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OPCAT COVID-19 report

Report on inspections of aged care facilities under the Crimes of Torture Act 1989

June 2020

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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

ISBN: 978-1-99-115261-9

Published June 2021

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Introduction

New Zealand has international human rights obligations under the United Nations Optional Protocol to the Convention against Torture (OPCAT)[1] 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.[2] 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.

COVID-19 pandemic

COVID-19 is a new type of coronavirus that affects lungs and airways.[3] COVID-19 is mostly spread because of close contact with people with the virus. People may also get infected if they touch surfaces or objects with droplets and then touch their mouth, nose or eyes. As of the date of this report's release, there have been 2,692 cases of COVID-19 in New Zealand.

If COVID-19 enters a place of detention, there is a high risk of an outbreak due to the close contact of staff and residents. Secure dementia facilities are a particularly at-risk place of detention, as they often house more vulnerable populations, such as people who are over 70 years old or have underlying health conditions. Of the 25 deaths due to the virus in New Zealand, the majority were people over 70, including 12 deaths associated with a cluster[4] at a rest home.

1 Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. More information about OPCAT and the Chief Ombudsman's National Preventive Mechanism (NPM) function can be found at https://www.ombudsman.parliament.nz/what-we-can-help/monitoring-places-detention/why-ombudsman-monitors-places-detention.

2 In the Gazette notice on 6 June 2018, the Minister of Justice clarified the Ombudsman's designation of National Preventive Mechanism for privately run aged care facilities. The notice of 2 July 2020 replaced that notice, continuing the designation: https://gazette.govt.nz/notice/id/2020-go2845

3 Coronaviruses are a large and diverse family of viruses which cause illnesses such as the common cold. The most recent diseases caused by them include severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS).

4 The Ministry of Health defines a cluster of cases as a group of ten or more people who likely caught the disease from one another: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-source-cases

To respond to COVID-19, the New Zealand Government implemented an 'Alert Level' system of public health and social measures to limit the spread of COVID-19.[5] There are four alert levels, with Alert Level 1 being the lowest and Alert Level 4 being the highest.[6]

COVID-19 OPCAT inspections

When the pandemic arose in 2020, I reviewed my pre-planned OPCAT programme of inspections and visits in light of COVID-19 and my designation as an essential service for OPCAT inspections.[7] I considered a wide range of information, including that provided by the United Nations. I considered advice from the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) on 7 April 2020 that inspectors *'should continue exercising their visiting mandate during the COVID-19 pandemic'*, while also devising methods that *'minimize the need for social contact but that nevertheless offer effective opportunities for preventive engagement'*.

I was acutely aware of the specific risks people in places of detention faced, both from the virus itself but also from the measures taken to prevent the spread of COVID-19 in those places. I was also conscious of the impact these measures may have on people's human rights.

I knew that, given the potential catastrophic impact COVID-19 could have—and has had—if it enters an aged care facility, the significance of these risks and measures in respect of residents' rights was even more acute. I decided that as well as using alternative methods for remote monitoring primarily through information gathering, I must carry out targeted physical on-site inspections focused on COVID-19 issues in order for me to provide effective independent oversight.[8]

My OPCAT COVID-19 inspections were carried out from April 2020 to June 2020 with full regard for health and safety. They were short and targeted, using specific COVID-19 relevant assessment criteria. The criteria, including some areas of interest under each criterion, can be found in Appendix 2.

5 A national emergency was also declared on 25 March 2020 at 12:21pm and was extended six times. The state of national emergency ended on 13 May 2020 at 12:21pm. It was replaced with a National Transitional Period to support a transition from response into the initial recovery phase. New Zealand was in Alert Level 3 for 48 hours from 23 March 2020, with the move to Alert Level 4 occurring at 11:59pm on 25 March 2020. The Government announced that New Zealand would move back to Alert Level 3 at 11:59pm on Monday 27 April 2020, for a period of two weeks. New Zealand then moved to Alert Level 2 at 11:59pm on 11 May 2020 and to Alert Level 1 at 11:59pm on 8 June 2020

6 The alert level system was designed to help the public to understand what public health and social measures are in place at any time. Levels have been applied in conjunction with specific response legislation and public health orders made by the Director-General of Health. Levels can be applied to a town, city, region, or the country as a whole. An overview of the Alert Level system and the implications of each Alert Level is at Appendix 1.

7 See https://uniteforrecovery.govt.nz/assets/resources/legislation-and-key-documents/COVID-19-national-action-plan-2-issued-1-April.pdf for more information about essential services during the Alert Level 4 'lockdown'.

8 My plan remains to commence full inspections of aged care Facilities from July 2021. See https://www.ombudsman.parliament.nz/what-we-can-help/aged-care-monitoring for more information about my designation to inspect privately-run as well as public secure aged care Facilities, the development of my planned programme, and my COVID-19 inspection programme.

The first OPCAT COVID-19 inspections of six secure privately-run aged care facilities[9] were undertaken between 17 April and 8 May 2020, when the country was under Alert Levels 4 and 3 (also referred to in this report as 'lockdown').[10] I published thematic findings, suggestions and recommendations from those inspections on 18 August 2020.[11]

This is the second thematic report following further OPCAT COVID-19 inspections of secure aged care Facilities (the Facilities) between 27 May and 18 June 2020, during Alert Levels 2 and 1.[12]

Engagement with the aged care sector

In early April 2020, I informed the Prime Minister, the Associate Minister of Health, the Minister for Seniors, and the Ministry of Health, of my expectations regarding the treatment and conditions of people detained in health and disability facilities during the pandemic.[13] I advised that I intended to inspect those places, including privately-run secure aged care facilities.[14] I shared my extensive health and safety policy and planning with them. I also confirmed all inspections would be announced in advance, to ensure proper health and safety arrangements could be made. All were supportive of my approach.

I also informed the District Health Boards (DHBs) and representatives of the aged care sector of my intentions. I received varied responses, with some organisations, such as Alzheimers New Zealand, welcoming my inspections, and some, such as the New Zealand Aged Care Association,[15] highlighting concerns associated with my Inspectors entering these Facilities. Concerns included the potential for my Inspectors to spread infection, and the perceived burden my inspections could place on already stressed staff during Alert Levels 4 and 3. I was aware that the New Zealand Aged Care Association had written to the Prime Minister on 10 March 2020, asking the Government to suspend my powers to inspect aged care facilities. I note that my legal authority includes reporting to Parliament on how facilities were responding to COVID-19 and treating this particular at-risk group of aged care residents.

Facilities inspected at Alert Levels 2 and 1 expressed less trepidation at my Inspectors visits than those Facilities inspected at Alert Levels 4 and 3,[16] particularly as restrictions on other visitors had lessened under Alert Levels 2 and 1. Nonetheless, Facilities still had robust procedures on entry. My Inspectors took care to maintain a cautionary approach, and wore required PPE and observed physical distancing. My staff were professionally received at all inspections.

9 The Chief Ombudsman inspects aged care facilities where residents are unable to 'leave at will'.

10 See Appendix 1 for more about New Zealand's COVID-19 alert system.

11 OPCAT COVID-19 report: Report on inspections of aged care facilities under the Crimes of Torture Act 1989: https://www.ombudsman.parliament.nz/resources/opcat-covid-19-report-report-inspections-aged-care-facilities-under-crimes-torture-act

12 See Appendix 1 for more about New Zealand's COVID-19 alert system.

13 See Chief Ombudsman's Statement of Principles: https://www.ombudsman.parliament.nz/resources/opcat-inspections-and-visits-during-covid-19-pandemic-update-and-statement-principles.

