

 **Ombudsman**

Fairness for all

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OPCAT COVID-19 report

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

August 2020
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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. 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.² On 7 January 2020, China confirmed COVID-19 (SARS-CoV-2). It had not previously been detected in humans or animals. At the time of this report being published, there had been 19.9 million confirmed cases of COVID-19 worldwide, and 732, 000 deaths, and no specific treatment or vaccination for COVID-19.

COVID-19 is spread from person to person by droplets. When an infected person coughs, sneezes, or talks, droplets containing the virus spread and can settle on surrounding surfaces or directly infect others. 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.

The way that COVID-19 spreads means that places of detention are at higher risk of an outbreak. Restrictions in place may limit the practicality of practising physical distancing and other preventative measures. Aged care facilities often house more vulnerable populations, such as those who are over 70 years old or have underlying health conditions, which place a person at greater risk of severe illness from COVID-19 infection.

New Zealand alert level system

The New Zealand Government implemented an 'alert level' system for responding to COVID-19. There are four alert levels, with Alert Level 1 being the lowest and Alert Level 4 being the highest. The alert level system was designed to help the public to understand what public

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 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).

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.

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.

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.

COVID-19 OPCAT inspections

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.³ 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 31 March 2020 that inspectors consider alternative means for inspecting quarantine facilities during COVID-19, as well as advice from the 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.⁴

³ 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'.

⁴ 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 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.

My OPCAT COVID-19 inspections were carried out with full regard for health and safety. They were short and targeted, using specific COVID-19 relevant assessment criteria.⁵ The criteria, including some areas of interest under each criterion, can be found in Appendix 2.

I have decided not to name the individual facilities inspected. Given the unprecedented nature of the time and circumstances, I considered it would be unfair to release the facility names. 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.

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.⁶ I advised that I intended to inspect those places, including privately-run secure aged care facilities.⁷ 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,⁸ 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 3 and 4. 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.

Several facilities⁹ initially expressed a degree of trepidation when I contacted them to announce I would be inspecting their facility. Their concerns were for the welfare of their residents and staff. I understood their concerns about new people entering a facility during a pandemic, and my staff took great care to work with the facilities in respect of the precautionary measures (such as wearing full PPE) Inspectors would take before entering any aged care facility under Alert Levels 3 and 4. At all inspections my staff were professionally received.

⁵ See: <https://www.ombudsman.parliament.nz/resources/criteria-opcat-covid-19-inspections> for the inspection criteria for the COVID-19 OPCAT inspections.

⁶ 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>.

⁷ The Chief Ombudsman inspects aged care facilities where residents are unable to 'leave at will'.

⁸ In a letter dated 16 April 2020.

⁹ Including both facility managers and head offices.

Management of one facility queried my authority to conduct physical on-site inspections during this time and indicated their intention to refuse me access. I encouraged them to seek legal advice as to the facility's obligations under the law and once they clearly understood my legal mandate for entry¹⁰ and the health and safety arrangements I had put in place, the inspections went ahead and again my staff were professionally received by those at the facility.

These inspections enabled me to provide effective independent oversight for Parliament and the New Zealand public as to how vulnerable people who were being detained during these unprecedented times were being treated. Several aged care facilities in New Zealand were experiencing clusters of the disease and sadly, a number of people died. My impartial monitoring of these places provides Parliament and the New Zealand public with reassurance about two areas in particular – that the facilities were doing all they could to prevent the virus spreading to those most at risk, and that steps were being taken to ensure the basic human rights of residents were protected.

Independent monitoring remains an essential preventive safeguard for the proper treatment of people who cannot leave a facility at will. It provides confidence to the New Zealand public that our most vulnerable people are being treated fairly. 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.

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.

Executive summary

This report outlines my key findings, suggestions, and recommendations in relation to OPCAT COVID-19 inspections of six secure aged care facilities¹¹ (the Facilities) between 17 April and 8 May 2020. These inspections took place during Alert Levels 3 and 4 (also referred to in this report as 'lockdown').¹²

As expected, the focus of all Facilities was on their residents' wellbeing. It was clear from these inspections that this was a challenging time, however, the Facilities were taking steps to keep residents safe. Overall, managers and staff were committed to minimising the impact that COVID-19 was having on residents.

