OPCAT Expectations Aged Residential Care

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

April 2024

Ombudsman
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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT – Expectations Aged Residential Care
Expectations for conditions and treatment of residents in health and disability places of detention – aged residential care

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The Ombudsman as a National Preventive Mechanism

As Ombudsman, I am designated to examine and monitor the treatment of persons in health and disability places of detention. This includes aged residential care where people are unable to leave at will.[1]

The purpose of my role is preventive, aiming to ensure that safeguards against ill-treatment are in place, and that risks, poor practices, or systemic problems are identified and addressed promptly.

My role helps to ensure New Zealand adheres to international human rights standards, to which all people are entitled. It also provides assurance that residents in aged residential care who cannot leave at will are treated humanely, and that their rights are respected, protected, fulfilled and promoted.

My role is broad and flexible. I examine the conditions and treatment of residents and can make recommendations for improvement where I consider this to be necessary. I may also identify good practice in the hope that this will promote the highest attainable standard of care for residents in aged residential care throughout New Zealand.

My powers include unrestricted access to places of detention and information about detainees. Central to my examination function are my visits to, and inspections of, aged residential care. My inspectors may visit announced or unannounced and are able to request electronic and physical documentation, observe aged residential care facilities and practice, and talk, in private, with residents, whānau,[2] staff, and with any persons who may be able to provide relevant information.

I am focused on the experience of, and outcomes for, residents in aged residential care who are unable to leave at will.

> *'The National Preventive Mechanisms represent the most significant single measure which States can take to prevent torture and ill-treatment occurring over time.'*
>
> Ms. Aisha Shujune Muhammad, Vice-Chair, United Nations Subcommittee on Prevention of Torture

Further detail about the legal framework under which the Ombudsman operates is located in Appendix 1.

1 Designation of National Preventive Mechanisms, Gazette Notice 2023-go2676, 22 June 2023

2 This document refers to whānau rather than family. In Te Ao Māori whānau encompasses family in the fullest meaning. Whānau may include immediate and extended family through whakapapa (genealogy), as well as all persons connected by emotional or spiritual bonds. Any person who has been involved in the care or welfare of a resident may also be considered whānau (kaupapa whānau).

A note on terminology

As Chief Ombudsman, I monitor aged residential care where people are not free to leave at will - primarily secure dementia level care and/or specialised hospital care (psychogeriatric level care).

The expectations in this document refer to 'residents', 'dementia' 'aged residential care' and 'facilities'. However, I acknowledge the importance of language and that people have different views on the meaning, accuracy, and effects of particular terms. I am open to hearing those views. Some people will have a preference for using other terms, including kupu Māori such as kaumatua (elder) and mate wareware (mate referring to being unwell, and wareware to forgetting or forgetfulness). I encourage, and may adopt, the use of kupu Māori or other terms when appropriate.

Dementia level care

Residents in secure aged residential care mostly have a diagnosis of dementia, along with varied other health or disability related needs. Dementia is an umbrella term, used to describe a group of symptoms affecting brain function. The symptoms each person experiences depends on the parts of the brain that are affected. However, the most common dementia symptoms include changes in memory, thinking, behaviour, personality and emotions. These changes affect a person's ability to perform everyday tasks and interfere with their everyday lives.[3]

Specialised hospital care (psychogeriatric level care)

This is a type of care for older people experiencing acute mental distress who require a high level of specialist nursing care and management of behaviour that challenges. They need a secure environment and the skills of specially trained staff.[4]

3 Dementia is progressive, which means that for most people the changes gradually spread through the brain and lead to the symptoms getting worse. Dementia is different for everyone – what people experience, and how quickly they are affected is unique to them. What they can do, remember and understand may change from day to day. See https://alzheimers.org.nz/about-dementia/what-is-dementia/

4 https://www.eldernet.co.nz/knowledge-lab/residential-care/residential-care-carerest-homes/what-are-levels-of-care-in-new-zealand

My expectations

This document sets out my overarching expectations for the conditions and treatment of residents in aged residential care who cannot leave at will. These are:

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

These expectations are intentionally high-level and apply to all residents in aged residential care who are not free to leave at will. All aged care facilities caring for residents who are not free to leave at will should be able to demonstrate how they are meeting, or working towards achieving, these expectations.

My intent, with these expectations is to provide residents, their whānau, aged residential care leadership, management and staff, Parliament, and the public with an understanding of some of the matters that I consider when fulfilling my examination function. These expectations will also guide my staff when they are carrying out my role, including when they are conducting visits and inspections.

Each expectation is accompanied in this document by example areas of interest. These areas of interest provide an indication of matters I may look at to consider whether or not my expectations are being met.[5] These are intended as a guide and do not exclude me from considering other areas that may demonstrate progress towards meeting these expectations, or considering the conditions and treatment of people in aged residential care more generally.

My examinations are not a 'check list' exercise. I must respond flexibly to issues affecting residents in aged residential care. Accordingly, the expectations and **example areas of interest** are indicative only and are not intended to be exhaustive.

5 Appendix 2 includes examples of evidence sources that I may to inform my view.

Human rights

My expectations and areas of interest are based on international and domestic human rights law and guidance, some of which is listed in **Appendix 3** to this document. They also draw on applicable domestic legislation, regulations, and policies that inform, but may not necessarily determine, my observations and recommendations.