14 The Chief Ombudsman inspects aged care facilities where residents are unable to 'leave at will'.

15 In a letter dated 16 April 2020.

16 OPCAT COVID-19 report: Report on inspections of aged care facilities under the Crimes of Torture Act 1989: https://www.ombudsman.parliament.nz/resources/opcat-covid-19-report-report-inspections-aged-care-facilities-under-crimes-torture-act

I am pleased to report that I received warm feedback from the Facility managers and their staff on site about their experience of the inspections. Many of the families whose loved ones were detained there also responded positively.

Outcome of inspections at Alert Levels 2 and 1

Although restrictions were lifted for the public under Alert Levels 2 and 1, residents in secure aged care facilities were still subject to restrictions, including limits on visitors. I used the same criteria for these inspections as was used for the inspections discussed in my first thematic report on inspections of secure aged care facilities during COVID-19.[17] Recommendations in my first report were all COVID-19 related, perhaps reflecting the higher Alert Levels Facilities were operating under. By comparison, the main issues I encountered and made recommendations on in this second thematic report concerned health and safety. I also made three recommendations on staffing levels.

These inspections enabled me to provide effective independent oversight for Parliament and the New Zealand public as to how vulnerable people, who were detained during those unprecedented times, were being treated. My impartial monitoring of these places provides Parliament and the New Zealand public with reassurance about two areas in particular – that the Facilities were working hard to prevent the virus spreading to those most at risk, and that steps were being taken to ensure the protection of residents' human rights.

I have decided not to name the individual Facilities inspected as the preventive objectives of OPCAT do not require it in this particular context.[18] The inspections, and this report, are not intended to rank Facilities against each another. The inspections were intended to give insight into how the sector was managing as a whole, and to provide feedback to the individual Facilities inspected to improve treatment and conditions.

While firm action to respond to COVID-19 and to keep people safe from the virus is necessary, extraordinary measures must not have an unnecessary or disproportionate impact on people's rights. It is important to note that human rights are inalienable; even during these extraordinary times people can expect to be treated with care and respect.

17 OPCAT COVID-19 report: Report on inspections of aged care facilities under the Crimes of Torture Act 1989: https://www.ombudsman.parliament.nz/resources/opcat-covid-19-report-report-inspections-aged-care-facilities-under-crimes-torture-act

18 Section 33(2) Crimes of Torture Act 1989 refers.

Executive summary

This thematic report outlines my key findings, suggestions, and recommendations in relation to OPCAT COVID-19 inspections of six secure aged care Facilities (the Facilities) between 27 May and 18 June 2020 (during Alert Levels 2 and 1).

I am empowered by section 27 of the Crimes of Torture Act 1989 to make recommendations for improving the conditions and treatment of detention and for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention. In some instances, where a statutory recommendation was not required, I made suggestions to Facilities for improving conditions and treatment. The Facilities were provided with an opportunity to comment on my findings, suggestions, and recommendations.

My recommendations and suggestions may provide useful insights for secure aged care facilities throughout the country, as may the areas of good practice I identified – where the human rights of people detained in secure aged care Facilities were supported and respected.

I made nine recommendations across four Facilities, and 23 suggestions across all six Facilities.

Health and safety

Six of my nine recommendations related to health and safety. Overall, I found Facilities provided an adequate level of health care, and safe and hygienic physical environments for residents. However, I had concerns about restraint use.[19] I expect Facilities to work towards minimising restraint. I was pleased that following issues raised in my provisional report, one Facility put in place an electronic restraint monitoring process to ensure comprehensive documentation for each episode of restraint. I made one recommendation regarding restraint.[20]

I found that Facilities had plans for infection control to respond to the risk of COVID-19. However, in one Facility, staff did not appear to be aware of or knowledgeable about guidance and plans to manage suspected, probable, or confirmed cases of COVID-19. I also found one Facility had not kept thorough records of COVID-19 tests performed on residents. I made recommendations on these two issues.

I also made eight suggestions in this area, concerning improvements to the physical environment, independent access to healthy snacks and drinks, the provision of activities in a timely manner, the clear definition of 'bubbles', and regular checks that residents were freely able to access secure outside areas.

19 Restraint involves using personal, physical, or environmental methods to restrain a person who is at risk of harming themself or others. See the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2 at https://www.standards.govt.nz/shop/nzs-8134-22008/.

20 The same recommendation was made to two different Facilities.

Contact with the outside world

Facilities were using innovative strategies to connect residents with loved ones and the wider community, despite the continued limits on visits under Alert Level 2. These included connecting with the local community via an activity board on a Facility's gates, and inviting an organist to perform in a Facility's carpark. Most Facilities required visitors to book before visiting, even at Alert Level 1. However, I was pleased that Facilities reported they would accommodate visitors if they arrived unannounced, or needed to visit a loved one in exceptional circumstances, such as when they were undergoing palliative care.

Several Facilities had adopted virtual communication methods during Alert Levels 4 and 3, and were continuing to use them under Alert Level 2, even with the resumption of visits. I made no recommendations under this criterion, and two suggestions related to internal and external activities provided for residents.

Dignity and respect

Overall, my Inspectors observed staff treating residents with dignity and respect, apart from an isolated instance. Openness to communicate with residents and provide information about COVID-19 is an important part of respecting residents' dignity. I found the Facilities used a range of strategies to engage with residents about the pandemic, including resident meetings, visual aids, written updates, and/or conversations with residents to explain why staff were wearing masks or why there were no visitors.

I was pleased that all Facilities showed good understanding of the communication needs of disabled residents, such as those with hearing impairments and mobility needs. However, several Facilities were not able to discuss with confidence how they met residents' cultural needs, including the needs of Māori residents.

I was pleased to learn that Facilities had made efforts to facilitate residents' access to their faith practices despite the COVID-19 restrictions.

I made no recommendations under this criterion, but made six suggestions.

Protective measures

Protective measures, like complaints processes, are safeguards against ill-treatment and are of particular importance when there are increased restrictions within an aged care facility. Residents should have safe and accessible ways to raise concerns and complaints and have them considered and responded to. Although I did not make any recommendations related to protective measures, I found the majority of Facilities had gaps in their systems for handling residents' complaints and I made suggestions for improvement. I made six suggestions to address this issue.

Staffing

Facility staff demonstrated resilience during this unprecedented, stressful time. Inspectors observed staff interacting warmly with residents and finding ways to emulate 'normal life' within the Facilities. Staff also took extra measures, like shopping for personal items for residents to mitigate the impact of COVID-19 related restrictions.

Inspectors observed good rapport between staff and management, and encountered managers who were empathetic to the stresses faced by staff working in the aged care environment during the pandemic. In individual interviews, staff at all six Facilities said they had felt well-supported by management, and had received clear communication. Several Facilities provided specific training related to the COVID-19 pandemic.

However, I found several Facilities did not have sufficient staff to provide the necessary services to residents. Therefore, I made three recommendations about staffing, and one suggestion.

Inspection methodology

My Inspectors conducted six inspections of secure aged care facilities in Hastings, Whanganui, Palmerston North, and Nelson, located in the Hawke's Bay, Whanganui, MidCentral, and Nelson Marlborough District Health Board regions.

When choosing where to inspect, I selected a small sample of secure aged care facilities that provide dementia and psychogeriatric care beds. I chose facilities across different geographic regions and facilities of different sizes. The Facilities ranged from a single unit of 22 beds to a two-unit Facility with 64 beds.