¹⁰ See section 29 Crimes of Torture Act 1989.

¹¹ The Chief Ombudsman inspects aged care facilities where residents are unable to 'leave at will'.

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

Health and safety

All Facilities were able to provide policies and plans on infection control, and access to handwashing and hygiene facilities was good. All but one Facility had hand sanitisation stations mounted on walls.

All Facilities applied the 'bubble' strategy to prevent COVID-19 from entering their premises. While it was reassuring to find that all Facilities were applying this practice in line with infection prevention measures, I had some concerns about the definition of some Facilities' 'bubbles'. In some Facilities it was unclear whether the 'bubble' was an individual unit or the entire Facility. Facilities had established entry and exit procedures as an infection control procedure – for example, signing a health declaration, hand sanitisation, temperature checks. Personal protective equipment (PPE) practices varied across Facilities. In some Facilities PPE was not applied consistently by visitors. This was particularly concerning as the use of PPE by those not included in the Facility 'bubble' should be applied consistently.

Most Facilities had not carried out COVID-19 tests on residents. Where it was done, testing practices varied. All Facilities recognised the COVID-19 test as invasive and potentially distressing for residents.

Contact with the outside world

All Facilities recognised the significant impact the 'no visitors' policy implemented as a result of COVID-19 had on residents. I was encouraged that the Facilities had processes in place to allow residents to remain in contact with loved ones outside of the Facility. Digital communications, such as Zoom and Skype, were successful methods facilities employed. Some Facilities had exercised discretion in allowing family members to visit residents, including to visit a dying relative.

Dignity and respect

Overall, my Inspectors observed staff treating residents with dignity and respect, apart from one isolated exception. There were warm interactions between staff and residents, and a commitment by Facilities to ensuring minimal disruption to residents' day-to-day experience. All Facilities said they would explain COVID-19 and its effect on practices at the Facility if they were asked by residents. Some Facilities were proactive in their communication with residents about COVID-19, using for example 'question and answer' sessions, easy-read booklets and signs about handwashing. I reminded several Facilities of the need for residents to be provided with information on matters that affect them, in various accessible formats and displayed in communal areas.

Eighty-five percent of surveyed whānau said Facility staff kept them informed about how the Facility was responding to COVID-19.

Tailoring the environment, activities and cultural responsiveness to be appropriate for all residents during Alert Levels 3 and 4 was a challenge for Facilities. While efforts were being made, I did make some suggestions where this could be improved.

Protective measures

All Facilities advised that protective measures such as complaints processes had not changed or been adversely affected by the COVID-19 restrictions. However, I was concerned that residents' ability to raise issues or concerns in private was reduced during Alert Levels 3 and 4. Whānau were unable to visit, and communication using digital means was available only with the assistance of staff. Complaints boxes were usually in reception areas, not commonly used by residents. I reminded Facilities of the need for residents to have direct access to complaints mechanisms.

Staffing

The Facilities' staff showed resilience during this unprecedented, stressful time. From my inspections, it appeared that management and staff had good rapport, and management had taken steps to respond to staff's changing needs during this time.

Recommendations and suggestions

I made specific recommendations and/or suggestions for improvements to residents' treatment and conditions in individual reports to each Facility. The Facilities were provided with an opportunity to comment on my findings, suggestions, and recommendations.

Inspection methodology

My Inspectors conducted six inspections of secure aged care facilities in Auckland, Christchurch, and Waikato, located in the Auckland, Waitematā, Waikato, and Canterbury 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 18 beds to a five-unit Facility with 100 beds.

Each inspection was carried out by a team of three Inspectors (the Teams). The inspections each lasted around two hours. This time included speaking to managers and staff, and touring the Facility.

Inspectors wore personal protective equipment (PPE) to conduct the inspections.¹³

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.

¹³ 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.