My role as a National Preventive Mechanism, and therefore my expectations, must be **responsive to rights of particular groups**. I am informed by law, policies, standards and best practice for upholding rights and ensuring the specific needs of these groups are met. This includes the rights of Māori, Pacific peoples and other ethnic groups, migrants and foreign nationals, women, LGBTQIA+ people, young and older people, and disabled people. The realisation of my expectations requires facilities and others to be aware of the individual and collective rights of residents in aged residential care. Responsive monitoring means that I will also have this awareness when examining conditions and treatment of residents, looking to be assured that human rights for these particular groups are evident in the experience of, and outcomes for, residents in aged residential care.

I recognise the **rights of staff** and others, as well as the obligations to staff under the Health and Safety at Work Act 2015, and my expectations should not be read in a way that is inconsistent with those rights or obligations. I believe that the conditions and treatment promoted through my expectations will ultimately also contribute to positive outcomes for staff, whānau, and others who spend time in places of detention.

Te Tiriti o Waitangi | the Treaty of Waitangi

My expectations are informed by Te Tiriti o Waitangi | The Treaty of Waitangi[6] and its principles, including those articulated in the Waitangi Tribunal's kaupapa inquiry into health services and outcomes (Wai 2575). These must be given due regard in the care of residents, including when interpreting my expectations.

I acknowledge Te Tiriti o Waitangi | The Treaty of Waitangi and will ensure my own processes and decision-making are consistent with its principles. One of my priorities as Chief Ombudsman is to be more responsive to tangata whenua. More information on what this means for my role is available in my **Strategic Intentions**.

6 I acknowledge there are two texts with different meanings.

This is a living document

This is the second version of my 'OPCAT – Expectations – aged residential care.' The expectations will be updated over time. I welcome feedback on this document, recognising that best practice is continually evolving, and that there will always be further or new areas relevant to monitoring places of detention.

Please visit **https://www.ombudsman.parliament.nz/what-ombudsman-can-help/monitoring-places-detention** for more information about the Chief Ombudsman's monitoring role, including information on how to provide feedback on these expectations.

Scope of my expectations

My role is focused on the outcomes for, and experience of, residents in aged residential care who are unable to leave at will.

Aged residential care is one part of a system providing care and support to residents. A number of agencies, organisations and professionals contribute to the conditions and treatment that residents experience. The expectations in this document cannot necessarily be met by the service provider alone, as they are working within an integrated health and disability system. My monitoring and prevention function is able to examine and make recommendations on all relevant parts of this system.

My expectations are therefore for all persons and agencies who may influence the conditions and treatment experienced by those people. This includes those responsible or accountable for the legislation, policies, standards, resources and practice governing the conditions and treatment of these people, at the national, regional, and facility level, whether in government or non-government agencies. Where I consider improvements are needed I may make recommendations to the person or agency with responsibility to make the necessary changes.

While my overarching expectations remain the same, achieving them may look different depending on the nature and purpose of the aged residential care facility, and the needs of the residents that are cared for there. It is for this reason that my expectations are focused on the outcomes I expect to see, and are not prescriptive about how these should be achieved.

1. People, principles, and practice

Expectation: The rights of residents are upheld by people, principles, and practice at all levels

Dedicated, rights-promoting leadership, policy, and governance is evident in the management and operations of facilities. Governance arrangements give genuine effect to any relevant obligations of Te Tiriti o Waitangi | The Treaty of Waitangi and its principles.

There is a clear and active understanding of, and commitment to, te Tiriti o Waitangi | the Treaty of Waitangi and ensuring equitable treatment of Māori residents, including building and maintaining relationships with mana whenua, and the protection and promotion of te ao Māori, te reo Māori and tikanga Māori.

Human rights standards are understood and met, including but not limited to those particular to older people, Māori, Pacific peoples and other ethnic groups, migrants and foreign nationals, women, disabled people and LGBTQIA+ people. They inform the values of the service, which are clear and well communicated.

Organisational culture reflects a person-directed and holistic approach to care with emphasis on nurturing residents' wellbeing, health, and enjoyment of their life. Practices at all levels reflect the values of the service. Residents, their Enduring Power of Attorney or Welfare Guardian (authorised representative), whānau and others, including staff members, have a role in decision-making about service management and operations. They are able to share their views and concerns, in particular about the conditions and treatment of residents. Residents, authorised representatives, whānau and community members have a high degree of trust in leadership and staff.

Examples of areas of interest

Leadership, integrity, and accountability

Leadership at all levels is committed to, and takes responsibility for, promoting human rights and providing safe, responsive and high quality care for residents. This is evident in the outcomes for residents.

Strategic and operational plans, including those relating to staffing, resourcing and quality improvement, show how the organisation realises, maintains and progresses best practice.

Leaders have genuine insight into, and understanding of, the culture and operational reality in relevant aged residential care facilities, and are engaged in monitoring and ensuring that appropriate conditions and treatment are provided. They act with integrity and take accountability, creating an organisational culture that reflects this.

Organisational culture

All staff respect the dignity of residents at all times. Clear organisational values and strong leadership support this.

A constructive, collaborative, and supportive culture is fostered in all parts of the organisation and is evident in the principles, policies and practices of staff.

Representation, participation, and engagement

Residents, authorised representatives, whānau, and community members are represented, and have avenues for participation, in matters of principle, policy and practice that affect them. Decision-making processes involve meaningful consultation and effective communication with these parties, as well as wider stakeholders such as those who have experience of the aged care sector, tangata whenua, and civil society. Representation and participation in principle, policy and practice matters are facilitated to the fullest extent possible, including through the involvement of consumer and whānau advisors, as appropriate.

