keeping their loved one safe and respecting their right to make their own choices. It can be hard for whānau to know whether to push back against something they are told is in their loved one's best interests by someone they think of as an expert.

There are also a number of residents who, for various reasons, do not have whānau or friends to visit or advocate for them.

My expectations

My Expectations for the conditions and treatments of residents in secure aged residential care guided my inspectors during visits (both drop-ins and inspections).



My overarching expectations are that:

- The rights of residents are upheld by people, principles and practices at all levels.
- Residents are safe and their independence is promoted.
- Residents are treated with dignity and respect.
- Residents enjoy the highest attainable standard of physical and mental health.
- Residents are in an environment that promotes their safety, independence, culture, dignity and wellbeing.
- Residents are supported by skilled, motivated and engaged people.

17 In this report, I refer to whānau rather than family. In Te Ao Māori, whānau encompasses family in the fullest meaning. Whānau may include immediate and extended family through whakapapa (genealogy), as well as all persons connected by emotional or spiritual bonds. Any person who has been involved in the care or welfare of a resident may also be considered whānau (kaupapa whanau), including people with an enduring power of attorney.

18 These fears may or may not be justified, but it is important to acknowledge they were genuinely held by the whānau who expressed them.

My Expectations are guided by international and domestic human rights law and guidance and informed by domestic legislation, regulations and policies. They are also informed by Te Tiriti o Waitangi | The Treaty of Waitangi.[19]

I must be responsive to the rights of particular groups. I am informed by law, policies, standards and best practice for upholding rights and ensuring the specific needs of these groups are met. This includes the rights of Māori, Pacific peoples and other ethnic groups, migrants and foreign nationals, women, LGBTQIA+ people, young and older people, and disabled people.

Visit methodology

I have a team of inspectors who assist me in my examinations of the conditions and treatment of residents. They gather information on the conditions and treatment of residents in secure aged care facilities in a number of different ways. This includes making information requests and visits to facilities. These visits can be short 'drop in' visits, inspections focussed on specific issues, or full inspections.



During a drop-in visit, it is usual practice for two of my inspectors to spend three hours in a facility. The visit involves a tour, observing activities, looking at facility records, discussions with residents, visiting whānau, staff and management, and a concluding discussion with facility management about inspectors' initial observations. A written summary of these observations is subsequently provided.

Drop-in visits enable my inspectors to become familiar with the facility, identify areas to focus on during a full inspection of the facility, and discuss my role and expectations with staff and management.

My inspectors typically spend several days at a facility during a full inspection. This enables a greater amount of time to be spent observing and speaking with residents and staff, contact with residents' whānau, and a more detailed review of facility records (including residents' clinical files, and facility registers and policies). On occasion, I will conduct surveys of staff, management and whānau.

Examination of residents' conditions and treatment can also continue after inspectors leave the facility, with further interviews conducted and information requests made where necessary.

After a full inspection, I provide facilities with a report setting out my observations, including positive practice observed, and recommendations on how the conditions and treatment of residents could be improved.

This thematic report uses information gathered from the 148 visits my inspectors have made to facilities over a three year period. Of these facility visits:

19 I acknowledge there are two texts with different meanings.

- 125 visits were drop-ins and 23 were full inspections.
- 106 visits were unannounced — facilities were not told in advance that my inspectors would be visiting.

The strength of this approach, combining drop-ins and inspections, is that my inspectors have visited a considerable number of facilities across all of the different parts of the country. This range has meant we have been able to introduce many facilities to the NPM role, speak to their staff and management about the importance of considering human rights when caring for residents, and provide initial suggestions about how the conditions and treatment of residents could be improved.

I acknowledge that a potential limitation of this approach is that I have not examined all of the issues I have identified in depth at each facility. The NPM role, however, is an enduring one, and these themes will be explored in more detail as OPCAT aged care monitoring continues.

My recommendations

As a result of the 23 full inspections carried out between July 2021 and June 2024, I made 115 recommendations. My recommendations related to all aspects of care.



My inspectors also made suggestions to facility management based on their observations during drop-in visits, and highlighted areas that may be looked into further during a full inspection.

When a facility accepts one of my recommendations, I ask that they provide me an action plan that sets out the changes they intend to make to achieve that recommendation. In future visits, my inspectors check on the facility's progress in implementing those changes.

At the end of each theme in this report, you will find examples of recommendations I have made to individual facilities and changes facility management told me have been made as a result.

I wish to acknowledge how responsive many facility managers have been to my recommendations, even though they are non-binding. Easy but impactful changes were sometimes able to be made during the inspections themselves. Management also often told me that they had found solutions and made changes immediately after the inspection, following the initial feedback they received. Despite this, many of the more challenging issues, and those requiring significant resources or investment, remain unaddressed.

Facilities visited

Visits took my inspectors across the country as part of my scheduled programme of visits to all facilities in New Zealand. I have chosen not to name specific facilities visited in this report, but I provide the following data to help readers understand the scope of my visiting programme over this three year period.

I anticipate that by mid-2025 all of the facilities in which secure aged care is provided will have been visited at least once.

Locations of facilities visited

Locations of facilities visited – by region	
North Island	**104**
Northland	3
Waitematā	20
Auckland	7
Counties Manukau	8
Waikato	24
Bay of Plenty	7
Tairāwhiti	1
Lakes	1
Taranaki	2
Whanganui	1
Hawke's Bay	4
MidCentral	14
Wairarapa	3
Hutt Valley	3
Capital and Coast	6
South Island	**44**
Nelson Marlborough	3
Canterbury	30
South Canterbury	2
Southern	9
Total	**148**

Locations of facilities visited – urban accessibility[20]	
High urban accessibility	**93**
Located in a major urban area (population greater than 100,000 people)	68
Located in a large urban area (population between 30,000 and 99,999 people)	21
Located in a small urban or rural area with high urban accessibility	4
Medium urban accessibility	**41**
Located in a medium sized urban area (population between 10,000 and 29,999)	31
Located in a small urban or rural area with medium urban accessibility	10
Remote or low urban accessibility	**14**
Total	**148**

Size of facilities visited

Facilities visited varied in size and in the types of care they provided to their residents. Some of the facilities visited provided only secure care; however, most also provided rest home or hospital level care.

Service focus	
Provided only secure care	18
Provided other aged residential care services in addition to secure care	130
Total	**148**

Facility size - number of secure care beds	
Small facility (12 secure beds or fewer)	17
Medium sized facility (between 13 and 24 secure beds)	78
Large facility (25 or more secure beds)	53
Total	**148**

20 Data sourced using the **Stats NZ Urban Accessibility Indicator 2023**. For an explanation of how Urban Accessibility is calculated, see Stats NZ (2020) *Urban accessibility – methodology and classification* available at **https://www.stats.govt.nz/methods/urban-accessibility-methodology-and-classification/**

Ownership of facilities visited

Provider size – secure aged care only	
Owned by a small provider of secure aged care	**57**
Provider owned a single facility which provided secure aged care	43
Provider owned two or three facilities which provided secure aged care	14
Owned by a large provider of secure aged care (provider owned four or more facilities which provide secure aged care)	**91**
Total	**148**

Provider business model	
Owned by a not for profit organisation	**19**
Owned by a for profit provider	**129**
NZX Listed company	43
Private company – major group[21]	40
Private company – minor group or single facility	46
Total	**148**

21 I have described a provider as a 'major group' if they own four or more facilities that provide aged residential care services.

Legal authority to reside in a secure unit

My expectations

No person should be deprived of their liberty unless in accordance with the law, and all associated legal protections. In respect of a resident's admission to a secure dementia or psychogeriatric unit, I expect thorough assessment to have been done, all legal processes followed, and appropriate documentation to be obtained and kept updated.

Restrictions on liberty, that is on the ability of individuals to leave a place at will, are inherent in the nature of secure aged care. Ensuring that there is a legal basis for placement in secure aged care assists to protect against any risk of arbitrary deprivation of liberty.