My Teams spoke to some staff by telephone after the physical inspections. An online survey was sent to residents' 'points of contact'¹⁴ from each Facility to hear from whānau about their experience of staying in touch with residents and communicating with the Facilities during Alert Levels 3 and 4.

Key observations

Health and safety

If the highly infectious COVID-19 enters an aged care facility, transmission is difficult to see and therefore control. My inspections considered whether appropriate planning and procedures were in place to ensure that residents were protected 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.

While the nature of COVID-19 meant that increased restrictions on movement were needed, my inspections provided an independent check that any restrictions applied by a Facility (including use of isolation) were necessary, proportionate, and legal in the circumstances. All Facilities were able to provide policies and plans on infection control and had taken steps to protect residents.

I was pleased that all Facilities were taking the health and safety of their residents seriously but there were some health and safety practices I felt could be improved. These practices are discussed under relevant headings below.

Access to handwashing and hygiene facilities

Inspectors viewed the washing facilities available to residents and these appeared to be clean and tidy. Facilities that had en-suites in their residents' bedrooms were at an advantage in being able to accommodate the toileting and bathing needs of residents. Those without en-suites did not all have the same bathroom to resident ratio. All but one of the Facilities also had hand sanitisation stations mounted on the walls throughout.

Cleaning standards and regimes

Some of the Facilities advised Inspectors that they had increased their cleaning regimes in response to the COVID-19 pandemic. There was reportedly increased cleaning of common 'touch points' throughout one Facility, and another advised that they had changed their cleaning products.

¹⁴ 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.

Inspectors noted that one area of a Facility smelled of urine. They were advised that the carpets had not been able to be deep-cleaned during the 'lockdown'. After raising this issue, Inspectors were advised that since the inspection, staff had been trained to use a 'wet vax' system which remained on site. This meant that carpets could still be cleaned, in the event that off-site professional cleaners were not able to access the Facility in the future.

Physical distancing and 'bubbles'

Aged care facilities, like the rest of New Zealand, used the 'bubble' strategy to prevent the potential spread of infection. My understanding is that a 'bubble' constitutes a defined, contained space or group of people.¹⁵ The definition and integrity of a 'bubble' is therefore of paramount importance. I consider 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.

I was pleased to see that a 'bubble' strategy was applied in all Facilities. However, some Facilities appeared to have unclear definitions of their 'bubble'.

When my Inspectors asked staff at several Facilities what their 'bubble' consisted of, the initial response was that their 'bubble' was one unit within the Facility. In seeking further clarification, Inspectors came to understand staff were moving between units, or 'bubbles', without PPE. I did note that, in general, steps were taken to minimise this movement where possible.

Also, other strategies were being employed to mitigate any negative impact of movement between units to maintain the integrity of the 'bubble'. At one Facility, managers who were not part of the inspected Facility's 'bubble' did not enter it. At another Facility, the Registered Nurse who worked across the site (that is, in more than one 'bubble') was required to wear PPE and change this before entering another 'bubble'.

All Facilities had established entry and exit procedures as an infection prevention control measure. Examples of procedures adopted included signing a health declaration, hand sanitisation, temperature checks, changing into uniforms at work, and entering a Facility through a different entrance than normal. I discuss the use of PPE by people entering Facilities in more detail below.

In one Facility I noted limited access on weekends by the Registered Nurse, and so the possibility of delays in providing medical assistance to its residents.

¹⁵ '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>.

While physical distancing¹⁶ within these types of facilities is particularly challenging, most made an effort to minimise unnecessary physical contact between staff and residents, and between residents. At one Facility, however, my Inspectors did not observe active attempts to implement this.

Personal protective equipment

PPE practices during Alert Levels 3 and 4 varied across Facilities. At one Facility, all staff ‘on the floor’ wore PPE in the form of masks and gloves. Inspectors were told that General Practitioners and other clinicians entering that Facility also consistently wore PPE, in the form of gloves and masks. In some other Facilities, staff used PPE when they carried out ‘personal care’¹⁷ tasks or were caring for a resident who was in isolation.