Each inspection was carried out by a team of three Inspectors (the Teams). The inspections each lasted around three hours, which included speaking to managers and staff, and touring the Facility. These inspections were longer than those my Team conducted in Alert Levels 4 and 3 (around two hours).

Inspectors wore personal protective equipment (PPE) to conduct the inspections.[21]

Each Facility was given advance notice of the inspection. At the point of announcing the inspection, information about the Facility was requested, including health and safety policies, COVID-19 and pandemic plans, and information about the daily running of the Facility.

My Teams spoke to some staff by telephone after the physical inspections. An online survey was sent to residents' 'points of contact'[22] from each Facility to hear about their experience of staying in touch with residents and communicating with the Facilities during Alert Levels 2 and 1.

Each Facility inspected was provided with a copy of my Provisional COVID-19 aged care thematic report and invited to comment. I did not receive any comments to include in my final report.

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21 Inspectors were supplied with disposable masks, gloves, aprons, and shoe covers by the Office of the Ombudsman and wore any other PPE as agreed with the Facility at the time of inspection.

22 The person or people the Facility contacts on matters concerning the resident. This might include, for example, a friend or whānau member with enduring power of attorney.

Key observations

Health and safety

My inspections considered whether the conditions and treatment provided by the Facilities ensured the health and safety of residents, particularly regarding COVID-19. Transmission of the highly infectious COVID-19 virus is difficult to control if it enters an aged care facility. I considered whether Facilities had appropriate planning and procedures in place to protect residents from COVID-19. This included pandemic planning, access to handwashing and hygiene facilities, and an appropriate level of cleaning and sanitation within the Facility. My Teams also looked to see if residents' other health needs were respected and they continued to have access to fresh air, nutritious meals, drinking water, and general medical care. Six of my nine recommendations concerned health and safety.

Preparedness for a COVID-19 case

None of the Facilities visited had experienced a COVID-19 case. I was satisfied, though, that the majority had policies, procedures and plans in place to respond to such an occurrence.

However, one Facility did not appear to be fully prepared to manage a COVID-19 case. The Facility did not have a 'ready-to-go' plan for handling a case. Rather, if a resident had showed symptoms of COVID-19, the Facility said it would have sought DHB advice, and potentially tried to isolate the person and get them tested for COVID-19. Inspectors were provided documentation that indicated the existence of a COVID-19 Outbreak Management Plan at the Facility. However, staff, including managers, did not reference or seem aware of it. **I recommended all staff (particularly those with management responsibilities) are aware of and knowledgeable about guidance and plans to manage suspected, probable, or confirmed cases of COVID-19.**

Isolation of residents

Facilities had varied processes and policies for isolating residents with suspected or confirmed cases of COVID-19. Some Facilities had isolated residents during Alert Levels 3 and 4 to manage suspected or confirmed cases of COVID-19. However, there were no residents in isolation for these reasons at the time of inspection in any of the inspected Facilities.

One Facility reported it had placed two residents into isolation in their bedrooms after they developed symptoms consistent with COVID-19. Both were tested and subsequently returned a negative result. However, I was concerned that those residents were not permitted to leave their room during the period of isolation. The Facility's policy at the time of the inspection considered the health and well-being of residents in isolation, and included direction about facilitating contact with whānau, keeping whānau updated, and providing appropriate activities to residents in isolation. However, it did not provide for residents to spend time outside their bedroom. In my provisional report, I raised the issue that COVID-19 guidelines on isolation should expressly include offering, and facilitating, if desired by the resident, time outside of the bedroom at least daily. I was pleased that in responding to my provisional report, the Facility advised that they had updated their guidelines to include residents being

supported to spend a period of time outside of their room daily, if desired, with a support person. I consider this response balances the need to reduce the risk of infection with the importance of facilitating time outside of the bedroom daily for residents.

Another Facility reported it had isolated two residents, and ensured they were escorted to the outside courtyard area daily.

A third Facility had not isolated any residents but had a Wellness Response Plan that proposed to isolate residents in their bedrooms to respond to a potential, suspected, or confirmed case of COVID-19. However, the Wellness Response Plan did not consider the impact of isolation on a resident's wellbeing. **I suggested that the Facility's Wellness Response Plan is updated to consider the risks to wellbeing posed to residents in isolation. This should include recognition of the need for time outside of the bedroom, as well as access to meaningful human contact and engaging activities.** The Facility informed my Team it intended to consider including the needs of residents who are in isolation in the next edition of its Wellness Response Plan.

Use of restraint

Facilities took varied approaches to the use of restraint. I was pleased that one Facility advised they were 'restraint-free'. Restraint should only be used as a last resort after all other options have been exhausted, and only when essential for the safety of the resident or others.

Although one Facility used three types of restraint (soft lap belts, chair/table restraints,[23] and bed rails), it advised it attempts least restrictive means before considering restraint. For instance, the Facility advised that staff walk hand in hand with a resident in lieu of using a lap belt. **I recommended that the Facility continue to work towards minimising restraint.**

Documentation about restraint use at one Facility contained minimal information. **I recommended that assessment and use of restraint documentation be thorough. Documentation for each incident of restraint use should include information such as, but not limited to, the reasons for initiating the restraint, the duration of use, monitoring of resident wellbeing during use, any views expressed by the resident (verbally or through body language) and the outcome of the use of restraint.**

In another Facility, two residents had 'restraint/enablers' already authorised as part of their general care plan. My Inspectors were told that the chair brief restraint was being used to assist with the management of isolation, to help keep isolated residents in their room. However, the Facility subsequently clarified that the implementation of safety restraint for these two residents was a component of their ongoing care plan, not an isolation management strategy. I was reassured to hear this, as any form of restraint as a way of ensuring a resident complies with isolation would be a matter of serious concern. I encouraged the Facility to ensure that all staff are clear about the standards that exist in New Zealand around the use of restraint.

Both residents' care plans indicated restraint should not be used for more than two hours at a time. Inspectors reviewed records showing the use of restraint for the two weeks prior to the inspection (which was not the period that they were in isolation), which indicated restraint had

23 A soft lap belt is a padded lap restraint belt. Chair and table restraints are used to make an individual remain seated in one place to prevent injury and harm to themselves or others. See the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2 at https://www.standards.govt.nz/shop/nzs-8134-22008/.

been used on both residents during this period. Records showed that for one resident the chair brief restraint was used several times every day; frequently for the maximum two hours. On one occasion, restraint was recorded as being used for more than two hours despite this being the maximum time the individual resident's general care plan advised they should be in the chair brief restraint.

For the second resident, restraint was used on two days out of the two weeks Inspectors reviewed. On one of those days the restraint was put on and taken off at least eight times, frequently for the maximum two hours. The resident spent over 11 hours in a chair brief restraint between 9.30am and midnight. For both residents, there was often a matter of minutes between the restraint being taken off and put back in place. I raised serious concerns about this practice.

The Facility provided a comprehensive response to my concerns, including the rationale for restraining the two residents. I have been informed that a recent review of one of these residents has resulted in restraint use being discontinued, and restraint use has been *'progressively reduced'* over the past six months for the other resident.

The appropriate use of restraint is critically important in my consideration of the conditions and treatment of residents under the OPCAT. The Facility's response indicates that my concerns have been taken seriously, and the Facility said they have already implemented improvements in reporting frameworks with restraint. **I recommended the Facility continue to work towards minimising restraint.** The Facility has further advised that restraint minimisation is a focus for them, and there has been no use of restraint in its special care unit for the last two months.