Equality, diversity, and inclusion

Behaviours, policies, strategies, and processes promote equality, respect diversity, and contribute to an inclusive organisational culture.

The conditions for, and treatment of, residents are fair and non-discriminatory, including when meeting the distinct needs of residents, or groups of residents.

2. Safety and independence

Expectation: Residents are safe and their independence is promoted

No person is deprived of their liberty unless in accordance with the law, and with all associated legal protections. Thorough assessment, legal processes, and the appropriate documentation are followed. Residents are the primary decision-makers in processes and decisions around their care to the fullest extent possible.

Residents, their authorised representatives, and whānau receive regular, timely, and comprehensive reviews of residents' health care needs and placement. Their voice is sought and heard in these processes.

Residents' rights are promoted and protected. Residents, their authorised representatives, and their whānau are routinely and fully informed of their rights, including their rights to statutory protections, the ability to challenge the level of care needed, as well as how to raise a concern or complaint and access advocacy services. Feedback and input are sought and considered. Residents can trust the processes and systems around them to be effective and fair.

The ability of residents to maintain independence and autonomy to the fullest extent practicable is central to their care. Residents have opportunities to be responsible for themselves, their environment, and their future. They are supported and well informed, and have opportunities for meaningful engagement with others. Independence is protected and nurtured by the facility environment and culture.

Residents are safe from harm, abuse, or neglect (including but not limited to physical, emotional, spiritual, cultural, financial, or sexual). Risks and harm are identified, recorded, and addressed.

Safety and security are preserved with no more restrictions than are allowed for by the principles of legality, necessity, proportionality, accountability, and non-discrimination. There is regular and responsive consultation with residents, their authorised representatives and whānau about their safety and wellbeing. An objective, fair, and consistent approach is applied to all residents.

Examples of areas of interest

Placement in the facility

Residents are accommodated in a facility, and unit, that is appropriate for their needs, including their proximity to their whānau. The law around placement is understood and correct

processes have been followed, including the fullest possible consideration and honouring of the resident's views and wishes.

The reasons for the resident being in secure aged residential care are clear and recorded, and explained to the resident in a way that they understand, including their legal rights. All appropriate documentation is obtained and held securely. Information for, and communication with, residents about their placement, including reviews and any movement/transfer between placements, is timely, clear and reliable.

Admission and induction

Before and on arrival, residents are welcomed and are treated with dignity and respect. Efforts are made to make them feel safe and supported. The admission environment and processes are conducive to this.

Any immediate needs upon arrival are identified and met. Safety risks are considered and assessed. Residents, their authorised representatives and whānau are informed of their rights and how to access support.

Residents are supported to feel comfortable in aged residential care, including through whānau involvement and appropriate welcoming services (such as mihi whakatau), depending on the resident's wishes.

Residents, their authorised representative and whānau receive a comprehensive induction and are provided with information in an appropriate language and accessible format to assist with the settling in process.

There is a comprehensive handover of information between professionals to ensure continuity of care.

Consent, consultation and supported decision-making

Residents are assumed to be primary-decision-makers and are supported to make decisions where they are not able to fully choose themselves. Where this is not possible, the appropriate combination of residents, their authorised representatives, and whānau are informed about and consulted on decisions or actions that impact the resident.

Consent to treatment from the relevant party is sought, recorded and adhered to. Where consent is not possible, there are robust processes in place to ensure that any treatment is necessary, appropriate and authorised and that residents have been involved in decision-making to the fullest extent possible.

Feedback, concerns, and complaints

Feedback from residents and others (such as authorised representatives, whānau and advocates) is actively sought, considered and used to inform and improve service planning and delivery.

There are accessible avenues to raise concerns and complaints independent of staff, without repercussions or fear of negative consequences, and for decisions to be reviewed in a timely manner and without difficulty. Residents and others are listened to when they raise concerns or make complaints, and the issues raised are addressed. Their views are taken seriously and responded to sensitively. Complaints systems are accessible to residents and others, well communicated,[7] culturally safe, confidential and effective. Outcomes are transparent, fair, communicated in a way the resident can understand, timely, documented and in line with a policy of full disclosure.

Advocacy and support

Residents, their authorised representatives, and whānau (as appropriate) are informed of and have easy and private access to independent advocates or support persons in a timely manner.

This includes residents having, where possible, whānau or others, such as trusted community members, with them when this is their preference.

Privacy and confidentiality

Residents' privacy and confidentiality are respected and preserved. Residents enjoy physical, visual, auditory, and personal privacy to the fullest extent possible. Any infringement on privacy is justified and proportionate.

All resident information is kept securely to preserve privacy and confidentiality.

Confidentiality and its limits are explained to residents, authorised representatives and whānau on admission and as necessary. This is done in an accessible format, and the provision of this information is recorded.

Safeguarding (freedom from abuse or neglect)

Residents are safe at all times, including in the facility, and in transport to-and-from aged residential care, and overnight.

Residents are not subjected to discrimination, coercion, harassment, bullying, or any form of

7 See 'Communication and language', under the expectation for 'Health, care, and wellbeing'.

exploitation. All concerns (including potential concerns or indications) about exploitation, violence, abuse or neglect are promptly documented and investigated, or referred to the appropriate authority for investigation. All appropriate steps are taken to prevent harm, and to provide restoration and redress where it occurs.

Personal autonomy

Residents live in an enabling environment. The physical layout, available resources and culture of the facility promote resident autonomy and independence.

Residents receive support to live and mobilise with the greatest possible independence. These measures include access to personal mobility aids, devices, assistive technologies (eg walker, wheelchair, mobility scooters, and canes) and other forms of assistance and intermediaries. Physical rehabilitation or exercise is provided as necessary.