During their visits, my inspectors look at whether there are robust processes in place for verifying the legal basis for each resident's placement in a secure unit. During a full inspection, they also look at the legal basis for each resident's placement in the secure unit. During a drop-in visit, my inspectors do not always review facilities' records of residents' placement authority or sometimes will look only at a sample. However, they always speak to facility management about how they ensure they have legal authority to keep residents in a secure unit.

Legal framework



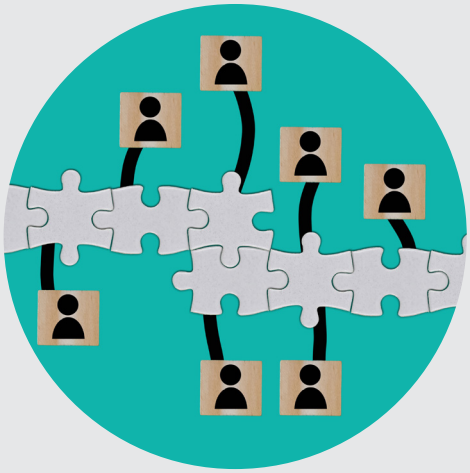
Most people take it for granted that they are entitled to make their own decisions about their personal care and welfare – including where they live, the healthcare they receive, and where they spend their time. However, where someone has been assessed as lacking capacity to make these types of decisions – for example, due to a diagnosis of dementia – there are legal processes which can enable others to make these decisions on their behalf. This includes the decision for a person to be admitted into secure aged care.

Placement in secure aged care involves a deprivation of liberty, which must be lawful. In this context the legal authority is typically the result of consent, usually given by a person authorised to do so such as an activated enduring power of attorney (EPOA) for the resident's personal care and welfare, or a court-appointed Welfare Guardian. The Family Court may also make a personal order for a person to reside in a secure dementia care unit.[22]

The Protection of Personal and Property Rights Act 1988 (the PPPR Act) is the key legislation which sets out mechanisms for this 'substituted' consent.

22 People may also be placed in secure aged care under the Mental Health (Compulsory Assessment and Treatment) Act 1992, although I did not find this often on my visits.

When a person makes an EPOA for personal care and welfare, they (the donor) appoint someone else (the attorney) to make decisions on a significant matter relating to the donor's personal welfare. For this decision-making ability to become active, a relevant health practitioner must issue a medical certificate stating that they have assessed the donor to be mentally incapable of making these decisions by themselves.[23] A court may also make this determination based on evidence. The donor can specify in the EPOA whether their attorney can make decisions on everything to do with their personal care and welfare, or only some aspects of these matters.[24]



Personal orders may also be made by the Family Court if a person lacks capacity to consent to receiving health services. Orders can be made for such things as provision of medical advice or treatment, or living arrangements. Orders can be sought by a number of people, including the principal manager of a secure aged care facility (refer section 7 of the PPPR Act).

A Welfare Guardian is someone appointed by the Family Court to make decisions about another person's personal care and welfare. They have certain powers and duties under the PPPR Act, and the Court can specify what decisions they can make. A Welfare Guardian order is only valid for a maximum of three years before it expires and a new order must be sought from the Court.

Another part of the legal framework is the Code of Health and Disability Service Consumers' Rights.[25] Right 7(4) of the Code allows for the provision of health services where a person is unable to consent and no person entitled to consent on their behalf is available. However, to rely on right 7(4) certain requirements must be met. Where right 7(4) is relied on as the basis for admission into secure care, the facility must ensure all the requirements are met and document how they were met. It is also important to note that right 7(4) is not designed to be relied on indefinitely. The steps being taken to obtain consent for admitting a resident into secure care, from someone who is legally entitled to consent on the resident's behalf, must be documented.

23 For more information on EPOAs see: **https://www.justice.govt.nz/assets/standard-explanation-epa-personal-care-and-welfare.pdf**

24 The paramount consideration of the attorney/welfare guardian is the promotion and protection of the welfare and best interests of the donor, while seeking at all times to encourage the donor to develop and exercise his or her capacity to: understand the nature and foresee the consequences of decisions relating to his or her personal care and welfare, and to communicate such decisions (e.g., see section 98AA PPPR).

25 The full Code of Health and Disability Service Consumers' Rights can be found at: **https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/**

What I have observed

A variety of factors played a role in whether facilities had a valid placement authority on file for their residents. For example, facilities receiving people with good support networks (such as whānau and/or previous care providers), and whose medical conditions had deteriorated gradually over time, often had correct legal paperwork with respect to EPOAs or Welfare Guardians appointed to make decisions on the resident's behalf.

Where residents had entered the facility in different circumstances, there were more frequently issues.

For example, facilities receiving people from a hospital can assume that the Needs Assessment Service Coordination (NASC) assessment and a psychiatrist letter are sufficient authority for admission into secure care. This is not the case. A NASC assessment is an assessment for the level of care required and/or government funding.[26] This assessment does not equate to, or replace, the need for lawful consent. This is a fundamental aspect of the admission process.



I have observed varying levels of understanding on the part of facility management, medical professionals, and whānau of what is legally required and why it is required for placement of someone in a secure aged care facility. Where it is not possible to demonstrate a legal basis for admission into secure care – i.e. through the consent mechanisms discussed above – there is a risk of an arbitrary deprivation of liberty.

Even in the case where there was an EPOA recorded and the attorney had consented to their loved one being placed in the facility, some facility managers did not understand that the EPOA must be 'activated'[27] in order for that consent to be lawful.

With respect to a pending Welfare Guardian appointment by the Court, facility managers often did not have the necessary paperwork to prove that the application has been filed in the Court. Some facility managers also did not understand that a placement order can be applied for through the Courts if the resident has no whānau to act as Welfare Guardian.

I have heard from facility managers that they find it difficult to know the right course of action when a resident has been assessed as lacking capacity to make their own decisions and needing secure care, but the facility has not been provided evidence that someone is lawfully able to consent on the resident's behalf.

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26 For more information about the NASC assessment process see: **https://www.govt.nz/browse/health/help-in-your-home/needs-assessment/**

27 An EPOA has no effect and the attorney has no power to make decisions, including consent to admit a person into a secure aged care facility, until the EPOA is activated. An EPOA can only be activated by a suitably qualified medical practitioner and only if they assess that the person does not have capacity to make decisions about their personal care and welfare.

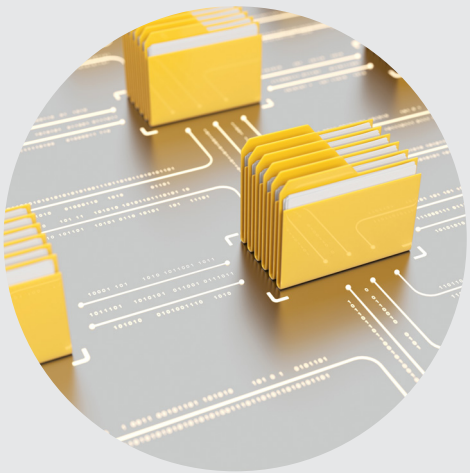
I have seen:

- No records held for some residents' placement in secure care.
- Capacity assessments completed incorrectly.
- EPOAs not being activated, being incomplete or not being followed.
- Whānau and staff having difficulty locating EPOAs.
- Reliance on expired welfare guardian orders.
- A lack of understanding of Right 7(4) of the Code.

In the vast majority of facilities visited where my inspectors reviewed the legal basis for each resident's placement, I found it to be lacking for at least one of the facility's residents. At a small number of facilities visited, this was missing for almost half of the residents.

Some residents appear to me to be at greater risk of being in this situation. For example, residents with no connection to their whānau, or whose whānau are not in a position to act as an authorised representative. I have seen examples of a probation officer acting as a resident's Welfare Guardian because the resident had no one else able to do so. I understand also that some whānau find the costs associated with these processes to be unaffordable and so cannot take on this role. This can be both the legal costs of getting an EPOA in place – prior to the loss of capacity – as well as going through the court process to appoint a Welfare Guardian. The ongoing general costs associated with being an attorney or Welfare Guardian can also be prohibitive for some people.