I also identified some inconsistent practices regarding the wearing of PPE by people entering some Facilities. At one Facility, my Inspectors were told that anyone entering, who was not part of its ‘bubble’, must wear PPE. However, this was not what my Inspectors observed. They saw someone entering the Facility who was not wearing PPE and were told this person was a visitor. At another Facility, my Team was told that General Practitioners visited twice a week, however they did not always wear PPE. It is important that the use of PPE by those not included in a Facility ‘bubble’ is applied consistently.

Staff at one Facility indicated they were initially concerned about having sufficient PPE stock available, however, they believed the issue had since been remedied.

Testing residents

The Facilities had varying approaches to COVID-19 testing. Most Facilities had not carried out COVID-19 tests on residents, and were aware of the potentially distressing nature of COVID-19 tests. Two of the Facilities had tested residents for COVID-19. All tests came back negative. At one of the Facilities, the COVID-19 test was carried out by a General Practitioner who administered the nasopharyngeal and oropharyngeal swabs. Managers confirmed this was the Facility’s standard practice.

Managers of that same Facility said they thought it would be ‘inhumane’ to ask all residents to be tested for COVID-19, and that many of their residents would resist such a physically invasive test. They discussed the ‘right to refuse’ and indicated that, if there was a potential case of COVID-19 in the Facility, and a resident did not consent to testing or was not able to be tested, they would instead isolate that resident. It is commendable that consideration was given to the rights of residents not to undergo testing, particularly testing that could cause significant distress.

¹⁶ At Alert Levels 2 and above the Ministry of Health recommends physical distancing of two metre 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>

¹⁷ ‘Personal care’ is a broad term used to refer to supporting someone with personal hygiene and toileting, along with dressing, and maintaining personal appearance.

At another Facility, a resident was tested in what I do not consider to be a dignified manner. My Inspectors reviewed the documentation provided and noted that, while a Nurse Practitioner administered the nasopharyngeal swab, a maintenance worker held the resident's head in position for this to occur. Both the Facility Manager and staff commented that the maintenance worker had a good relationship with residents. However, I do not consider the presence of a maintenance worker during a clinical procedure was appropriate. I advised the Facility of my position in this regard, and the Facility Management accepted this.

At one Facility, where no residents had been tested for COVID-19, my Inspectors were told that residents with 'suspected' or 'probable' cases of COVID-19 would be isolated rather than tested, because of the difficulty of obtaining residents' consent and conducting a swab test. At another Facility, my Inspectors were told that if testing was required, the resident's family would be 'linked in' virtually, and the resident's favourite staff member would be present. I am pleased that Facilities gave consideration to arrangements and alternative options in advance of the need for testing.

Isolation of residents

Plans and processes for isolating residents with suspected or confirmed cases of COVID-19 from other residents varied across Facilities.

Some Facilities inspected had residents in medical isolation, or had residents who had been medically isolated during Alert Levels 3 and 4. These residents were either new admissions to the Facilities, or the resident had been off-site to attend hospital and was isolated on returning.

My Inspectors were told that isolation generally meant residents remained in their bedrooms, including for meals and activities, such as being read the newspaper, or playing a board game. Staff entering an isolated resident's room wore PPE in the form of gloves, mask, apron, and shoe covers. If a resident wanted to leave their room, for example to go for a walk, this would be accommodated, and the resident was usually accompanied by a staff member.

Time out of bedroom

In all of the Facilities visited, some residents were observed outside of their bedrooms. Inspectors observed residents in most of the Facilities making use of the outdoor areas, such as courtyards and gardens. I am encouraged by this; the ability to move from one's room and engage in meaningful activity is important, physically and psychologically, for residents.

Most Facilities had courtyards where residents could exercise and move around independently, which was pleasing to see. However, in one Facility the length of the grass in the courtyard area presented a possible tripping or falling hazard.