Residents have individualised supports to meet their hearing, visual and sensory impairment needs (eg hearing aids and batteries, glasses and/or magnifying devices, access to picture board or large alphabet, Braille, Sign Language interpreter).

Restrictions

Residents are not subject to greater restrictions than are assessed as necessary and proportionate for identified and considered reasons. Any such restrictions adhere to the principles of legality, necessity, proportionality, accountability, and non-discrimination.

There is active work to minimise practices that are restrictive or coercive, this is supported by clear policies, operational guidelines and reporting on their use to relevant authorities, where appropriate. Blanket restrictions are avoided in preference to individualised interventions, which are subject to discussion and review by all relevant parties.

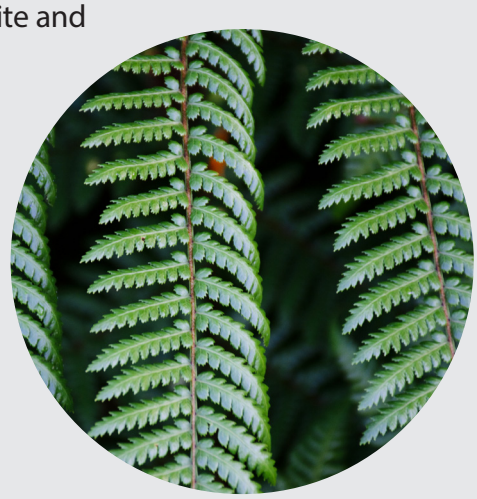
Practices such as withholding items, mail or phone calls, cancelling or preventing visits or outings are not used unless in accordance with resident, authorised representatives and whānau (as appropriate) consultation, reflected in the resident's support/care plan and supported by relevant assessment and evidence. This means that prior efforts have been made to prevent these restrictions being required. Where they are implemented they are regularly reviewed and documented. Restrictions are never used to punish or humiliate.

Access to shelter, warmth, a comfortable environment, leave, water, food, fresh air, exercise, confidentiality or reasonable privacy are never restricted or used as a 'reward' or 'privilege' dependent on residents' behaviour.

Restraint

Restraint, in all its forms is recognised as a serious intervention with potentially harmful effects on residents.

There is proactive work to achieve a restraint free environment, as well as to reduce and minimise its immediate use. Policies and practices, including site and service specific plans, evidence this.



Restraint is only used as a last resort and only when strictly necessary for the immediate safety of residents or others. All other, less restrictive, options are considered first. Where restraint is used it is authorised on a case-by-case basis, documented, reviewed, and followed-up appropriately, including with a person centred debrief. Use of restraint is reported to the appropriate authority.

Use of restraint adheres to the principles of legality, necessity, proportionality (including the shortest period of time), accountability and non-discrimination.

The specific needs, including cultural needs and disability needs, of residents are considered before, and met throughout, restraint events. Relevant advice is sought in order to maintain safety.

Means of restraint which are unlawful and/or inherently degrading are never used. Residents are never restrained in a way that involves pain compliance, or is unsafe, including in any way that impacts on their airway, breathing or circulation.[8]

Restraint is never used as a punishment, discipline, or a form of behavioural modification. This includes the use of medicines, which must be prescribed and used for valid therapeutic indications.

Meaningful human contact

All residents have the opportunity for meaningful human contact - contact that is of sufficient quality and duration - daily. The importance of kanohi ki te kanohi (face to face) engagement is acknowledged. Communication and contact with whānau, in-person association with other residents, and empathetic engagement with staff, other professionals, volunteers and community members, are encouraged and supported to the greatest extent possible for the resident.

8 The mouth and/or nose are never covered and no pressure applied to the neck region, rib cage and/or abdomen. Planned or intentional restraint in a prone position (lying face down) on any surface, not just the floor, does not occur.

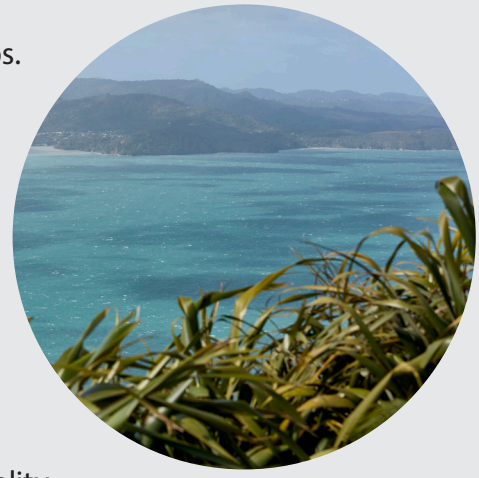
3. Dignity and respect

Expectation: Residents are treated with dignity and respect

All residents are valued as individuals, with their own history, experience, views, needs, and abilities. Residents are able to maintain and foster connections that are important to them, including with loved ones, and with spiritual or cultural practices, through choices about their daily life and opportunities to express themselves.

Responsiveness to diversity is demonstrated through specific strategies and services, which are based on a well-informed understanding of the relevant population groups of residents and which do not take a 'one size fits all' approach.

Staff and residents have constructive and positive relationships. These are seen as an integral part of maintaining a safe environment with the best outcomes for residents.



Examples of areas of interest

Respect for the individual

Residents' wishes, views, and preferences are sought, recorded, and evident in their care and support. They are respected and valued as individuals, whose background, current health status, gender identity, culture, religion, nationality or disability, among other factors, are important to who they are, their wellbeing and sense of self.