What can be improved



A robust process for verifying and recording the legal basis for residents' placement in secure care must be in place in all secure aged care facilities, and that process must be followed. Where legal authority is not in place, there should be a clear plan and steps underway to obtain it. Also, where there is reliance on right 7(4) of the Code, this should be clearly recorded. I look for this on all visits to secure aged care facilities.

I acknowledge that this is a complex area of law, and that it often falls to providers with varying resources to administer these legal processes. However, it is imperative that facility managers improve their understanding of, and compliance with, the legal framework under which residents can be placed in secure care.

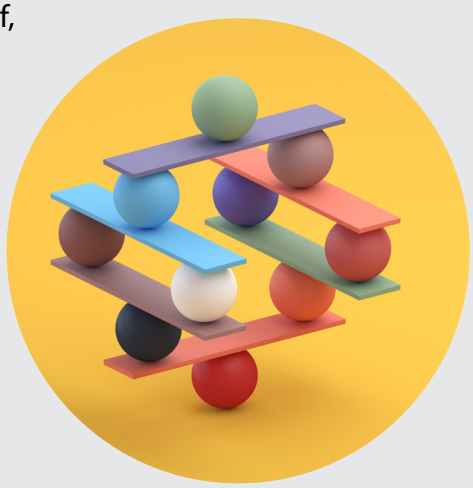
I have engaged with Health New Zealand | Te Whatu Ora (Health NZ) on this as I consider clear guidance would help many facility managers.

The Law Commission | Te Aka Matua o te Ture recently consulted on the potential benefit of establishing a national register for EPOAs within their review of adult decision-making capacity law.[28] I consider there would be significant benefit to establishing a centralised register, supported by national guidance, and with appropriate mechanisms in place to mitigate any matters regarding costs or privacy concerns. A robust, well resourced, equitable, culturally responsive, and accessible EPOA registration system may reduce the need to apply for Welfare Guardians or personal orders under the PPPR Act.[29]

My recommendations

An example of a recommendation I have made to facilities

- Implement appropriate processes so that they are aware of, maintain up to date records of, and independently verify the legal basis for placement of each resident.



I have also recommended that Health NZ

- Provide national guidance for facilities on how to verify and record that each resident has a valid legal basis for their placement in secure care.

In response, some facilities have told me that they have

- Provided staff training on the PPPR Act.
- Changed their processes. They now ensure legal authority is on file for each resident when they are admitted.

28 Law Commission | Te Aka Matua, *Review of Adult Decision-Making Capacity Law | He Arotake I te Ture mō ngā Huarahi Whakatau a ngā Pakeke*, Second Issues Paper 52, Chapter 14. Available at: **https://www.lawcom.govt.nz/our-work/review-of-adult-decision-making-capacity-law/tab/second-issues-paper**

29 My submission to the Law Commission can be read here: **https://www.ombudsman.parliament.nz/resources/submissions-chief-ombudsman-review-adult-decision-making-capacity-law**

Leadership and staffing

My expectations

I expect residents' rights to be upheld by people, principles, and practices at all levels.

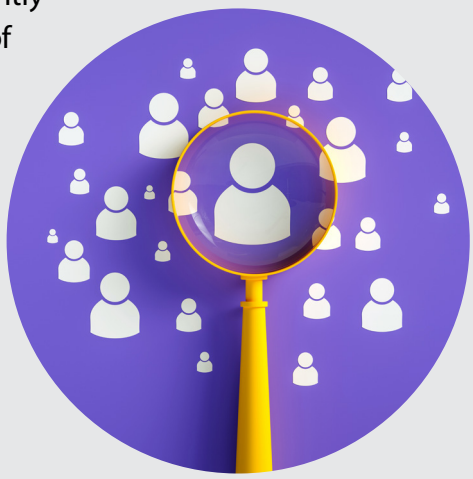
Dedicated, rights-promoting leadership, policy and governance should be evident in a facility's management and operations. A facility's organisational culture should reflect a person-directed and holistic approach to care with emphasis on nurturing residents' wellbeing, health and enjoyment of their life.

I expect residents to be cared for by skilled, motivated, and engaged people. Sufficient permanent staff, with the appropriate training and knowledge, should be employed to ensure the facility is safe, and residents' needs are met.

What I observed

Most facility managers and staff want to provide the best quality care to their residents

I have observed that secure aged care facilities are predominantly staffed by people who are highly dedicated to the wellbeing of the residents they care for.



My inspectors have met staff at many facilities who went the 'extra mile'. These included staff who came in on their days off to help put on events for residents, purchased and refurbished furniture so that the facility felt less like an institution, and who would make sure they kept on-hand a resident's favourite food.

I have seen rights-promoting leaders successfully create a culture shift at their facilities, resulting in improved treatment of residents.

At one facility, for example, inspectors spoke to a staff member who had initially been resistant to moving away from a rigid schedule when caring for residents. She described how her perspective changed when she saw her manager take on the role of a carer in providing personalised care to a long-time and much loved resident at the end of their life. The manager also shifted the facility's approach to activities. Rather than playing *'video after video'* to entertain residents, a range of activities, including painting and regular van outings, was provided.

Whānau also saw an improvement at this facility. One commented to inspectors that:

> *The new facility manager has been making positive changes and has really focussed on [my loved one] as an individual. [My loved one] is happier, and healthier as a result. There was a while when he started to withdraw a bit, but now he is opening back up and enjoying things he used to more, like being outside and colouring.*

However, I have also seen facility owners and managers make operational decisions which negatively affected the conditions and treatment of residents. For example, not employing dedicated cooking staff, which led to lower quality food and care staff needing to take time away from attending residents to prepare meals.

Generally, my inspectors observed that the care provided by staff was commendable – they treated all residents as individuals, adapted the care they provided to each resident's individual needs and gave residents a great deal of freedom to decide their own routines. However, I found instances staff were clearly stretched and frustrated to not have the resources or time to consistently provide the quality of care residents should expect. This includes prioritising cooking and cleaning tasks over one to one engagement with residents.

What can be improved

Increased management presence is required in some secure units.

I consider it important that leaders have genuine insight into, and understanding of, the culture and operational reality of what is happening in secure units. They should be engaged in monitoring and ensuring that appropriate conditions and treatment are provided to all residents.



My inspectors have visited facilities where I found facility management did not have the level of awareness of the conditions and treatment of residents in the secure unit that I would expect to see. This was particularly evident when facility management at large sites were responsible for several types of units – ie, rest home, hospital level, psychogeriatric and dementia units. In these situations it is vital that there are good processes in place so that management are aware of what is happening in each unit and that there is strong leadership within each secure unit. I have seen that where there is this level of strong engagement and leadership within secure units, there has been better oversight, responsiveness and accountability for the treatment that residents experience.

Staff need to feel able to speak up about concerns

It was pleasing that most staff who spoke to my inspectors said that they felt supported by facility and unit management. Although, disappointingly, some staff did not feel they could raise concerns with management about the treatment of residents. Some staff were concerned about repercussions if they were to 'speak up', others were put off from speaking out after seeing management fail to take actions in relation to other issues. I expect management to create and maintain a culture in which it is safe for all staff to speak up.

Staff were under pressure

There appears to me to be a real risk of burnout for many staff working in the sector.

During my visits, this has often been apparent with regard to Registered Nurses (RNs). RNs play a vital role in ensuring that residents' health needs have been identified and any changes to their condition are promptly recognised. RNs tended to be responsible for clinical oversight in the secure units visited, especially in smaller and less resourced facilities which may not have a more senior clinical manager. In these situations, the RN is the first port of call when there is an issue, and they often have to make decisions without specialist expertise immediately available to them.



Many RNs spoken to described having a heavy workload. My inspectors heard from RNs who were considering leaving the aged care sector because of the pressures of always being on call. At one facility, the sole RN worked on-site weekdays from 7.30 am until 3.30pm. They would then be on-call in all of their 'off hours'. When they needed to take leave, the support available to caregivers was provided by phone by the RN from another facility owned by the same company.