I also raised concerns with this Facility that, of the records viewed, there was minimal recording of the rationale for the use of restraint, or well-being of the resident while restrained. The times recorded on restraint forms also appeared to be approximated. In order for restraint documentation to be thorough, I raised in my provisional report that documentation for each episode of restraint should be completed comprehensively and include information such as, but not limited to:

- the less restrictive measures that have been attempted before each episode of restraint;
- the reasons for initiating the restraint;
- the duration of use;
- monitoring of resident wellbeing during use;
- any views expressed by the resident (verbally or through body language); and
- the outcome of the use of restraint.

In responding to my provisional report, the Facility acknowledged the importance of documentation of each of the above factors in relation to any episode of restraint. The Facility said it had put in place a new electronic restraint monitoring process that includes all of the above information to ensure comprehensive documentation for each episode of restraint. I am pleased to learn this.

Adequate facility environment

Facilities were generally clean and comfortable for residents. Facilities provided opportunities for residents to personalise their own rooms. One Facility displayed a 'map of life' on residents' bedroom walls that outlined their hobbies, family, and previous employment.

However, one Facility had challenges in providing a homely environment. Parts of the Facility required significant maintenance. There were missing and dirty light fittings, peeling wallpaper, and a cracked bathroom window. A number of residents' beds appeared old and had wire bases and tubular steel framing.[24] The Facility Manager did not provide details about any planned maintenance or upgrades to the Facility**. I suggested that the Facility prioritise repairs to the physical environment and beds to ensure residents were living in comfortable conditions.** My Inspectors have subsequently been advised that all maintenance has now been completed. I am pleased to hear this.

Attention to postural care

At one Facility, residents had fallen asleep in communal areas without first being made comfortable. In particular, one resident was asleep in a dining chair at a table, with their neck bent forward at a significant angle. Inspectors raised this issue with staff and managers during the inspection and they acknowledged that the sleeping position was not ideal. No clinical information was provided at the time or subsequently that alleviated my concern. While it is positive that residents can sleep in areas other than their bedrooms, I am particularly mindful of the importance of good postural care. Therefore, **I recommended that residents are aided to rest or sleep in positions which are safe and comfortable.** Similar observations were made at other Facilities, but this instance was significant enough for me to make a recommendation.

Access to handwashing and hygiene facilities

Hand hygiene and washing facilities were readily available for staff and residents in the majority of Facilities, including wall-mounted hand sanitisation stations. It was positive to see one Facility had considered residents' different hand hygiene needs and provided hand wipes for those who would have had difficulty using hand sanitiser.

Cleaning standards and regimes

Facilities had enhanced their cleaning regimes in response to the COVID-19 pandemic, including by taking measures like employing an additional cleaner, contracting an antimicrobial protection service, and/or changing their cleaning products. Several Facilities had increased the regularity of cleaning of 'high-touch areas', such as handrails and door keypads.

The smell of urine was evident in two Facilities. I consider it unsanitary and unpleasant for residents to live in homes where urine permeates the carpet. **I suggested to one Facility that it remove the carpet and underlay as soon as practicable and replace it with a form of**

24 Inspectors observed that tubular beds have a wire base which can make it difficult and unsafe for a resident to get in and out of bed, particularly if the resident has mobility issues.

flooring that does not easily allow urine to permeate. The second Facility did not have a carpet cleaning schedule and, instead, used a Rug Doctor 'as required'. **I suggested that the Facility regularly and proactively ensures carpets are kept clean and free from odour.**

Observation of physical distancing

Most Facilities made an effort to maintain physical distancing[25] and minimise unnecessary physical contact between staff and residents, and between residents.

Integrity of 'bubbles'

While my inspections took place under Alert Levels 2 and 1, my Inspectors examined how Facilities had used the 'bubble' strategy during Alert Levels 4 and 3. My understanding is that a 'bubble' constitutes a defined, contained space or group of people.[26] The definition and integrity of a 'bubble' is of paramount importance. I considered it essential that Facilities clearly communicated to residents, whānau and staff, who was able to come in and out of certain areas, and when PPE was required.

Several Facilities had well-defined 'bubbles' during Alert Levels 4 and 3, but some did not. One Facility had attempted to demarcate their two separate units as separate 'bubbles' by preventing staff movement between units, and requiring Registered Nurses (RN) and managers to wear personal protective equipment (PPE) if they had to move between units. However, all staff used the same staff room, and were entering and leaving through the same reception areas without using PPE. The integrity of the two-bubble system was therefore compromised and I considered the whole Facility was actually a single bubble.

Similarly, although movement between Units was reduced compared with pre-COVID times, another Facility did not require staff to wear PPE when covering staff absences in the other Unit. Therefore, the whole Facility appeared to be one bubble. **I suggested the Facility ensure the size and integrity of its 'bubble' was well defined, and there was clear and consistent communication about 'bubble' practice during the pandemic.**

The entry and exit procedures in the Facilities visited at Alert Level 2 were generally robust. At one Facility, staff were required to change into and out of their uniform at work, and complete a health declaration and a temperature check at the beginning of each shift. Visitors were met at the gate to the site, their details were taken, and a temperature check conducted. At the site reception, further details were taken and all visitors were provided with PPE before they entered the Facility. My Inspectors observed visitors entering the Facility, and noted that the entry procedures were followed consistently, including whānau being required to wear face masks while on site.

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25 At Alert Levels 2 and above the Ministry of Health recommends physical distancing of two metres outside home or one metre in controlled environments like schools and workplaces. See: https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf

26 'Bubble' is a term used by the New Zealand Government to communicate the social distancing requirements of Alert Level 4 and 3. A 'bubble' in an aged residential care (ARC) setting is made up of all the people in the ARC Facility at 'lockdown'. This includes ARC staff and residents. See: https://www.health.govt.nz/system/files/documents/publications/independent-review-covid-19-clusters-aged-residential-care-Facilities-may20.pdf.

Personal protective equipment practices

PPE practices during Alert Level 2 varied across Facilities. At several Facilities, staff were not routinely wearing masks and were only required to wear one when providing personal care[27] to residents. One Facility required staff, at the end of each shift, to record which residents they had had physical contact with. Staff at one Facility reported that wearing PPE had not had an adverse impact on their ability to care for residents.

Testing residents for COVID-19

Most Facilities had carried out a small number of COVID-19 tests of residents since Alert Level 4 began. I was pleased to see Facilities taking steps to uphold residents' dignity in what could be a distressing or traumatic experience. At one Facility, records showed three clinical staff members were present during a resident's test, one of whom held the resident's hand during the procedure. Another Facility gave residents the option of sitting or lying down for the test, and was able to provide a throat swab for a resident who did not agree to a nasal swab. I am pleased these Facilities adopted residents' preferences in COVID-19 testing. Whānau (or preferred points of contact) were contacted.

However, management at one Facility could not tell my Inspectors the exact numbers of COVID-19 tests that had taken place, and were unsure what information was given to residents prior to the tests taking place or whether residents had had a nasal swab, throat swab, or both. Medical records for two COVID-19 nasal swab tests were later provided to my Team. However, these records did not detail information about consent sought, information shared, who was present during the test or how the residents responded to testing. **I recommended thorough records are kept regarding significant medical events, such as COVID-19 testing. This would include information such as who conducted the test and what information was provided to the resident and resident's point of contact, including consent to treatment.**

Another Facility was able to confirm how many tests had been performed, but care records on those tests included limited detail. The records showed a General Practitioner had been present when residents were tested for COVID-19, but had no further details of how the test was carried out, who else was present, what information was provided to (and asked of) the resident, or how the resident responded to the test. From the information available it appeared COVID-19 testing took place in an appropriate manner. To this Facility, **I suggested that thorough records are kept regarding significant medical events, such as COVID-19 testing. This would include information such as who conducted the test and what information was provided to the resident and resident's point of contact, including consent to treatment.**[28] The Facility agreed that though their policy was followed, documentation around it could have been more detailed.