Choice

Residents have choice wherever possible. Their choices are respected and honoured to the fullest extent possible, including through supported decision-making. Support to make positive choices, which contribute to health and wellbeing, is provided through engagement, education and encouragement. Coercion is not used.

Residents are the primary decision-makers in relation to day-to-day life decisions such as what clothes to wear, personal grooming, food, where to spend time and with whom, entertainment, and daily routine (eg, when to shower, get up, or go to bed). If choices cannot be honoured the reasons why are appropriately explained to the resident, documented and regularly reviewed.

Whānau and community connections

The importance of loved ones in the life of the resident is acknowledged and valued. Contact with whānau, and the wider community, is promoted in diverse ways in line with the resident's preferences and privacy.

Residents are located as close to their home, whānau, hapū, iwi, other community connections, and whenua as possible, where this is their preference. Measures are taken to prevent and address disadvantages faced by residents located far from their whānau or connections. Foreign nationals, or those whose connections are outside of New Zealand, have access to the appropriate services and supports (including translation if required), including access to the relevant consulates.

The role of kaitiakitanga (caregiving) in the oranga wairua (spiritual wellbeing) of the collective whānau is understood, respected and facilitated. The role of whānau as a key part of residents' care is recognised and valued.

Residents can connect with the wider community and be engaged as citizens. They have opportunities to follow the news, keep themselves informed of key events and exercise their relevant civil and political rights.

Visits

Residents are offered the fullest visiting arrangements possible, in terms of frequency, duration and quality. Visitors are made to feel welcome. The visitor environment is private, accessible, safe, comfortable and child friendly.

Identity, culture, faith, and lifestyle

Diversity is welcomed. No resident experiences discrimination based on their identity, culture, faith (or spirituality), lifestyle, or any of the 'prohibited grounds' for discrimination.[9]

Residents, their authorised representatives, and whānau (as appropriate) are asked about what matters to the resident, and this is reflected in their care, support, services and activities at the facility. They are able to observe practices and traditions that are important to them. Provisions are made to support the expression of identity, culture, or faith, eg they have access to kaumātua, and others who can provide cultural and/or spiritual support, such as pastors or chaplains.

9 The prohibited grounds are outlined in Section 21 of the Human Rights Act 1993.

Communication and language

Communication[10] with, and about, residents is humanising and respectful.

Communication and language (including te reo Māori and sign language) are understood to be central to identity and well-being of residents.[11] Communication used is responsive to the individual, including their age, culture, gender identity and needs. Spoken, visual, tactile and contextual approaches to communication are used to maximise understanding and participation, eg information is available in easy-read formats wherever possible.

Residents are supported to communicate as freely as possible. Speech, language, and communication needs are well understood and accommodated, including through specialist advice and services, functioning devices, communication tools, and practices, according to their needs and wishes.

Language interpretation and translation services and tools are used, and are tailored to the individual and the situation.

Where residents are not able to communicate through language (including sign language) other accessible means are used to help determine their needs and views.

Information, resources, and activities are provided in languages and formats that reflect the needs and preferences of residents.

10 Article 2 of the Convention on the Rights of Persons with Disabilities provides a useful definition of 'communication' as including '*languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology'.*

11 This includes how we express and receive communication, how we interact with others and with the world around us.

4. Health, care, and wellbeing

Expectation: Residents enjoy the highest attainable standard of physical and mental health

Residents are cared for in a holistic manner that nurtures and strengthens all areas of their wellbeing, including taha tinana, taha hinengaro, taha whānau and taha wairua.[12] Health is understood in its broadest sense, and all aspects of life in aged residential care are conducive to the wellbeing of residents.

Residents are listened to, and their health, disability and wellbeing needs are effectively identified and addressed. Residents receive timely and quality care and support from appropriately trained professionals, and have access to the range of services and supports they need.

Continuity of care is assured through close work with health services in the community. As patients, residents are treated with dignity, respect and kindness. Their right to privacy and medical confidentiality is respected. Preventive health services are implemented, and staff are aware of their role in responding to, documenting and reporting on health, care and wellbeing matters.

Examples of areas of interest

Welfare

Residents receive the care and support they require in a manner that is person-directed, culturally and life-course appropriate, trauma-informed and maintains dignity.

Staff are mindful of the physical and mental wellbeing of residents, and respond to their needs appropriately.

Residents are encouraged and have the opportunity to participate in recreational, sporting, religious and cultural activities to support wellbeing, including tikanga Māori, te reo Māori, principles relating to Māori health practice, and cultural practices specific to Pacific peoples. They are consulted in planning the activities offered with cultural needs appropriately acknowledged and taken into consideration.

12 The four pillars of health under the Te Whare Tapa Whā model. Taha tinana (physical health), taha hinengaro (mental health), taha whānau (family health), taha wairua (spiritual health).

Health assessment

Residents, their authorised representatives, carers and whānau (as appropriate) consent to, and are informed about and engaged in health assessments, their processes and outcomes. They are given time and assistance to understand and contribute to planned care and support, including reviews, and to think about and plan for the future. Plans are provided to residents in an accessible format, based on their preference.

Residents have a comprehensive health assessment on admission and regularly thereafter. This includes assessing and recording any evidence of prior ill-treatment,[13] and identifying any physical or mental health condition requiring medical attention, in a timely manner. Health examinations are conducted in a private setting, in a manner which is appropriate and comfortable for the individual and their needs. In particular, medication needs are assessed on admission and met without delay, as appropriate.