This issue, however, was not limited to RNs. Many other care staff spoke to my inspectors about being required to or feeling pressured to work double shifts. At one facility visited, both staff working the night shift were working double shifts. At other facilities visited, staff expressed frustration at not having time to provide individualised care to residents.

I have also seen that a lack of cooks and cleaning staff can have a significant impact on residents' quality of life. At one facility my inspectors saw residents sitting immobile and unoccupied for long periods of time while care staff folded the laundry. As I discussed above, I have found there were also negative impacts on residents when care staff were made responsible for preparing residents' meals.

Many whānau members spoke to my inspectors of their concerns about staffing levels. However, they were understanding that facilities had limited resources. Whānau at some facilities described providing assistance to residents (not necessarily their own whānau) because staff were not present or available.

One whānau member said: *'I would see a resident trying to get up, but no one around. I would ask what they need and try to do that for them.'*

Sometimes this help was with small domestic tasks like making residents cups of tea but whānau also reported having to help residents to the bathroom. Whānau helping residents with these intimate tasks presents obvious risks, and it is inappropriate for whānau and residents to be put in this position.



A recent report commissioned by Health NZ came to the conclusion that the Aged Residential Care sector was *'under extreme pressure at the moment.'*[30] I understand that the Government's review is considering actions to address this. It will be important that this specifically includes addressing the lack of sufficient, trained staff which impacts negatively on residents' care, and consequently, on their fundamental human rights.

My recommendations

Examples of recommendations I have made to facilities

- Review their staffing levels to ensure residents' safety, dignity, and other needs are met at all times.
- Ensure all staff who work in the secure units are experienced in dementia care and are familiar with the residents.

In response, some facilities have told me that they have

- Hired more staff.
- Provided more training on caring for people with dementia.

30 Moore, D., Loan, J., et al. A review of aged care funding and service models. (16 January 2024) Sapere, Wellington. Page 11. Available online at **https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review**

Resident-centred care

My expectations

I expect all residents to be treated with dignity and respect. They should be valued as individuals, with their own history, experience, views, needs and abilities.

Residents should be the primary decision-makers in process and decisions around their care to the fullest extent possible. Residents should have opportunities to be responsible for themselves, their environments and their future. Maintaining their independence and autonomy to the fullest extent possible should be central to the care residents receive. Their preferences should be sought and followed to the fullest extent possible. Their feedback should be sought on all matters and considered. Residents should be well informed about how to raise a concern or complaint.

There should be regular and responsive consultation with residents, their authorised representatives and whānau about residents' safety and wellbeing

What I observed

Overall, residents were treated with respect

At almost all facilities visited, my inspectors observed staff interacting with residents in a caring, respectful and warm manner. Whānau confirmed this was also the case when my inspectors were not on site.

Some of the positive comments from whānau included:

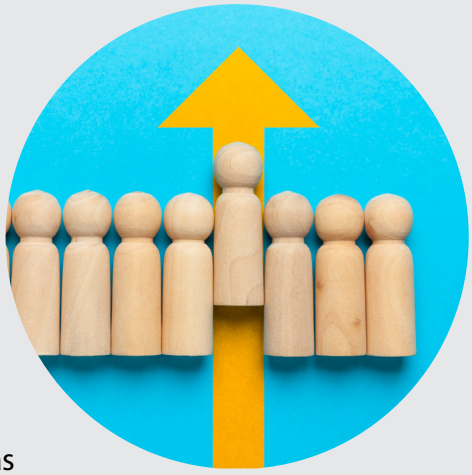
> *The staff, who are often flat out, consistently show respect, care and love for mum — for which we are truly grateful.*
>
> *They always put the person first.*
>
> *We have been thoroughly delighted with the whole experience. None of us worry about mum at all.*
>
> *All the little things they do takes away the stress.*
>
> *I'm speechless at how nice staff were.*
>
> *They're fantastic.*
>
> *I couldn't imagine [my loved one] being treated better anywhere else.*



At multiple facilities, 100 percent of whānau I surveyed agreed that their family member was treated with dignity and respect. I hope this continues to be seen across all secure aged care facilities.

My inspectors have spoken to whānau who had concerns about particular aspects of the care their loved one received. However, even these whānau tended to follow up their comments with acknowledgments that staff were trying to provide care that was respectful to their loved one.

My inspectors saw many examples where, despite being busy, staff took the time to stop and have patient and meaningful conversations with residents. Staff at many facilities were able to talk to inspectors about residents as individuals. They knew their likes and dislikes, their personal histories, hobbies and interests.



I found residents clearly appreciated the respect shown by staff, with many residents telling inspectors how much they liked the staff. For example, a resident at one facility said they particularly liked the staff because they were kind, treated him well, and spoke nicely to him. Another resident was very keen to make sure inspectors knew that the staff were *'so good'*.

A cleaner at a facility told inspectors: *'I notice how patient the staff are, and how they use all these different ways to make the resident feel okay if they are having a bad day.'*

My inspectors visited only a small number of facilities where staff appeared to be more focussed on completing tasks, at the expense of engaging with residents.

I note this was seen more often, but not exclusively, at facilities that had staffing constraints. Examples included staff who were inattentive to residents while providing them care (for example, when helping residents to eat), staff who did not give residents advance warning or explanation before touching them, and who appeared to ignore residents while completing administrative tasks or cleaning.

At a very small number of facilities, my inspectors saw more significant examples of disrespectful or undignified treatment of residents. Examples included staff issuing orders or telling residents off for not following instructions, residents' daily care needs being neglected, and residents wearing unclean clothes (including wearing the same dirty clothes on multiple days).

As the primary decision-makers in relation to their care, residents' wishes need to be listened to

I found that many staff thought it was important to be guided by what residents themselves wanted rather than forcing them to adjust to facility routines.

Comments from staff included:

> *You let the residents do things how they want to and don't stick to a rigid schedule. If they don't want to do something, staff just let them be and try again later.*

7am, half the residents will be walking around already, some will still be in bed. A couple will remain in bed, so we will save breakfast for when they decide to get up.

One of the policies is to encourage choice and self-determination. It can be tricky for activities scheduling as we may need to change the activities at a moment's notice if the residents want to do something different.

I saw this attitude reflected in care plans at facilities that were committed to supporting residents to be as independent as possible. Examples included:

[Resident] is encouraged to make daily decisions around care to promote independence.

[Resident] wants to be independent in most ADLs [activities of daily living]; he just needs supervision or limited assistance with hygiene and shower to ensure that tasks are completed in the proper way.



During their visits, I ask my inspectors to look to see if these commitments are put into practice. They saw a particularly good example at a facility where staff regularly took the time and care to find out how each individual resident was feeling. Each resident would take turns sitting with a caregiver to have a chat about how they were feeling that day. Inspectors watched staff check in with a resident who appeared to be tired and not their normal self. The resident mentioned that they were not sleeping well and they were frustrated with the weather. The staff member then told the resident that they would take them for a walk around the facility and they could sit in the sunshine inside together, as the sun was now shining.

However, my inspectors also saw examples of staff making decisions on behalf of residents (substitute decision-making), where they may have been able to make their own choices if support was provided.

My inspectors saw:

- Clothes picked out for residents by staff, with no option for residents to choose for themselves.
- Residents made to sit at the dining table when they were asking to do something else.
- Residents given no choice about their meals, or the facility's menu more generally.
- Staff bringing residents hot drinks without asking what the resident would like to drink.
- Blanket restrictions placed on the television programmes residents could watch.
- Restrictions on access to the news in case it was distressing.

In some cases, additional environmental restrictions were also in place, which I discuss further later in this report.