Facilities had, of necessity, made changes to their usual activities programmes. Many of the activities which had previously taken place in Facilities, for example volunteers coming in to sing with the residents, were not able to take place in the same way under Alert Levels 3 and 4. My Inspectors were told by most Facilities that activities were taking place in-house, and in

smaller groups. Residents' off-site activities were generally not taking place. Facilities varied as to what alternative activities they offered residents. In one Facility I suggested that there could be more clarity on options for residents to exercise in order to promote independence and well-being.

Contact with the outside world

Contact with the outside world is an essential safeguard against ill-treatment and is critical for the psychological well-being of residents. Restricting visitor access was one of the most significant changes for aged care facilities under COVID-19 and the introduction of the Government's Alert Level system. Where visiting regimes are restricted, even in these unprecedented circumstances, I expect that sufficient alternative methods for residents to maintain contact with the outside world is facilitated and encouraged. These should be frequent and free.

Visiting practices were disrupted in all Facilities at Alert Levels 3 and 4, however in general Facilities did a good job of ensuring that residents maintained contact with the outside world.

New approaches to communication

I am pleased that all Facilities had increased the range of communication options available to residents so they could keep in contact with the outside world, mitigating the effect of the restriction on visitors. In Alert Levels 3 and 4, staff in all Facilities were assisting residents and whānau to make video calls, such as Skype and Zoom, and exchange emails, letters, and phone calls. I suggested one Facility explore the possibility of continuing religious or spiritual services by digital means, such as Skype or Zoom.

Whānau survey results showed that whānau were grateful for the alternative ways to keep in contact with their family members. More than 60 percent of whānau surveyed said they were satisfied with the level of communication they received from their loved one's Facility during 'lockdown'.

I was particularly heartened that several Facilities made arrangements for loved ones to wave through closed windows at residents, from a safe distance outside the Facility. Inspectors told me they observed a resident opening a birthday card, watched by her daughter, who stood in the carpark outside and waved through the closed window. These were examples of creative approaches to enable meaningful connection between residents and loved ones during Alert Levels 3 and 4.

A number of Facilities told my Inspectors that they intend to continue using digital communication methods in future, having seen how successful these methods had been in enabling residents to engage with the outside world.

Allowing visitors in exceptional circumstances

Facilities were rightly cautious of allowing visitors into the Facilities during the COVID-19 pandemic. However, in certain circumstances, for example when a resident was in palliative

care, Ministry of Health guidelines allowed exceptions to be made to the 'no visitors' policy, on compassionate grounds.

Although a general rule of not allowing visitors to enter a Facility's 'bubble' was appropriate during Alert Levels 3 and 4 and in line with government guidelines, I was pleased to learn that some Facilities had exercised discretion in allowing family members to visit, including visiting a dying relative.

I was concerned by the indication from one Facility that, although the situation had not arisen, their default position would have been to refuse visitors, even if a resident was in palliative care. Applications for exceptions should be considered and, where appropriate, visits facilitated, such as for residents receiving palliative care.

Dignity and respect

Residents must be treated with dignity and respect, and COVID-19, or any other emergency, should not impact this. My inspections were concerned with how residents were being treated in this unusual environment, in particular, how staff were communicating with residents. I expect aged care facilities to ensure that staff and residents have access to information about COVID-19, as well as information about what it means for them in terms of their routine within the Facility and why any changes were occurring.

My Inspectors observed warm interactions between staff and residents at all Facilities. Most of the Facilities visited were making an effort to support residents through the changes implemented as a result of the pandemic.

Generally, my Inspectors observed a commitment by Facilities to ensuring minimal disruption to residents' day-to-day experience. There were however some areas for improvement, particularly regarding proactive communication with residents about COVID-19. Also, in one Facility I considered that a staff member, in their conversation with Inspectors, did not demonstrate dignity and respect for a particular resident.

Although external visitors could not bring animals into Facilities during Alert Levels 3 and 4, two Facilities provided sensory items, including soft toys replicating animals. Two Facilities had staff acting as hairdressers during the 'lockdown'. This is an example of recognising individuals' needs and the promotion of personal expression.