Medical care and equivalence of care

Residents have access to health care providers and services, outside of the facility, on an equitable basis, or of an equitable standard, as the general population. Residents, their authorised representatives, and whānau (as appropriate) have direct confidential access to health professionals (including health and disability advocacy services) and discuss the resident's health, care and support needs.

Preventive healthcare practices, including education, are implemented effectively including in relation to communicable diseases, and the maintenance of hygiene and infection control standards.

Residents have timely access to quality dental services based on clinical need, including oral health promotion.

Medication and health treatments

Residents, their authorised representatives, and their whānau (as appropriate) are involved in, and able to make decisions about, the medication and treatment they receive to the greatest extent possible. They are helped as appropriate to understand the clinical actions and effects, limitations, and potential side effects of the medication or treatment prescribed and to contribute to decisions about these.

Medication and other treatment changes are discussed with residents, their authorised representatives, and their whānau (as appropriate) before they commence, including any

13 In line with the 'Role of health professionals in documenting torture and ill-treatment in different contexts' outlined in the United Nations *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 2022.

change in treatment from community-services. Informed consent is sought and residents are able to exercise their right to decline or refuse medication or health treatments, except as provided for by law.

The medication and treatment needs of residents are met by staff who are qualified and competent to do so. They are prescribed safely, in accordance with evidence-based practice, are documented, reviewed regularly, including through second opinions when requested or necessary, and administered at clinically appropriate times by qualified staff, with due regard for confidentiality. Records are kept in cases where residents do not or are unable to consent to medication or treatment.

Additional disability identification and supports

There are consistent and comprehensive ways to identify residents with additional disabilities and ensure their needs are well understood, recorded, and known by appropriate parties. Screening for additional disability happens early in the aged residential care journey, recognising that the aged residential care environment can be further disabling and that additional barriers to care and treatment can be created if the needs of residents are not properly identified and reasonably accommodated.

Staff have a good understanding of the social model of disability.[14] Disabled residents are appropriately supported, including with physical and cognitive tasks such as showering, reading, understanding rules, participating in programmes and making complaints. Disabled residents are consulted and provide informed consent, including on decisions pertaining to their disability, including if or when other residents may provide support.

The experience and needs, whether physical, mental or psychosocial, of residents are well considered and provided for, including for those who are, or become, disabled.

14 '*The social model of disability specifies that individuals do not have disability - it lies in society. The experience of disability occurs when people with impairments are excluded from places and activities most of us take for granted. It happens when our infrastructure and systems do not accommodate the diverse abilities and needs of all citizens. The experience of disability is influenced by the nature of a person's impairment. Gender, age, ethnicity and culture can also have a profound and sometimes compounding effect on an individual's experience of disability*'. See the Office for Disability Issues | Te Tarī Mō Ngā Take Hauātanga, Guidance for policy makers, and the New Zealand Disability Strategy 2016-2026.

Reasonable accommodation

Additional barriers that may exist for individuals or groups are recognised and addressed through positive action or/and reasonable accommodation.[15] Where reasonable accommodation is not possible, the reason should be explained and alternative supports offered. Residents live in an enabling environment and receive the resources and aids they require to meet their mobility and sensory needs. Support is individualised and aligns with individual preferences.

Activities and engagement

Suitable and meaningful activities are offered and available for residents throughout the day. Residents, authorised representatives and whānau (as appropriate) are consulted about the interests and preferences of residents as to how they spend their time.

Residents are able to spend active and meaningful time with other people. The needs of specific groups, including spiritual and cultural needs, are identified and supported.

Therapeutic interventions

Residents are offered therapeutic interventions (such as psychological, sensory, occupational, and speech-language services) to promote their well-being. Interventions informed by tikanga and mātauranga Māori,[16] including rongoa,[17] are available.

Therapeutic interventions for residents are based on a person-directed and person-centred understanding of their individual history, goals, interests, and needs.

Time away from the facility

Residents have the opportunity to leave the facility regularly, based on their personal preferences and needs, in the company of whānau or staff who are able to provide orientation and support where required.

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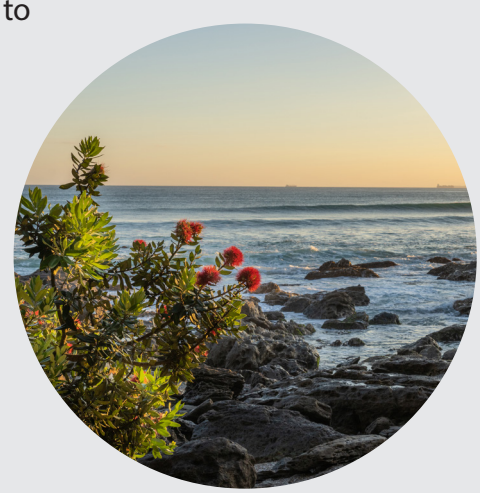
15 "Reasonable accommodation" is defined in Article 2 of the Convention on the Rights of Persons with Disabilities to mean '*necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms*'.
For more information on reasonable accommodations, see New Zealand's Independent Monitoring Mechanism guide **'**Reasonable accommodation of persons with disabilities in New Zealand**'.**

16 See Waitangi Tribunal. (2011). Ko Aotearoa tēnei: A report into claims concerning New Zealand law and policy protecting Māori culture and identity. WAI 262-Waitangi Tribunal report 2011. Lower Hutt, New Zealand: Legislation Direct, page 22: *''Mātauranga' derives from 'mātau', the verb 'to know'. 'Mātauranga' can be literally translated as 'knowing' or 'knowledge'. But 'mātauranga' encompasses not only what is known but also how it is known – that is, the way of perceiving and understanding the world, and the values or systems of thought that underpin those perceptions*.'