What can be improved

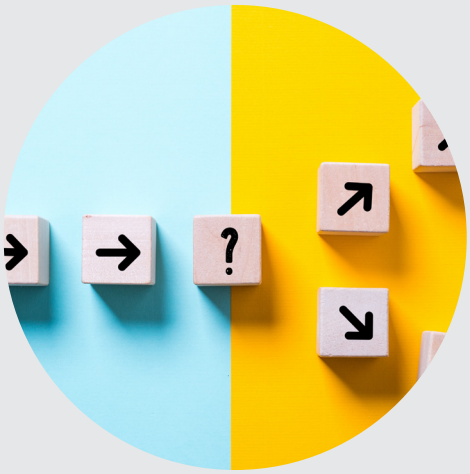
Supported rather than substitute decision-making

Residents should be supported to maintain their independence and autonomy to the fullest extent possible.

Autonomy involves two different aspects:

1. The ability and freedom to make a choice.
2. The ability and freedom to carry out the choice you have made.

A person does not stop having wishes or preferences about an issue when they no longer have the ability to carry out these wishes themselves.



In relation to autonomy, supported decision-making is a key principle and one that the Convention on the Rights of Persons with Disabilities highlights.[31] Supported decision-making offers disabled people – including those with dementia – the opportunity to make their own decisions based on their will and preferences, so they have control over their life.

A key element of supported decision-making is that assessments of a person's capacity must be done in relation to the specific decision to be made.

Supported decision-making has no set structure or process on how it is practised. It depends on each person, the circumstances involved, their circle of support, and the type of decision being made.

It includes, but is not limited to, the decision maker:

- Having access to information in a way they can understand.
- Having the time needed to be able to make a decision.
- Having support in expressing their views.
- Having advocates speak on their behalf if necessary.
- Being free from undue influence.

Staff providing care in secure aged care units should always ask themselves, in the current situation, am I ***'supporting'*** this resident to make their own decision, or am I ***'substituting'*** my view for theirs?

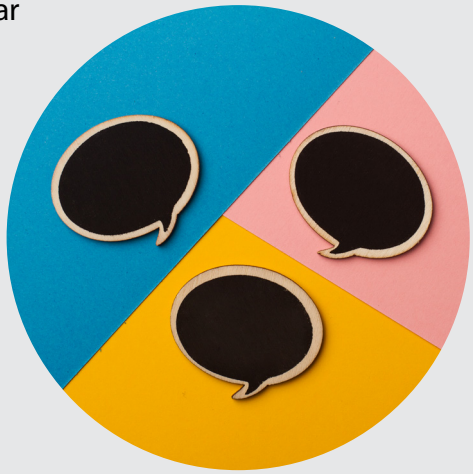
31 The UN Convention on the Rights of Persons with Disabilities: **https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd**

Anyone would find it distressing to have their preferences ignored. However, people with more severe dementia, who may not be able to explain to staff the cause of their distress, may find others interpret their distress as being a symptom of their dementia rather than an indication that their needs are not being met.

Residents need accessible ways to complain

I found that there were several facilities that had good feedback and complaints processes in their rest home or hospital units but these were not available to residents in secure units.

Some facilities had independent advocates regularly run meetings for the wider facility, but it was disappointingly common that residents from the secure units were not included in these meetings. Some facilities also held regular meetings for whānau to raise matters, but again residents themselves weren't always included in these discussions.



I found that complaints boxes were often located in areas not accessible to residents in the secure units: for example, where complaints boxes and forms were located in the facility's foyer, before the locked doors of the secure unit. I also found that some facilities displayed posters about complaint processes and the Health and Disability Commissioner on walls in places where residents of the secure unit could not see them.

Given the impact of dementia on residents' information processing abilities, thought should be given to how to provide complaint and advocacy information in a way that meets each resident's needs. The Health and Disability Commissioner, for example, has produced 'Easy Read' resources. Despite this, my inspectors rarely saw these in place at facilities. Facilities must ensure that every resident is aware that they can, and know how to, raise concerns.

I was very concerned to hear an attitude from a small minority of facility staff and management that as residents had dementia they were not capable of making complaints. I heard of some senior staff mentioning that as residents have advanced dementia it would be inappropriate to remind them of their rights and that making complaint forms available to residents would never work. I disagree strongly with these attitudes and have made that clear to those who have made these comments.

Residents are the experts on their experience of care. All residents have the right to share their opinions and be heard. There must be ways for residents to let someone know should they feel unsafe or dissatisfied with the care that they are receiving. At some facilities, this is provided by activities staff discussing with residents what they would change about the care they receive.

My inspectors have often seen residents with a range of abilities within each unit, and that some residents may be able to make use of a complaint box to make anonymous complaints. Where a mechanism like a complaint box does not work for the present group of residents,

I expect facility management to find other ways to provide opportunities for residents to raise their concerns without having to rely on staff to act as an intermediary. This may include proactively providing access to an independent advocate, for example.

I was pleased that in response to my recommendations several facilities responded by implementing ways for residents to make an independent complaint or provide feedback.

My recommendations

Examples of recommendations I have made to facilities

- Ensure residents are always dressed in clean clothes.
- Ensure residents are showered in accordance with their care plans.
- Provide accessible information to residents about how to make complaints, including to external bodies, and how to access an independent advocate.
- Provide accessible avenues for residents and their whānau to provide anonymous feedback and complaints.



In response, some facilities have told me they have

- Increased their oversight of whether residents are showered in accordance with their care plans.
- Reminded staff to ask residents for their preferences.
- Informed residents and their whānau about complaint processes at regularly held residents meetings.
- Placed posters and pamphlets in unit lounges that explain how residents and whānau can make complaints.

Restrictions on residents

My expectations

Residents should live in an enabling environment. Residents should not be subject to greater restrictions than are assessed as necessary and proportionate for identified and considered reasons. Blanket restrictions on all residents in a facility should be avoided.

Restraint in all its forms should be recognised as a serious intervention with potentially harmful effects on residents. I expect restraint to only be used as a last resort and only when strictly necessary to address immediate safety concerns.

What I observed

A restrictive approach



Of the restrictions seen placed on residents, blanket environmental restrictions were the most common. For example, where staff locked the doors to the unit's secure outdoor areas, preventing residents from going outside. When my inspectors asked staff about this practice, they often heard that staff were worried about residents falling should they go outside. While preventing falls is a very important consideration in aged care, I do not consider preventing all residents from freely accessing the outdoors to be a proportionate response. Instead, facilities should be sufficiently staffed to ensure residents can be appropriately supervised when outside, and outdoor environments should be well-maintained, safe and accessible.

Other common restrictions I have seen were restrictions on access to storage in bedrooms, access to basic facilities, including drinking water, and areas of the unit only being unlocked at certain times of the day.

Restraint

All facilities inspected had policies in relation to restraint. Broadly, these policies contained:

- A commitment to minimising the use of restraint.
- A list of training staff were required to complete.
- Instructions that restraint is to be used as a last resort, with all other less restrictive options tried first.
- Recognition that there must be clinical rationale and oversight when restraint is used.

- Instructions for:
    - Authorising the use of restraint.
    - Monitoring a resident who is restrained.
    - Recording and reviewing the use restraint.

However, during my inspections I found evidence that restraint policies were not always followed. This included staff blocking or restricting residents' movement. Staff did not always record or report these actions as an incident of restraint.

Additionally, no restraint policy I have seen provided staff guidance on what to do if they saw a resident who was restrained without authorisation.

It was uncommon for my inspectors to see physical restraint used intentionally in the secure dementia units visited. However, in many instances it was clear that staff did not fully understand how certain actions result in residents being restrained. On occasion, my inspectors saw residents sat in recliner-style chairs with their legs raised. Staff spoken to had not realised that as the particular residents were too frail to independently get out of the chairs, making them effectively restrained.



Staff were often unaware that locking doors to outdoor areas is environmental restraint. It was also relatively common that staff did not understand why it is problematic to verbally pressure residents to remain in communal areas when they wish to leave. Nor did some staff understand the risk of potential restriction with 'bolt-locks' on residents' bedroom doors. As a result, I frequently observed a lack of typical safeguards when restraint is used in place in relation to these restrictions. For example, management oversight, review of its use, and accurate and complete records kept. The restraint policies I have seen also did not specifically draw staff attention to these restrictions as potential environmental restraint.

However, my inspectors did see examples of facilities that had made significant efforts to manage residents' behaviour in a way which did not involve restraining or restricting them.