In one Facility, my Inspectors were advised that residents in medical isolation who were in a room without an en-suite would be provided with a commode or a urinal. I suggested the Facility investigate alternative ways of managing medically isolated residents' bathroom needs, according to the individual resident's preference.

I also expressed concern to one Facility about a measure taken to manage a resident's potentially self-harming behaviour. However, I acknowledge the challenges such behaviours present.

Communication about COVID-19 information

All Facilities said they would explain COVID-19 and its effect on practices at the Facility if they were asked by residents.

Surveyed whānau felt Facilities' communication with them about changes resulting from the COVID-19 pandemic was good. Eighty-five percent of surveyed whānau said Facility staff kept them informed about how the Facility was responding to COVID-19.

Whānau were less confident about how well this information was being conveyed to the residents. Fifty-one percent agreed that the resident had been kept informed about changes to their care and routine during Alert Levels 3 and 4.

Some Facilities were proactive in their communication with residents about COVID-19. One Facility held a 'question and answer' session with residents, and another had an easy-read booklet to aid discussion with residents about the virus. Willingness by Facilities to have proactive discussions about COVID-19 is a positive example of treating residents with dignity and respect. Managers and staff at several Facilities noted that continual discussion of COVID-19 may cause distress to some residents, so their messaging was regulated to mitigate against this.

My Inspectors observed that some, but not all, Facilities had signs displayed advising residents about the importance of washing their hands. One Facility had a large, easy-read poster with information about the importance of washing hands displayed. I suggested to other Facilities that information for residents, such as signs about the importance of regular and effective handwashing, is displayed in accessible formats throughout the Facilities.

Disability rights

Specific needs of residents, including disability-related needs, should be taken into account when planning or implementing infection control practices, particularly during COVID-19 Alert Levels 1-4. Tailoring the environment and activities to be appropriate for all residents during Alert Levels 3 and 4 was a challenge but was important for promoting residents' dignity and respect.

I am pleased that all Facilities visited were physically accessible for residents of all mobility levels. In one Facility my Team noted some conflation between mental health needs and intellectual disability. I suggested that the particular needs of different groups among residents, including those with additional disabilities, be identified and met by the Facility. The Facility acknowledged the suggestion and said that they would review these residents' needs with the District Health Board's speciality teams.

All but one Facility ensured that residents with hearing impairments were supported to have hearing aids. One Facility advised my Team that it was not practicable to provide residents in a dementia facility with hearing aids, as hearing aids are often lost or require ongoing repairs. I consider this does not provide reasonable accommodation for disabled residents. While I accept there may be challenges associated with managing hearing aids in a dementia facility I consider that efforts should be made to help residents maintain their hearing. All other

Facilities inspected by my Teams had plans in place to support residents to use hearing aids. I note that communication difficulties might be exacerbated in the COVID-19 environment, particularly when staff are wearing masks.

Cultural responsiveness

It is important for Facilities to consider the impact COVID-19 may have on specific groups, such as those from different cultural backgrounds. A good understanding of te ao Māori, for example, would be beneficial now and in the future, enabling managers and staff to respond appropriately to residents' cultural needs.

Inspectors observed varying degrees of cultural responsiveness across the Facilities. Few Facilities had specific activities aimed at incorporating Māori culture into the overall Facility, though one Facility did have an appointed Māori cultural advisor.

One Facility said that its residents had a 'cultural assessment' on arrival, so the Facility could respond to their specific cultural needs.

A second Facility told Inspectors that some staff had developed a basic competence in languages other than English, to communicate with residents whose first language was not English. At this same Facility, Māori kai was served on a weekly basis. A resident had been losing weight during 'lockdown' and missing aspects of their traditional diet which had been routinely provided by family members. In response to this, kitchen staff learnt how to cook some traditional dishes.

At another Facility, my Inspectors were told that meeting the cultural needs of residents was a priority. Managers gave an example of how the Facility responded to a Māori resident who was frustrated with other residents interacting with them in a way that was culturally inappropriate. Training was provided to staff on how to prevent the situation from occurring, including de-escalation if it happened again. Staff also explained to other residents that their actions were culturally inappropriate.