17 Traditional healing. Ibid, page 22

Understanding changed behaviours as a result of dementia



Changes in behaviour, including those which may be referred to as Behavioural and Psychological Symptoms of Dementia, are addressed with an emphasis on humane, individual, and compassionate interventions based on current, evidence-based best practice.

There is awareness of the relationship between changes in behaviour and the unmet needs of residents. Responses to complex behaviour consider how to identify and address those needs, as well as how these are best met in the future.

Where potentially harmful events or behaviour occur, de-escalation strategies are tailored to individual needs and circumstances. These strategies are based on knowledge of the individual and any advanced directives or preferences.

Residents, their authorised representatives, and whānau (as appropriate) are involved in identifying individualised de-escalation approaches, and agreed strategies are recorded and shared.

Referrals and access to services

Residents are referred to other services with the resident's (or authorised representative's, as appropriate) consent. They are fully informed of the reasons for the referral (unless urgent/emergency care is required) to appropriate health, care, and wellbeing services and specialists in a timely manner. Residents are supported to access services, activities, groups and resources of their choice, including those that are associated with specific cultural, spiritual or other practices.

5. Living environment

Expectation: Residents live in an environment that promotes their safety, independence, culture, dignity, and wellbeing

Residents experience a safe and healthy physical environment, which is fit-for-purpose for aged residential care. The accommodation promotes resident wellbeing, dignity, privacy and independence. Space, ventilation (including fresh air), temperature, lighting (including natural light), utilities and fixtures are all conducive to this, and are well maintained.

Design and resourcing of the facility ensures an environment that is appropriate for the varied needs of residents, which includes those related to disability and accessibility, culture, gender or health.

Fundamental rights of residents are met, including the right to adequate and nutritious food, clothing, fresh air, rest, exercise and purposeful activity. They have access to the natural environment, and are able to spend sufficient time outdoors regularly (at least daily) according to their preference. Spending time outside or away from the facility is encouraged and supported for those who wish to.

Residents are able to have input into their living environment to the greatest extent possible. Living environments should be individually appropriate, including personal space.

Examples of areas of interest

Physical environment

The building, facilities and grounds are appropriate for their purpose (eg dementia-friendly), and well maintained. The environment promotes the comfort, health, and wellbeing of residents and their enjoyment of daily life. The facility is recognised to be a place where people live, and so is 'home-like'.

Opportunities are sought for residents, consumer advisors, those with lived experience, whānau and relevant specialists to contribute to decisions about the physical environment.

Residents can physically access the building and facilities, and their physical, sensory and learning needs are accommodated. Care is taken to ensure signage and information is presented in languages, formats and locations suited to the needs of residents.

There are appropriate, designated spaces for residents based on their needs and care requirements.

Outside space, fresh air, and nature

Residents can freely access safe outside areas or gardens, and are supported to do so as desired. The outside areas provide space for social interaction and exercise, as well as fresh air, natural light, seating and shade.

Outside spaces enable engagement with the natural environment to the greatest extent possible. Ways of enhancing outside spaces and access to nature are considered and implemented, in recognition of the important benefits that connection with the natural environment provides for residents and staff.

Food, drink, and nutrition

Safe drinking water and nutritious food are available to residents in sufficient quantity, quality and variation. Residents have input into the options provided and when to eat.

Meals and food served provide for residents' dietary, cultural or religious needs and are served at an appropriate temperature and times.

Residents have independent access to food and drink options. Any restrictions are based on individualised risk assessment. Drinking water is freely available to every resident.

Food and drink are provided in a manner that recognises and respects residents' religious, cultural, and personal practices and customs, unless there is a justifiable and proportionate reason that this is not possible. There is a clear understanding of how food can bring people together, and help residents feel at home, but also recognition of the challenges food and eating can bring to residents for a variety of reasons.

Personal possessions and provisions

Residents have their own personal space, and the ability to personalise this, as appropriate.

Residents can have possessions that are familiar or important to them, especially in their personal space (such as bedrooms). They are able to access their stored possessions on request. Respect and appropriate care are shown for the personal possessions of residents.

Residents have their basic personal requirements met, including access to a range of toiletries, clothing, bedding, and personal hygiene materials. Disability aids, where needed, are available to residents and are individualised and well maintained.

There are adequate cleaning and laundry facilities and practices. Items that need to be washed, such as clothing and bedding, are kept clean and in good condition, and are labelled and returned correctly to their owner.

Bedrooms and sleep

Residents have a dedicated and comfortable place to sleep, securely store their belongings, and relax in privacy. Residents are accommodated in designated bedrooms that meet all their health requirements, including adequate floor space, and appropriate temperature and ventilation/ fresh air.

Emergency preparedness

There are clear, site specific, comprehensive strategies for dealing with disasters and emergency situations, preventing infection, and managing potential infection outbreaks. Policies and practices appropriately prioritise residents' rights, needs, and preferences. Plans and procedures are well communicated, tested and understood.

6. Staffing and quality improvement

Expectation: Residents are cared for by skilled, motivated, and engaged people

Staff reflect the diversity of New Zealand society, are appropriately trained, culturally competent, and employed in sufficient number.

Staff are conscientiously selected, recognising that the residents' safety and wellbeing depends upon the staff members' integrity, humanity, knowledge, skills, and personal suitability.