Sundowning, where someone experiences increased agitation or confusion in the afternoon, is a common issue for people with dementia. An example of positive practice was seen at one facility where two residents were given enjoyable tasks away from other residents as a way to manage their increased activity levels at this time of day and to limit any potential conflict with other residents. Staff said the size of the facility and having a number of different resident areas within the unit helped to manage sundowning behaviours.

Restraint use will continue to be a significant area of interest going forward, including use of physical and chemical restraint.

My recommendations

Examples of recommendations I have made to facilities

- Ensure residents have independent access to water.
- Ensure residents are able to freely and safely access outdoor areas.
- Ensure staff understand the facility's restraint policies.
- Train staff on identifying restraint.
- Document every episode of restraint fully and accurately.



In response, some facilities have told me that they have

- Provided staff more training on restraint.
- Required staff to complete questionnaires to check their understanding of the facility's restraint policies.
- Required that staff notify an RN before applying a restraint.

Living environment

My expectations

Residents should live in an enabling environment. Residents should not be subject to greater restrictions than are assessed as necessary and proportionate for identified and considered reasons. Blanket restrictions on all residents in a facility should be avoided.

Restraint in all its forms should be recognised as a serious intervention with potentially harmful effects on residents. I expect restraint to only be used as a last resort and only when strictly necessary to address immediate safety concerns.

What I observed

Most facilities were clean and hygienic

I was very pleased to see this. However, there were a small number of facilities where I have recommended cleanliness and hygiene issues were addressed.

A significant number of facilities were not optimally designed for residents with dementia

A dementia-friendly living environment is one which:

- Makes it easy for residents to orient themselves. This includes making it easy for residents to identify their own bedrooms, bathrooms and communal living areas.
- Has easy outdoor access.
- Has enough space for the number of residents living at the facility.
- Has spaces where residents can spend time alone and spaces where they can spend time with others.
- Makes it easy for staff to see where residents are.



When these features are missing, the living environment can be unsafe, cause residents unnecessary distress and lead to increased conflict between residents.

In some facilities, the secure units were located on upper floors, making it difficult for residents to access the outdoors. While residents in some of these units had access to fresh air through courtyards located on upper levels, the small size and lack of meaningful connection to the natural environment undermined the value of these spaces.

Residents can become confused and distressed when they find they cannot enter an area. The location of reception areas, nursing stations, offices and other staff-only areas was poor in some facilities as they appeared to be areas that residents could enter. Facility management may be able to address this in part by camouflaging the doors to some areas, but I appreciate that there were no easy fixes in some situations.

Often there were pathways that lead to 'dead-ends'. I found that there were easy environmental changes many facilities could make to ensure residents did not reach a dead end or use unintended pathways to move about facilities.



I have also found that some facilities would have benefitted from having more living spaces available. Communal living comes with noise and sensory stimulation. My inspectors visited a number of units which had been converted from residential homes. While it is positive that these units provided a homely environment, in some cases the available living space did not allow residents to spend quiet time away from other residents (other than in their bedrooms).

Resident privacy had also not always been well ensured. My inspectors visited facilities where, when the curtains were open, residents' bedrooms could be looked into from other areas of the unit. Residents in a secure unit may not be able to independently close their bedroom curtains, making this a particular concern.

Providers were taking steps to make environments more dementia-friendly

My inspectors saw facilities use design techniques to make their environments more dementia-friendly.

These included:

- Use of large pictures on signage, not just words.
- Use of specific paint colours. For example, painting all bathroom doors green, making it easier for residents to identify them.
- Use of wall art. For example, theming the art used in particular unit areas, such as animals in one corridor, landscapes in another.
- Making residents' bedrooms easily identifiable. For example, by placing '*memory boxes*' beside their doors containing items of particular significance to the resident.
- Use of lighting. For example, guiding lights on a sensor which direct a resident back to bed if they have spent a long time in the ensuite.

These efforts were especially impactful in facilities where the building and layout was otherwise not ideal for people living with dementia.

Outdoor areas

My inspectors visited facilities which had small outdoor areas, outdoor areas which were poorly maintained and had trip hazards, and areas which did not have outdoor furniture or it was in poor condition.

However, my inspectors did visit some facilities with outdoor areas that were safe, spacious and provided residents with appropriate ways to interact with the natural environment. Some rural facilities visited had paid particular attention to creating a familiar outdoor environment for their residents. These facilities had chicken coops, orchards and sheds with safe tools.

My recommendations

Examples of recommendations I have made to facilities

- Ensure the secure units are clean.
- Ensure residents' bedrooms provide adequate privacy.
- Make outdoor areas safe, dementia-friendly and fit for purpose. This includes having shade and appropriate furniture available.
- Regularly identify and promptly remedy any potential hazards in residents' living environment.
- Ensure all furniture is well-maintained.
- Use wayfinding aids to make the facility easier for residents to navigate.



In response, some facilities have told me that they have

- Hired more cleaners.
- Replanted and tidied up overgrown gardens.
- Replaced flooring.
- Repainted walls and added sensory features.
- Made handrails safe.
- Fixed broken call bells.
- Added residents' names and familiar photos to their bedroom doors.
- Painted toilet doors a specific colour to help residents identify them.

Culture and communication

My expectations

Residents should be supported to maintain the spiritual and cultural practices they find important. I expect facilities to make provisions to support residents' expressions of identity, culture, and faith, including ensuring they have access to those who can provide cultural and spiritual support.

I expect facilities to understand that communication and language are central to residents' identity and wellbeing. Residents should be supported to communicate as freely as possible. Their speech, language and communication needs should be well understood and accommodated, including through specialist advice and services, tools and practices. Information, resources and activities should be provided to residents in languages and formats that reflect residents' needs and preferences.

At present, the majority (approximately 88%) of residents receiving the full range of aged residential care services are NZ European.[32] Nevertheless, every resident should feel confident that their cultural needs will be met when they move into secure care.



No resident should feel isolated because they cannot speak or understand English. Facilities may be required to care for residents who have reverted to their 'mother tongue' as their dementia has progressed or who have never been able to communicate in English. Not being able to communicate with staff or other residents can make the experience of being in care isolating, and there are indications language barriers can contribute to residents experiencing greater agitation and overall neuropsychiatric symptoms.[33]

32 This data relates to aged care generally rather than those in secure aged care specifically. See page 81. **https://www.tewhatuora.govt.nz/assets/For-the-health-sector/Specific-life-stage/Health-of-older-people/FINAL_A-review-of-aged-care-funding-and-service-models_strategic-assessment.pdf**

33 Cooper, C., P. Rapaport, S. Robertson, L. Marston, J. Barber, M. Manela, and G. Livingston. "Relationship Between Speaking English as a Second Language and Agitation in People With Dementia Living in Care Homes: Results From the MARQUE (Managing Agitation and Raising Quality of Life) English National Care Home Survey." International Journal of Geriatric Psychiatry 33, no. 3 (October 3, 2017): 504–9. **https://doi.org/10.1002/gps.4786**

What I observed

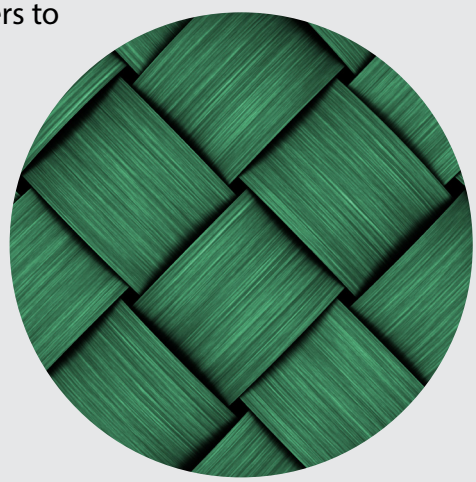
Many facilities relied heavily on whānau to meet residents' cultural needs

When asked how they met residents' cultural needs, staff at many facilities said residents' whānau would take responsibility for this. They relied on whānau to bring specific food to the facility, take residents out to attend cultural activities, and to act as translators. In these instances, when whānau were not around, cultural support appeared to be very limited.