Protective measures

Residents should have safe and accessible ways to raise concerns and have these considered and responded to. Protective measures are safeguards against ill-treatment and are of particular importance when there are increased restrictions within an aged care facility. Action taken as a result of COVID-19 should not impact on residents' access to complaints mechanisms.

Complaints mechanisms

Complaints mechanisms are an important tool for creating change in a facility. It is important that residents can express their views about areas for improvement, and raise any matters of concern.

All Facilities advised that protective measures such as complaints processes had not changed or been adversely affected by the COVID-19 restrictions.

Most Facilities inspected had some complaints mechanisms in place, however, information about these often appeared to be directed towards whānau or other visitors, rather than to residents themselves. Given that all Facilities had a 'no visitor' policy in place during Alert Levels 3 and 4, most of the Facilities appeared to have no confidential way in which residents could raise a complaint. This was because complaint processes generally relied on residents communicating with the Facility via whānau. Most communication with whānau during the 'lockdown' could only occur with the assistance of staff. Any concerns raised with whānau at this time were therefore not confidential.

One Facility told my Inspectors that their head office had established a dedicated email address for whānau to use to raise COVID-19 related issues and questions. Another advised my Team whānau were contacted on a weekly basis with updates, and this was an opportunity to discuss any concerns. Another Facility advised my Inspectors that its preference was to communicate with whānau verbally rather than in writing, so any complaints were received, and responded to, over the telephone. While it is commendable that personal contact occurs between staff and the whānau of residents, in order for a complaints process to be fair and robust, there must be adequate systems in place to ensure complaints are documented and appropriately responded to.

Visitor oversight is an important protective mechanism and one that has the potential to be impacted in secure aged care facilities as a result of the COVID-19 environment. Most Facilities said they received fewer complaints or other communications during Alert Levels 3 and 4.

All but the most independent of residents will require assistance to make a complaint. I am concerned that residents' ability to raise issues or concerns in private was reduced during 'lockdown'. Whānau were unable to visit, and communication using digital means was available only with the assistance of staff.

Complaints boxes were in most Facilities, however, these were usually in the reception areas, not commonly used by residents. Not all were in good working order. Although I acknowledge that there may be some challenges in doing so, I would like to see Facilities doing more to ensure that the voices of the residents are heard.

I believe it is even more important during a pandemic that Facilities ensure residents are able to raise any concerns they may have, and be able to do so confidentially. COVID-19 and the lack of visitors within a Facility inevitably reduces oversight of conditions and treatment within a Facility. Maintaining contact methods such as private telephone calls are therefore important, though so too are taking steps to inform and empower residents to advocate for themselves wherever possible.

Compliments are also an important indicator of the treatment and conditions of residents in a Facility. All the Facilities commented that they had received compliments during the 'lockdown' period.

Information about residents' rights

Most Facilities had posters displayed advising of residents' rights. While this is positive, I was concerned that these were generally not in places frequented by residents. For example, they were usually seen in the reception or visiting area.

I was pleased to note that at one Facility, there were a number of posters displayed in the Facility informing residents of their rights.

Staffing

Staff must be trained, and supported by management, in order to keep residents safe.

Sufficient staffing levels are crucial; they ensure residents are properly supported and cared for, and promote staff well-being. Although maintaining staffing levels presented a challenge to some Facilities, overall I was pleased to see the steps being taken by Facilities to ensure adequate staffing levels during Alert Levels 3 and 4.

The Facilities' staff demonstrated resilience during this unprecedented, stressful time. Despite the difficult circumstances, staff were observed to treat residents with care, respect and compassion, and there appeared good rapport between staff and managers.

Staffing levels

Facilities took different approaches to managing staffing levels during the pandemic. At least one Facility employed additional staff, while in another staff within the Facility's 'bubble' picked up extra shifts to cover absences. Several Facilities noted that staff absences, for example due to illness, had decreased during Alert Levels 3 and 4.