All residents tested for COVID-19 at the inspected Facilities returned a negative result.

27 Personal care involves providing assistance with a resident's personal hygiene eg, washing, showering, bathing, dressing, feeding, and toileting.

28 In this instance, this was a suggestion, rather than a recommendation.

Access to the outdoors

I was pleased that several Facilities had external courtyard areas with accessible paths and spaces for residents to walk and rest. Inspectors observed residents freely accessing outdoor areas at one Facility. Several Facilities had also facilitated residents to take walks nearby the Facility at all COVID-19 Alert Levels, by providing staff members to accompany them. In another Facility, residents could go outside whenever they desired and a sensory light had been installed to aid them at night. One Facility also provided an environment where residents could develop connections with animals, and my Team observed cats, dogs, and chickens on the premises during their inspection. Staff reported residents at that Facility had particularly enjoyed the presence of pets during the 'lockdown'. I am pleased that these Facilities prioritised the needs and wishes of residents, and maintained access to fresh air and exercise.

However, at several Facilities, residents' access to the outdoors was restricted by locked doors. Free access to the outdoors is particularly important in light of COVID-19 restrictions, with residents leaving the Facility less frequently. **I suggested that all doors to secure outside areas are kept unlocked, and that this is regularly checked by Facility staff.**

Access to drinking water and snacks

Several Facilities did not provide unrestricted access to snacks or water for residents. For example, although one Facility had kitchenette areas, there were no glasses next to the sink, and snacks were stored in the cupboard – meaning that residents would need to ask a caregiver for access. In these instances, **I suggested that the Facility enables residents to independently access drinking water and healthy snacks at all times.**

Contact with the outside world

Contact with the outside world is beneficial for residents' health and well-being and is an essential safeguard against ill-treatment. Restricting visitor access was one of the most significant changes for aged care facilities under the COVID-19 Alert Levels. I observed that Facilities were using innovative alternative methods to connect residents with the outside world. I made no recommendations in this area, but made two suggestions, which are discussed in the next section.

Provision of activities inside and outside the Facility

External activities are important for residents' wellbeing and connectedness. Facilities took different approaches to resuming external activities during Alert Levels 2 and 1. Only one Facility allowed residents to exit the Facility with whānau at Alert Level 2, and asked whānau to be cautious about residents going to public places where they may be more at risk of picking up infection. To support this practice, **I suggested that clear re-entry procedures are in place when residents return to the Facility to minimise any risk of COVID-19 entering the Facility.**

Of the four Facilities visited at Alert Level 2, three had not resumed external activities such as van trips. One Facility reported managers were considering re-implementing trips outside

of the site. One Facility had resumed van trips, but informed my Team that residents would remain in the van and the focus would be on sightseeing. I consider that this approach balanced the potential risk of COVID-19 to the residents, and the importance of reintroducing external activities that residents missed during earlier stages of lockdown. Both Facilities visited under Alert Level 1 had resumed external activities.

Facilities informed my Team they had enhanced their internal activities rosters during the pandemic. One Facility had made positive efforts to maintain connections with the local community by displaying an activity board to passers-by. One Facility had found novel ways to provide entertainment for residents during the COVID-19 pandemic, including having an organist perform in the car park so that residents could watch or listen from inside the Facility or from a safe distance in the car park.

At another Facility, residents were sitting unoccupied in communal areas with seemingly little to do. An activity schedule indicated an exercise activity was scheduled, but this was not happening. When my Inspectors asked about this, staff began preparing for the exercise class. When I raised this with the Facility, they indicated that sometimes flexibility in timing of activities is important in the care of residents with cognitive impairment. **I suggested that unless there is a reason for delaying an activity, the Facility ensures it takes place on time and that priority is given to providing meaningful, engaging activities for residents.** The Facility let me know they intend to reinforce with all staff the importance of ensuring times are adhered to.

Visitor policies

Compared to Alert Levels 4 and 3, there were fewer restrictions on visitors in the inspected Facilities during Alert Levels 2 and 1. However, policies varied across Facilities. Most Facilities required visitors to book before visiting. However, one Facility informed Inspectors that if a resident's visitor arrived without an appointment they would try and facilitate the visit if possible. Several Facilities imposed a limit of only one visit to each resident per day during Alert Level 2, with some Facilities further restricting these visits to thirty minutes.

Managers and staff told my Team that residents had been more unsettled by an absence of visitors. Some residents had expressed anxiety and were concerned about whether loved ones were safe and well. A survey of whānau members indicated that some residents felt 'abandoned' or lost weight.

New approaches to communication

I am pleased that all Facilities had increased the range of communication methods accessible to residents to mitigate the effect of visitor restrictions on residents. Staff had helped residents use virtual communication (such as Zoom, Skype, FaceTime and Google Hangouts), and make telephone calls, alongside other communication methods like sending emails, photographs, and letters. One Facility provided electronic tablets in each resident's bedroom, with Zoom installed. Tablets were, however, primarily a tool for staff, who used them to update residents' records while with them in their bedroom. Residents were not able to use the tablets without staff present.

Results of surveys with whānau showed that the majority of residents' families were satisfied with the level of contact they had with residents during the 'lockdown'. Virtual communication methods had still been used at Alert Level 2, even with the resumption of whānau visits. Some Facility staff stated that residents did not respond in the same way to virtual communication as to in-person visits of their whānau. However, other staff described the use of digital communication as positive, and as a tool to strengthen communication with loved ones. I welcome any such learnings which may positively impact the conditions and treatment of residents in secure dementia facilities.

Allowing visitors in exceptional circumstances

I was pleased to learn that several Facilities had allowed visitors in exceptional circumstances during Alert Levels 4 and 3. For instance, whānau of residents undergoing palliative care were permitted to enter one Facility. The resident and whānau were designated a specific bedroom and supplied with PPE. The bedroom was sanitised after each visit. Another Facility allowed the whānau of a new resident to enter the Facility, wearing PPE, to help settle in the resident. In another case, a Priest was also able to visit the Facility when a resident became significantly unwell. I commend Facilities for ensuring that residents could receive compassionate visits in a safe manner, despite the COVID-19 restrictions.

Dignity and respect

Residents in secure dementia facilities must be treated with dignity, respect and compassion, regardless of COVID-19 or any other emergency. This includes meeting residents' particular disability, cultural and spiritual needs, and keeping residents informed about COVID-19 and its impact on their routines. Overall, my Team observed warm interactions between staff and residents, and attempts to emulate 'normal life' within the Facilities. Staff also took extra measures, like doing shopping for residents to get personal items, to mitigate the impact of COVID-19 related restrictions. I generally found residents were treated with dignity and respect.

Communication about COVID-19

Openness to communicate with residents and provide information about COVID-19 is an important way of respecting residents' dignity. Facilities used a range of strategies to engage with residents about the pandemic. These included resident meetings, visual aids, written updates, and/or conversations with residents to explain why staff were wearing masks or why there were no visitors. Some Facilities provided more information, including written updates, to residents who displayed interest, for instance those with medical backgrounds. I was pleased that Facilities took individualised approaches to sharing COVID-19 information with residents and were willing to repeat messages as necessary.