While I am always pleased when facilities recognise how important whānau are in residents' lives, and recognise their cultural expertise, they should not be the only source of cultural support available to residents. A resident's culture is a core part of their identity, and caring for this is an important aspect of providing person-centred care.

Some facilities appeared to have made a real effort in this area

- One facility visited had ensured aspects of Māori culture were integrated into the daily lives of their Māori residents. Waiata were included in the unit's singing activities, and a weekly Mātāwaka (kinship group) had been created where residents were encouraged to speak about themselves in te reo Māori. They were also encouraged to take ownership of the group to ensure it was meaningful for them. Facility management said that they were planning for a hāngī and poi performers to visit the facility shortly after my inspection.



- A facility visited had created a '*cultural communication manual*' which included specific advice to increase staff's cultural awareness. It also included cards to assist staff in communicating in a range of languages (including Korean, Fijian, simplified Chinese, Hindi, Japanese, Croatian, Tagalog, German, among others). Having these resources pre-prepared meant that staff would be able to provide a base level of culturally-aware care for a resident as soon as they arrived at the facility.
- Another facility visited had created a '*cultural committee*' made up of staff members from different cultural backgrounds. They gave advice to facility management on how they could better meet the cultural needs of all residents. Committee members said they felt facility management listened to their advice and were committed to making any changes needed.
- A Māori resident at one facility had been assigned a Māori staff member as their kaiako (teacher). Signage was also written in te reo Māori, which a whānau member said was particularly helpful for their loved one. Facility management were also able to describe how they managed the impact on the Māori resident where actions of other residents did not align with tikanga (eg, sitting on tables).

- Inspectors visited facilities that particularly prided themselves on the culturally-sensitive care they provided to residents in the last days of their lives. These included facilities that had provided staff guidance on Māori perspectives on death and dying, and how to meet the needs of Māori residents during periods of serious illness and while they are dying.
- Spiritual advisors visit some facilities and residents are taken out to attend church services at other facilities.
- Some facilities had built relationships with external groups who could support them to meet residents' cultural needs.

What can be improved



While some facilities had made efforts to provide culturally-aware care, it is clear that there is more work needed for the sector to be able to ensure a resident's cultural requirements are considered and met by those providing them care.

Facilities also need to ensure they have a considered an individualised approach to speaking with residents. Some facilities had identified in residents' care plans translation tools which would assist them in doing so. However, my inspectors saw times where these were not used in practice. Identifying these tools is vital, but residents cannot benefit from them if staff do not use them.

My recommendations

Examples of recommendations I have made to facilities

- Ensure residents' communication needs are met.
- Ensure that residents are able to practice their spiritual or religious beliefs, and that they have access to appropriate services.

In response, some facilities have told me that they have

- Set up monthly korero groups run by a kaumatua.
- Accessed interpreters through Health NZ.
- Displayed cards with useful phrases in various languages.

Engagement and activities

My expectations

I expect that residents' right to purposeful activity is met. Suitable and meaningful activity should be available to residents throughout the day. Residents, their authorised representatives and whānau (as appropriate) should be consulted about the interests and preferences of residents about how they spend their time. I expect residents to be offered therapeutic interventions (such as psychological, sensory, occupational, and speech-language services) which promote their wellbeing. Therapeutic interventions should be based on each resident's individual history, goals, interests and needs.

Providing residents support with mental and physical stimulation reduces their boredom, helps them maintain their mobility, and can reduce behavioural and psychological symptoms of dementia such as agitation, aggression, depression and apathy.

What makes an activity meaningful will depend on the person – but a meaningful activity will do more than just keep a person occupied. Meaningful activities are ones that are enjoyable, engaging and align with the person's interests, preferences and abilities.

What I observed

Group activities were common, including games with balloons or balls, karaoke, quizzes and table-top games. Inspectors also saw residents doing individual activities like puzzles, colouring in, reading or receiving massages or aromatherapy.



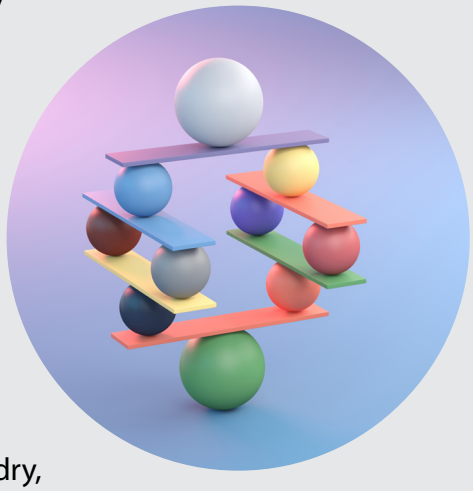
A significant number of whānau spoken to were concerned that their loved one was not getting enough physical or mental stimulation and, during their visits to facilities, my inspectors spoke to residents who said that they were bored. Staff at many facilities also told my inspectors that it was common for scheduled activities to be cancelled when staff were stretched.

Many residents did not receive tailored or individualised activities – even when their care plans recorded their specific likes, hobbies and interests.

At times group activity descriptions did not represent the activity in practice and residents were seen observing the activity rather than participating. Some group activities observed did not engage the interest of all residents as they were not meaningful or responsive to their needs. This was also the case with some individual activities not suiting resident's abilities. Some staff appeared to be unaware when activities were unsuitable, and did not offer alternatives when residents were not engaged.

In contrast, inspectors saw residents more actively engaged when staff ensured they were fully involved in group activities by asking them questions and giving them responsibilities for doing specific tasks for the activity.

My inspectors met many knowledgeable activities staff. They were focussed on how the activities they did with residents helped the resident achieve their goals. They encouraged residents to maintain their independence by doing activities that were meaningful to them.



Residents at some rural facilities would help feed the chickens. At one facility, my inspectors met a resident who had a previous habit of dismantling the outdoor furniture. Rather than placing restrictions on the resident – such as preventing him from accessing the outdoor area – the facility purchased construction activities for him, knowing he had worked in that field.

Where residents wished it to, meaningful activity included participating in household chores like gardening, folding laundry, doing the dishes, and vacuuming.

Residents at some facilities had been given their own plots in the garden. My inspectors met one resident who took pride in being responsible for taking out the rubbish. One facility had set up a '*General Store*' filled with knick-knacks so residents could have the familiar experience of shopping. A resident at another facility regularly 'treated' the other residents to lunch using imitation money he'd earned for doing household tasks. Residents may find these activities meaningful when they help them maintain continuity in their habits from before they entered the facility or as a way for a resident to maintain their independence.

What can be improved

When considering whether residents in secure dementia facilities are provided enough and stimulating activity during their day, I consider a number of factors.

. **Are there enough activities available?**

  - Are there days when the facility has no planned activities available?
  - How do management ensure that residents still receive enough purposeful activity when designated activities staff are away?

. **Do scheduled activities take place?**

  - Do publicised activity schedules reflect the reality of residents' experiences?
  - Do staff shortages require activities staff to assist with care tasks rather than activities?

- **Are the activities provided suitable and individualised?**
  - Do residents find the activities provided engaging and enjoyable?
  - Are the activities provided responsive to residents' individual abilities and needs? Do they support residents' to achieve their goals and are staff able to explain how they do so? For example, these goals might include maintaining continence, balance, ability to eat solid food.
  - Do the activities provided meet residents' cognitive, social, physical, cultural and spiritual needs?
  - Are there opportunities for residents to participate in large group activities, small group activities, and receive one-on-one engagement from staff?
- **Do residents have choice about the activities provided and whether to take part?**
  - Are residents provided alternative purposeful activity if they do not wish to participate in scheduled large group activities?

My recommendations

Examples of recommendations I have made to facilities

- Review their activities programme to ensure the activities provided:
  - cater for the preferences and abilities of all the residents
  - support residents' physical, mental and social wellbeing.