In one Facility, my Inspectors observed a number of residents in their bedrooms when staff were mainly in the common areas. Facilities need to ensure that sufficient staff are available to assist residents throughout the Facility.

Relationships and support

My Inspectors reported that there appeared to be good rapport between management and staff in the Facilities. Several Facilities noted that staff had initially been very anxious about COVID-19, and management had ensured they were more visible and available to discuss staff concerns. Managers were aware of the difficulties their staff were facing and had taken steps to support them and respond to staff's changing needs during this time.

Some of the Facilities told my Inspectors about additional steps they were taking to communicate with their staff about COVID-19. This included, for example, additional staff meetings and text communications.

Training

Good training must be provided to ensure staff are able to offer the highest possible standard of care to residents in the Facility. Training to prevent and respond to COVID-19 must be timely, up-to-date, and in line with the latest authoritative clinical information.

Managers at most of the Facilities told my Teams about the recent training their staff had undertaken prior to or during Alert Levels 3 and 4. My Teams were advised that training conducted included use of PPE; infection control; hand hygiene; and COVID-19 symptoms and procedures.

These are positive steps taken by Facilities to ensure the health and safety of both residents and staff.

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 detainees 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 four recommendations across two Facilities:

- The Facility clearly defines the composition of its 'bubble'. The use of PPE by those not included in the Facility's 'bubble' is applied consistently.
- Applications for exemptions are considered and, where appropriate, visits are facilitated, such as for residents receiving palliative care.
- Only clinical or health care staff are present during medical or health-related procedures, including COVID-19 testing, and contemporaneous records are kept.
- Hearing aids are provided to residents with hearing impairments who wish to use them so they can communicate in the COVID-19 environment.

I also made 21 suggestions across all six Facilities:

Health and safety

- The Facility considers the size and integrity of its 'bubble', and is clear and consistent in its 'bubble' management during the pandemic.
- The Facility review its position on physical distancing, and ensure that staff understand and are supported to implement this practice.

- Information for residents, such as signs about the importance of regular and effective handwashing, is displayed in accessible formats throughout the Facility.
- Install wall-mounted hand sanitisation stations in communal areas so that residents can freely sanitise their hands without relying on staff.
- Consideration is given to ensuring residents are able to access safe and timely medical assistance at all times, including whether adjustments are needed during the current pandemic.
- The Facility takes additional steps to ensure resident safety and prevent injury, in a manner that respects personal dignity.
- The courtyard's grass is regularly mowed to reduce risk of residents tripping or falling.

Contact with the outside world

- Greater emphasis is placed on communicating proactively with residents about any limitations imposed on the number of visitors they may receive during the pandemic, and alternative ways of communicating with whānau.
- Continue to publish guidance for whānau which outlines key COVID-19 policies.
- Explore the possibility of continuing religious or spiritual services by digital means, such as Skype or Zoom.

Dignity and respect

- All staff at the Facility are reminded that residents are to be spoken about with dignity and respect.
- The particular needs of vulnerable groups among residents, including those with additional disabilities, are identified and met by the Facility.
- The specific needs of residents, including disability related needs, be taken into account when planning or implementing infection control practices, particularly during COVID-19 Alert Levels 1-4.
- More is done to integrate and reflect te ao Māori in a broader sense within the Facility.
- Investigate ways of managing medically isolated residents' bathroom needs, according to their individual preference.
- There is clear communication with residents about their options for exercise at all COVID-19 Alert Levels, in order to promote their independence and well-being.

Protective measures

- Residents are supported to express their concerns and make complaints.

- Feedback and comments boxes are also provided within the Facility in places accessible to residents, that residents are made aware of how to use these, and are freely encouraged and able to do so.
- Adequate systems are put in place to ensure complaints are documented and appropriately responded to.
- Residents are further supported to express their concerns and make complaints.

Staffing

- Sufficient staff are available to assist residents throughout the Facility.

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 crisis¹⁸, 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 detainees 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 detainees, including in regard to the provision of food, drinks, sanitary items and medicine, and contact with the outside world.

¹⁸ 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.

- 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.

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 detainees 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.