However, at one Facility, respondents to a point of contact survey were not certain that the residents had been kept informed about changes to their care and routine, with more than half neither *'agreeing nor disagreeing'* or responding *'don't know'* when asked whether they agreed residents were kept informed. **I suggested that the Facility takes a more proactive approach to communicating with residents about issues that affect them, such as the changes to their routine as a result of COVID-19.**

Respecting residents' voices

People with dementia have the same right to be heard and respected as anyone else. I was pleased to see one Facility made sure residents' voices were heard by hosting bi-monthly meetings with residents, staff, and whānau about residents' ongoing needs.

However, during one inspection, my Team witnessed a staff member addressing a resident in a manner that did not demonstrate dignity and respect, within earshot of other residents and staff in the lounge area. **I suggested that staff speak to all residents in a respectful manner. Any conversations which may be embarrassing to the resident should be done in private.** The Facility has responded saying it was embarrassed and surprised to read these comments, and this is not typical of staff behaviour. It has advised that this will be followed up as it is not acceptable behaviour at any time. I am pleased similar behaviour was not observed at other Facilities.

Disability rights

I was pleased that all Facilities showed a good understanding of the communication needs of disabled residents, such as those with hearing impairments, during the COVID-19 pandemic. Staff were supportive of residents who used hearing aids, and ensured there was always a supply of spare batteries available. Managers displayed awareness of the importance that people with hearing impairments could hear, and comprehend, COVID-19 related information. Several Facilities acknowledged that staff wearing masks presented a communication difficulty for residents with hearing impairments. At one Facility, managers described how staff could move two metres away in order to remove their mask and communicate, but also used body language, signage, and had a whiteboard to write down messages for residents.

All inspected Facilities were also physically accessible, which allowed residents (many of whom had mobility needs) to move about freely and go outside. The potential for residents, in particular those with disabilities, to feel isolated or confused was exacerbated by COVID-19 restrictions. I welcome the thought that had been given to adapting to these challenges.

Cultural responsiveness

Several Facilities were not able to discuss with confidence how they met residents' cultural needs. In particular, they did not know important information such as whether residents spoke te Reo, or their iwi affiliations, and did not seek to record this information as part of a resident's care plan. One Facility had links to a local Marae and had planned a Matariki week celebration, which I considered positive examples of fostering te Ao Māori. However, it did not appear the Facilities had considered how to meet residents' cultural needs in every-day care. **I suggested one Facility ensure that the individual cultural needs of residents are carefully considered and responded to, including during times of change and crises such as COVID-19.** To another Facility, **I suggested more is done to understand and respond to the cultural needs of the Facility's Māori residents and to integrate and reflect te Ao Māori in a broader sense throughout the Facility.**

One Facility took a flexible approach to accommodating residents' various cultural and religious needs during 'lockdown'. The Facility provided ingredients to one resident's family to prepare their meals off-site in a culturally appropriate manner, then deliver them to the resident. I congratulated the Facility for this practice.

Spiritual responsiveness

I was pleased to learn that Facilities had made efforts to facilitate residents' access to faith practices, despite the COVID-19 restrictions. Primarily these were Christian practices. Although Chaplains and Ministers were generally not able to visit during Alert Levels 4 and 3, Facilities had conducted Zoom services or played video messages from Anglican and Catholic ministers. One Facility had offered residents the opportunity to speak to a Chaplain over Zoom. Several Facilities had provided Easter church services for residents who wished to attend. One Facility had hosted an Easter service and replicated a church environment by laying out chairs and giving service handouts to residents. Another Facility read verses of the Bible to residents, or talked to them about their beliefs.

In-person visits from Chaplains resumed under Alert Level 2 in some Facilities. Residents were able to attend church in the community again in one Facility visited at Alert Level 1. However, another Facility had not reinstated residents' access to weekly Catholic church services or monthly interdenominational services, or made alternative arrangements. **I suggested that plans are made and implemented to meet the spiritual needs of residents at all Alert Levels.**

Protective measures

Protective measures, like complaints processes, are safeguards against ill-treatment and are of particular importance when there are increased restrictions within an aged care facility. Residents should have safe and accessible ways to raise concerns and complaints and have these considered and responded to. Although I did not make any recommendations related to protective measures, I found the majority of Facilities had gaps in their systems for handling residents' complaints and I made some suggestions to address those gaps.

Complaints mechanisms

It is even more important during a pandemic that residents can raise any concerns they may have, and do so confidentially. I was pleased to learn that no serious complaints had been raised at any inspected Facility since COVID-19 restrictions were in place. However, I considered some Facilities mechanisms for receiving complaints could be improved.

The majority of Facilities' complaints mechanisms appeared to be directed towards whānau or other visitors, rather than to residents themselves. This was because complaint processes generally relied on residents communicating with the Facility via whānau. Most communication with whānau during Alert levels 3 and 4 could only occur with the assistance of staff. Any concerns raised with whānau at this time were therefore not confidential. As a result, I consider that all but the most independent of residents would have required assistance to make a formal complaint during Alert Levels 4 and 3. **I suggested to one Facility that**

complaints processes are readily available and accessible for residents and their whānau, with particular consideration on how to ensure this during any restrictions related to COVID-19.

The lack of functioning complaints or suggestions boxes in several Facilities hindered residents' ability to directly raise complaints. Three Facilities did not provide complaints or suggestion boxes for residents to make complaints in writing. My Inspectors were advised that residents generally made complaints verbally, directly to staff. **I suggested that a complaint and suggestion box is installed in a common area of one Facility. I also suggested that complaints are recorded in residents' progress notes, along with information on how the Facility has managed them.** To another Facility, **I suggested the Facility install a complaint and suggestion box in a common area as one option to enable residents to express their concerns and make complaints confidentially in writing.**

The complaints and compliments boxes in one Facility were not fully functional, and staff confirmed they were not often used. **I suggested that the complaints and compliments boxes in both dining areas are appropriately labelled and residents are made aware of where they are and what they are for.** I was informed that, since the inspection, the complaints and compliments boxes have been repaired and are available to residents in each area.

Positive feedback

Compliments are also an important indicator of the treatment and conditions of residents in a facility. Several Facilities highlighted they had received a number of commendations from whānau since COVID-19 restrictions had been in pace. Facilities can be proud of the positive feedback they have received during this challenging time.

Information about residents' rights

Not all Facilities displayed the Health and Disability Commissioner's (HDC) 'Your Rights' poster in a way that was accessible to residents. For instance, at one Facility, an HDC 'Your rights' poster was displayed in English and te Reo. However, it was placed in a corridor before the entrance into the Facility and so could not be readily or freely seen by residents. There were no signs visible about complaint processes or residents' rights processes in areas of the Facility where residents could access this information. My Inspectors raised this with staff, who accepted the suggestion to move the HDC poster to a location where it would be accessible and easily visible for residents. **I also suggested to another Facility that visual or written information about residents' rights, such as the Health and Disability Commissioner's 'Your Rights' poster, be displayed in communal areas.**

Staffing

Facility staff demonstrated resilience during this unprecedented, stressful time. Inspectors observed staff interacting warmly with residents and they found ways to emulate 'normal life'. Staff also took extra measures, like shopping for residents to get personal items, to mitigate the impact of COVID-19 related restrictions.

Inspectors observed good rapport between staff and management, and encountered managers who were empathetic to the stresses faced by staff working in the aged care environment during the pandemic. In individual interviews, staff at all six Facilities confirmed they had felt well-supported by management, and had received clear communication. Several Facilities provided specific training related to the COVID-19 pandemic.

However, I found several Facilities did not have sufficient staff to provide the necessary services to residents. Therefore, I made three recommendations about staffing.