In response, some facilities have told me that they have

- Hired more activities staff.
- Increased the time activities staff spend in the unit.
- Sought feedback from residents and their whānau about what activities are enjoyable.
- Created an activities kit for caregivers to use when activities staff are away.
- Refreshed the activities programme – making sure it meets the needs of the current residents.
- Created separate activities schedules for residents of the facility's secure dementia and psychogeriatric units.



Connection with the outside world

My expectations

I expect residents to have the opportunity to leave the facility they live in regularly, based on their personal preferences and needs, in the company of whānau or staff able to provide orientation and support where required.

What I observed

Some residents rarely get to leave the facility

My inspectors met some residents who had not left the facility in which they lived for some years.



Several facilities visited struggled to provide all residents with regular time away from the facility due to one or a combination of: a lack of suitable transport, resident numbers, and staff availability. Some facilities did not own a van, or vans were shared across multiple sites meaning they could only be used every second week. Several facilities had also found that their vans were not suitable for all residents' mobility needs. In some cases, staff said that when transport wasn't available they would use their personal vehicle to take residents out of the facility to attend appointments.

Facilities which did not have regular access to vans often relied on whānau to take residents out. However, those without whānau did not have this opportunity. While whānau involvement and time with their loved one is to be encouraged, facilities have a responsibility to ensure all residents have the opportunity to leave the facility regularly.

Good planning and record systems need to be in place to ensure that all residents, rather than a select few (for example those with good mobility or who are easy to manage), regularly get offered the opportunity to leave the facility. This includes recording and tracking who has been offered time away from the facility and whether they wanted to go. These processes were lacking at some facilities.

My recommendations

Examples of recommendations I have made to facilities

- Ensure outings are available to all residents on a regular and equitable basis.
- Document when residents have gone on or declined offers of an outing.

In response, some facilities have told me that they have

- Purchased new vans.
- Improved how they track who has and has not gone on outings.

Systemic matters under scrutiny

It is important that appropriate services, resources, and processes are in place to ensure all residents receive the highest attainable standard of care on an equitable basis. Responsibility for this sits not just with individual facilities, but also the government and wider aged care sector.

My Office's ongoing monitoring of the secure aged care sector includes consideration of these more systemic matters, where they have the potential to affect the conditions and treatment of residents. For example:



- Oversight of how medications are used.
- Oversight of restraint use.
- Whether residents receive care on an equitable basis.
- Whether the resources available to providers allow residents to receive the highest attainable standard of care.
- Coordination and cooperation between private providers of aged residential care and public health providers.
- How the services available meet the diverse needs of those who live in secure aged care facilities.

Conclusion

This report contains key themes arising from a number of visits, both drop-ins and full inspections, to secure aged care facilities. I have provided examples of good practice and areas for improvement under each theme. It is a 'snapshot' of what I have found and recommended to individual facilities, but it is not an exhaustive list of matters I examine through inspections.



My overall impression from the visits covered in this report was of a dedicated workforce committed to providing residents with the best quality of care possible. Warm respectful interactions were seen at almost all facilities visited. Most facilities provided supported decision-making and a homely environment for residents, with some rural facilities paying particular attention to creating supportive outdoor environments for their residents. My inspectors also met many knowledgeable activities staff who were focussed on providing engaging and appropriate activities. They encouraged residents to maintain their independence by doing activities that were meaningful to them.

However, there has also, at times, been a failure to acknowledge the impact on basic human rights that can result from living in a secure facility. This can lead to a more restrictive and limiting approach than I consider necessary.

I was concerned at the varying levels of understanding facilities, medical professionals and whānau had on the required documentation for legal authority for residents. Poorly designed environments in some facilities did not support residents with way-finding, or providing privacy in bedrooms. There were often limited spaces to allow residents to spend quiet time away from others. Many residents did not receive tailored or individualised activities – even when their care plans recorded their specific likes, hobbies and interests.

I expect management and staff to always reflect a human rights based approach in the care of such vulnerable people. My visits and recommendations are designed to support them in doing so.

As OPCAT Aged Care monitoring continues, my office will continue to build on the knowledge gained through visits when looking at how the responsible government agencies, as well as individual facilities and providers, are ensuring residents who cannot freely leave, experience appropriate conditions and treatment.

This broad view will be necessary as the aged residential care system currently has a number of systemic features which have the potential to affect the conditions and treatment of residents who cannot freely leave the facility in which they live.

It has been a privilege to have led such important independent oversight work for New Zealand. I am humbled by the people that care for our most vulnerable in society. While I have identified areas for improvement, I wish to acknowledge the commitment shown to delivering the best treatment and conditions to people living in secure aged care facilities.

Appendix 1. Further reading

My aged care publications

Expectations for conditions and treatment of residents in health and disability places of detention – aged care

OPCAT COVID-19 report: Report on inspections of aged care facilities under the Crimes of Torture Act 1989 - August 2020

OPCAT COVID-19 report: Report on inspections of aged care facilities under the Crimes of Torture Act 1989 - June 2021

New Zealand legislation, standards and guidance

Full title	Type	Abbreviation
Crimes of Torture Act 1989	Legislation	COTA
New Zealand Bill of Rights Act 1990	Legislation	NZBORA
Protection of Personal and Property Rights Act 1988	Legislation	PPPR Act
Human Rights Act 1993	Legislation	HRA
Ngā paerewa Health and disability services standard NZS 8134:2021	Standards	
New Zealand Disability Strategy 2016-2026	Strategy	NZDS
New Zealand Disability Action Plan 2019-2023	Action plan	NZDAP
Improving Dementia Mate Wareware Services in Aotearoa New Zealand Action Plan	Action plan	

International treaties, standards and guidelines

Full title	Type	Abbreviation
UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Treaty	'Convention against Torture' or 'the Convention'
UN Optional Protocol to the Convention Against Torture and other Cruel, Inhuman, and Degrading Treatment	Treaty	OPCAT
United Nations Universal Declaration of Human Rights	Treaty	UDHR
UN International Convention on the Elimination of All Forms of Racial Discrimination	Treaty	CERD
UN Convention on the Rights of Persons with Disabilities	Treaty	Disability Convention
UN Declaration on the Rights of Indigenous Peoples	Declaration	UNDRIP
UN Principles for Older Persons	Principles	
UN Political Declaration and Madrid International Plan of Action on Ageing	Plan of action	

Additional resources can be found in my Expectations.

Appendix 2. Where residents and their whānau can find information

Below is a non-exhaustive list of services that offer support and information for people living in secure aged care facilities, and their whānau.

- **Te Whatu Ora | Health NZ** services for older people.
  Visit **https://info.health.nz/services-support/older-people/**
- **Health and Disability Commissioner (HDC)**: (Freephone 0800 11 22 33). If you are unhappy about a health or disability service you or someone else, including a whānau member, received, you have the right to complain to HDC. Visit **www.hdc.org.nz**.
- **Health and Disability Advocacy Service**: (Freephone 0800 555 050 or visit **www.advocacy.org.nz**). The Nationwide Health and Disability Advocacy Service offers free, independent, confidential advice and support to help you resolve issues with health and disability services and talk through your options for making a complaint.
- **The Office for Seniors | Te Tari Kaumātua**: (phone +64 4 916 3300 or visit: **www.officeforseniors.govt.nz**). The Office for Seniors is the lead advisor in government on the issues affecting older people. It is located in the Ministry of Social Development.
- **Age Concern**: (Freephone 0800 65 2 105) offers services including social connection and support, and preventing and addressing elder abuse.
  Visit **https:/www.ageconcern.org.nz/**.
- **Seniorline**: (Freephone 0800 725 463) is a national information service to help older people and their whānau | family navigate the health system. Visit **https://www.seniorline.org.nz/**.
- **Alzheimers New Zealand**: (Freephone 0800 004 001) represents people living with dementia by raising awareness, providing information and resources, advocating for services, and promoting research. Visit **https://alzheimers.org.nz/**.
- **Dementia New Zealand**: (Freephone 0800 444 776) supports the dementia community through awareness and knowledge. Visit **https://dementia.nz/**.

Ombudsman

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