Staffing levels

One Facility had a 'cover pool' of additional staff to cover the roster and provide a safe level of care, if current staff should have to stand down. Another Facility had hired additional staff at the beginning of the pandemic. Other Facilities had not made plans to ensure sufficient staffing levels. I considered several Facilities had inadequate staffing levels to maintain a high standard of health and wellbeing for residents.

At one Facility, it appeared a number of clinical and managerial staff were performing more than one role. I was concerned these pressures prevented a high standard of care being provided for residents. **I recommended that the Facility concerned undertake a review to ensure it has adequate staff available to cover key roles and ensure the wellbeing of residents at all times.**

Another Facility had no formal contingency plan in case staff had to stand down due to COVID-19. I consider it of paramount importance that plans for ensuring adequate staffing levels are in place prior to a crisis. **I recommended that the Facility ensures it has plans in place to maintain safe and responsible staffing levels if required to stand staff down for any reason.**

Several Facilities also had low general staffing levels. At one Facility, my Inspectors observed a resident having difficulty getting up from a chair in their bedroom, and being left unassisted by staff for several minutes. **I suggested the Facility ensures it has adequate care staff covering all shifts at all times.** Another Facility only had one caregiver on-site over night shifts. I was concerned this would negatively impact residents' health and safety, including their ability to go to bed at a time of their choosing. **I recommended that the Facility reviews whether having one caregiver on a shift within a home is sufficient staffing coverage.**

COVID-19-specific training for staff

I was pleased that Facilities had instigated specific COVID-19 related training on topics such as transmission of COVID-19, cleaning, hand hygiene, using PPE and infection control. One Facility had provided training on dealing with anxiety and stress. Managers reported they had used a variety of communication methods to train and update staff, including providing written information, setting up app-based chat groups, sending letters, putting memos on noticeboards, and sending emails and phone messages. Several Facilities had also been able to continue with their normal training schedules.

Staff relationships and support

My Team observed mutual respect between managers and staff, and managers who were proud of their staff and the work they had done during this difficult time. Staff who spoke to my Team said they felt well supported by management throughout the additional stresses of working in the COVID-19 environment. Managers acknowledged staff wellbeing was a critical aspect of responding to COVID-19 restrictions and said they had used methods like maintaining an 'open door' policy to make sure they were available for staff. One Facility had appointed a 'workplace support person' who was available for staff to meet with via Zoom, and in-person at Level 1. Staff at that Facility were encouraged to 'be kind to each other' and morning teas and other initiatives were arranged in order to foster morale. Inspectors observed good rapport between managers and staff during the inspection.

Recommendations and suggestions

I am empowered by section 27 of the Crimes of Torture Act 1989 to make recommendations for improving the conditions and treatment of detention applying to residents and for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention. In some instances, where a statutory recommendation was not required, I made suggestions to Facilities for improving conditions and treatment.

As I explained above, I have decided not to name the individual Facilities inspected. However, my recommendations and suggestions may provide useful insights for secure aged care facilities throughout the country.

I made nine recommendations across four Facilities:

- the Facility continue to work towards minimising restraint;[29]
- assessment and use of restraint documentation is thorough. Documentation for each incident of restraint use should include information such as, but not limited to, the reasons for initiating the restraint, the duration of use, monitoring of resident wellbeing during use, any views expressed by the resident (verbally or through body language) and the outcome of the use of restraint;
- residents are aided to rest or sleep in positions which are safe and comfortable;
- thorough records are kept regarding significant medical events, such as COVID-19 testing. This would include information such as who conducted the test and what information was provided to the resident and resident's point of contact, including consent to treatment;
- all staff (particularly those with management responsibilities) are aware of and knowledgeable about guidance and plans to manage suspected, probable, or confirmed cases of COVID-19;
- the Facility undertake a review to ensure it has adequate staff available to cover key roles and ensure the wellbeing of residents at all times;
- the Facility ensures it has plans in place to maintain safe and responsible staffing levels if required to stand staff down for any reason; and
- the Facility reviews whether having one caregiver on shift within a home is sufficient staffing coverage.

I also made 23 suggestions across all six Facilities:

Health and safety

- the Facility prioritise repairs to the physical environment and beds to ensure residents are living in comfortable conditions;
- the Facility enables residents to independently access drinking water and healthy snacks at all times;

29 The same recommendation was made to two different Facilities.

- the Facility regularly and proactively ensures carpets are kept clean and free from odour;
- the Facility remove the carpet and underlay as soon as practicable and replace it with a form of flooring that does not easily allow urine to permeate;
- the Facility ensures the size and integrity of its 'bubble' is well-defined, and there is clear and consistent communication about 'bubble' practice during the pandemic;
- snacks and beverages are as freely available as possible for residents to access independently as desired;
- all doors to secure outside areas are kept unlocked, and that this is regularly checked by Facility staff; and
- thorough records are kept regarding significant medical events, such as COVID-19 testing. This would include information such as who conducted the test and what information was provided both to the resident and resident's point of contact, including consent to treatment.

Contact with the outside world

- clear re-entry procedures are in place when residents return from time out of the Facility to minimise any risk of COVID-19 entering the Facility; and
- unless there is a reason for delaying an activity, the Facility ensures it takes place on time and that priority is given to providing meaningful, engaging activities for residents.

Dignity and respect

- staff speak to all residents in a respectful manner. Any conversations which may be embarrassing to the resident should be done in private;
- the Facility's Wellness Response Plan is updated to consider the risks to well-being posed to residents in isolation. This should include recognition of the need for time outside of the bedroom, as well as access to meaningful human contact and engaging activities;
- plans are made and implemented to meet the spiritual needs of residents at all Alert Levels;
- more is done to understand and respond to the cultural needs of the Facility's Māori residents and to integrate and reflect te Ao Māori in a broader sense throughout the Facility;
- the Facility ensures that the individual cultural needs of residents are carefully considered and responded to, including during times of change and crises such as COVID-19; and
- the Facility takes a more proactive approach to communicating with residents on issues that affect them, such as the changes to their routine as a result of COVID-19.

Protective measures

- complaints processes are readily available and accessible for residents and their whānau, with particular consideration on how to ensure this during any restrictions related to COVID-19;
- a complaint and suggestion box is installed in a common area of the Facility;
- complaints are recorded in residents' progress notes, along with information on how the Facility has managed them;
- the complaints and compliments boxes in both dining areas are appropriately labelled and residents are made aware of where they are and what they are for;
- visual or written information about residents' rights, such as the Health and Disability Commissioner's 'Your Rights' poster, is displayed in communal resident areas; and
- the Facility install a complaint and suggestion box in a common area as one option to enable residents to express their concerns and make complaints confidentially in writing.

Staffing

- the Facility ensures it has adequate care staff covering all shifts at all times.

Acknowledgements

I am grateful to Facility staff for supporting my Inspectors in conducting their inspections. I appreciate that this is a difficult time, and am heartened by the helpful approach taken by management and staff. I acknowledge the work that would have been involved in collating the information sought by my Inspectors.

Also, thank you to the whānau around the country who have discussed difficult and personal information with my Teams.

Finally, I would like to thank my Inspectors and supporting staff for the work undertaken during this challenging period.

Peter Boshier

Chief Ombudsman

National Preventive Mechanism

Appendix 1. New Zealand COVID-19 Alert Level system

Alert Level 1 — Prepare

The disease is contained in New Zealand.

Risk assessment

- COVID-19 is uncontrolled overseas.
- Isolated household transmission could be occurring in New Zealand.

Range of measures that can be applied locally or nationally

- Border entry measures to minimise risk of importing COVID-19 cases.
- Intensive testing for COVID-19.
- Rapid contact tracing of any positive case.
- Self-isolation and quarantine required.
- Schools and workplaces open, and must operate safely.
- No restrictions on personal movement but people are encouraged to maintain a record of where they have been.
- No restrictions on gatherings but organisers encouraged to maintain records to enable contact tracing.
- Stay home if you're sick, report flu-like symptoms.
- Wash and dry your hands, cough into your elbow, don't touch your face.
- No restrictions on domestic transport — avoid public transport or travel if you're sick.
- No restrictions on workplaces or services but they are encouraged to maintain records to enable contact tracing

Alert Level 2 — Reduce

The disease is contained, but the risk of community transmission remains.

Risk assessment

- Household transmission could be occurring.
- Single or isolated cluster outbreaks.

Range of measures that can be applied locally or nationally

- People can reconnect with friends and family, and socialise in groups of up to 100, go shopping or travel domestically if following public health guidance.
- Keep physical distancing of 2 metres from people you don't know when out in public or in retail stores. Keep 1 metre physical distancing in controlled environments like workplaces, where practical.
- No more than 100 people at gatherings, including weddings, birthdays, funerals and tangihanga.
- Businesses can open to the public if following public health guidance including physical distancing and record keeping. Alternative ways of working are encouraged where possible.
- Hospitality businesses must keep groups of customers separated, seated and served by a single person.
- Maximum of 100 people at a time in a defined space.
- Sport and recreation activities are allowed, subject to conditions on gatherings, record keeping, and physical distancing where practical.
- Public venues such as museums, libraries and pools can open if they comply with public health measures and ensure 1 metre physical distancing and record keeping.
- Event Facilities, including cinemas, stadiums, concert venues and casinos can have more than 100 people at a time, provided there are no more than 100 in a defined space, and the groups do not mix.
- Health and disability care services operate as normally as possible.
- It is safe to send your children to schools, early learning services and tertiary education. There will be appropriate measures in place.
- People at higher risk of severe illness from COVID-19, for example those with underlying medical conditions, especially if not well-controlled, and older people, are encouraged to take additional precautions when leaving home. They may work if they agree with their employer that they can do so safely.

Alert Level 3 — Restrict

High risk the disease is not contained.

Risk assessment

- Community transmission might be happening.
- New clusters may emerge but can be controlled through testing and contact tracing.

Range of measures that can be applied locally or nationally

- People instructed to stay home in their bubble other than for essential personal movement — including to go to work, school if they have to or for local recreation.
- Physical distancing of 2 metres outside home including on public transport, or 1 metre in controlled environments like schools and workplaces.
- Bubbles must stay within their immediate household bubble but can expand this to reconnect with close family/whānau, or bring in caregivers or support isolated people. This extended bubble should remain exclusive.
- Schools between years 1 to 10 and Early Childhood Education centres can safely open but will have limited capacity. Children should learn at home if possible.
- People must work from home unless that is not possible.
- Businesses can open premises, but cannot physically interact with customers.
- Low-risk local recreation activities are allowed.
- Public venues are closed. This includes libraries, museums, cinemas, food courts, gyms, pools, playgrounds, markets.
- Gatherings of up to 10 people are allowed but only for wedding services, funerals and tangihanga. Physical distancing and public health measures must be maintained.
- Healthcare services use virtual, non-contact consultations where possible.
- Inter-regional travel is highly limited to, for example, essential workers, with limited exemptions for others.
- People at high risk of severe illness such as older people and those with existing medical conditions are encouraged to stay at home where possible, and take additional precautions when leaving home. They may choose to work.

Alert Level 4 — 'Lockdown'

Likely that disease is not contained.

Risk assessment

- Community transmission is occurring.
- Widespread outbreaks and new clusters.

Range of measures that can be applied locally or nationally

- People instructed to stay at home in their bubble other than for essential personal movement.
- Safe recreational activity is allowed in the local area.
- Travel is severely limited.
- All gatherings cancelled and all public venues closed.
- Businesses closed except for essential services, such as supermarkets, pharmacies, clinics, petrol stations and lifeline utilities.
- Educational Facilities closed.
- Rationing of supplies and requisitioning of Facilities possible.
- Reprioritisation of healthcare services.

Appendix 2. Criteria for OPCAT COVID-19 inspections

Criteria

An initial set of criteria has been developed to align with the Chief Ombudsman's statement of principles to guide Facilities in managing this crisis[30], while meeting New Zealand's international human rights obligations. While the type of Facility will inform the Chief Ombudsman's specific areas of interest under each criterion, some examples are listed below.

The criteria are a guide for consideration by the Chief Ombudsman's Inspectors, not a checklist or a set of rules. They are not an exhaustive list of all matters that could be relevant to the Chief Ombudsman's examination of treatment and conditions.

Health and safety

- Adequate level of cleaning/sanitation throughout all areas of the Facility.
- Access to hand washing Facilities.
- Access to bathing Facilities.
- Appropriate supplies available in order to allow residents the same level of personal hygiene as the population as a whole.
- Appropriate plans and policies for the management of suspected or confirmed cases of COVID-19, including access to medical care off-site, if needed. People in detention with suspected or confirmed cases of COVID-19 should be able to access urgent, specialised healthcare without fuss.
- Ability to be "physically distant" from people, in line with Ministry of Health guidelines.
- Access to fresh air, drinking water and nutritious meals.
- Appropriate amount of time out of the room in which they sleep.
- Ability to have meaningful human contact.
- Medical isolation should be prevented from taking the form of disciplinary solitary confinement; medical isolation must be on the basis of an independent medical evaluation, proportionate, limited in time and subject to procedural safeguards.
- During a quarantine or isolation there should be open and clear communication by management to residents, including in regard to the provision of food, drinks, sanitary items and medicine, and contact with the outside world.
- Regular medical care to those who are in need of it remains available and accessible.
- Rationing of health responses and allocation decisions are guided by human rights standards, based on clinical status and do not discriminate based on any other selection criteria, such as age, gender, ethnicity and disability.

30 The Chief Ombudsman's Statement of Principles can be found at www.ombudsman.parliament.nz/resources/opcat-inspections-and-visits-during-covid-19-pandemic-update-and-statement-principles.

Contact with the outside world

- Ability and frequency to communicate with other people outside of the Facility, such as whānau and legal advisors.
- Where visiting regimes are restricted for health-related reasons, sufficient compensatory alternative methods are provided to maintain contact with families and the outside world, for example by telephone, internet/e-mail, video communication and other appropriate digital means. Such contacts should be both facilitated and encouraged, be frequent and free.

Dignity and respect

- Treated with dignity, respect and compassion.
- Consideration is given to the particular needs of vulnerable groups, including those with disabilities.
- Information about COVID-19 has been communicated to those under the care of the Facility in sufficient regularity, depth and in a way in which can be understood. Information should be reliable, accurate and up to date, concerning all measures being taken, their duration, and the reasons for them.

Protective measures

- Mechanism to inform, receive and deal appropriately with complaints is functioning, effective, and clearly communicated to all residents and their whānau.
- Effective, proactive communication around measures being taken in respect of COVID-19, including timeframes.

Staffing

- Management are supporting and supportive of staff. Management are proactive in planning the work of members of staff during the COVID-19 pandemic, share the emergency preparedness plan, and provide support for relatives of members of staff. Specific training and equipment should be provided to all staff, and efforts to increase healthcare and hygiene provision should be prioritised.
- Sufficient staff to provide the necessary services to the number of people in the Facility and their needs.