Staff are supported and equipped to provide the highest attainable standard of care.

Continuous quality improvements and innovation are evident. Transparency and openness amongst staff and residents support this. Findings and learnings, including from oversight bodies, incidents, complaints, and developments in best practice, are shared and acted upon. There is an ongoing commitment to providing the best outcomes for residents.

Examples of areas of interest

Staff resourcing

Sufficient permanent staff, with the appropriate training and knowledge, are employed to ensure the facility is safe, and resident needs are met, including residents' cultural needs.

Staffing arrangements are determined based on the purpose, nature and needs of the specific facility and residents in the facility. Staff resourcing prioritises residents' safety, independence, wellbeing, dignity and rights. Residents are never unsafe due to staffing shortages. Staff shortages do not prevent residents from receiving care or having access to meaningful activities.

Staff recruitment, training, and development

All staff are aware of the important role they play in conditions and treatment experienced by residents in aged residential care. Their work is acknowledged and they receive the support, training, and supervision necessary to be able to do their best for residents.

Staff are recruited and supported to provide a high standard of care and support to every resident. Facility and role-specific induction and training are provided, including training in trauma-informed care. Records of training are kept up to date.

All staff receive training on, and are familiar with, residents' rights under New Zealand law, and relevant international law, including on laws relating to the prevention of torture, and cruel, inhuman and degrading treatment or punishment and the rights of disabled people. They are

informed on the rights of particular groups such as older people, Māori, Pacific peoples and other ethnic groups, foreign nationals and migrants, women, LGBTQIA+ people, and disabled people.

Cultural education is valued at all levels within the facility and organisation, and is reflected in training opportunities being provided and required for all staff. This training includes the principles in the articles of the United Nations Declaration on the Rights of Indigenous Peoples and Te Tiriti o Waitangi | The Treaty of Waitangi. Staff are able to demonstrate an understanding of tikanga Māori values, te reo Māori and principles relating to Māori health practice.

Quality improvement

There are quality improvement strategies across the organisation, including at the aged residential care facility level, used continuously to assess and improve the care and support of residents. Strategies include responding to actions and learnings arising from past issues, incidents and complaints, regular quality assurance activities, and keeping good records. Best practice models and up to date research are used to improve care and support.

There are processes to ensure that staff, residents, authorised representatives, and whānau are able to influence and contribute to quality improvement initiatives.

Sufficient information is gathered and analysed to ensure that management is aware of any concerns about the conditions or treatment of residents and addresses these.

Appendix 1. Overview of OPCAT legal framework

The Optional Protocol to the United Nations (UN) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights agreement that New Zealand ratified in 2007.[18]

OPCAT establishes international and national monitoring mechanisms to inspect places where people are detained, with the overall aim of preventing torture and other cruel, inhuman or degrading treatment or punishment (ill-treatment).

Monitoring places of detention, including through inspections, helps to ensure that people who are deprived of their liberty are treated humanely, and their rights are respected, protected and fulfilled. It also ensures New Zealand is seen nationally and internationally as a good global citizen, adhering to agreed international human rights conventions.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention

Section 16 of COTA identifies a *'place of detention'* as:

> *…any place in New Zealand where persons are or may be deprived of liberty*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) is designated a National Preventive Mechanism (NPM) by way of Gazette Notice for certain places of detention, including health and disability places of detention.[19] In 2018 the wording of the designation was amended to explicitly include privately-run aged care facilities.

Under section 27 of COTA, an NPM's functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
    - for improving the conditions of detention applying to detainees;
    - for improving the treatment of detainees; and
    - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

18 Both OPCAT and the UN Convention it supplements – (the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) are on the UN Human Rights Office of the High Commissioner's website (www.ohchr.org).

19 Designation of National Preventive Mechanisms, Gazette Notice 2023-go2676, 22 June 2023

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and
- choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate the OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on their behalf.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read Ombudsman reports online: ombudsman.parliament.nz/opcat.

Appendix 2. Examples of evidence sources

- Observation of facility and daily activities
- Observation of interactions amongst staff and residents
- Observation of daily routines such as scheduled activities and provision of care
- Observation of meetings and review of minutes
- Discussions with residents
- Discussions with authorised representatives
- Discussions with whānau
- Discussions with staff, including volunteers and outside agencies or services, eg Chaplain
- Discussions with advocacy services
- Survey responses (for those who are sent a survey, eg staff and whānau)
- Review of resident files and clinical notes
- Review of policies and procedures
- Review of documentation such as complaint registers, restraint logs and incident reporting
- Review of post-incident debrief documents
- Review of staffing data, including rosters
- Review of staff training records
- Review of menus, activities schedules
- Review of documentation held by parties such as Ministry of Health, Te Whatu Ora or Service providers, which may inform how the expectations are being met.

Appendix 3. Domestic legislation and international conventions, standards and guidance

These lists are not exhaustive:

Table 1: New Zealand legislation, standards and guidance

Full title	Type	Abbreviation
Crimes of Torture Act 1989	Legislation	COTA
New Zealand Bill of Rights Act 1990	Legislation	NZBORA
Protection of Personal and Property Rights Act 1988	Legislation	PPPR Act
Human Rights Act 1993	Legislation	HRA
Pae Ora (Healthy Futures) Act 2022	Legislation	
Mental Health (Compulsory Assessment and Treatment) Act 1992	Legislation	Mental Health Act
Privacy Act 2020	Legislation	PRA
Te Tiriti o Waitangi / The Treaty of Waitangi	Treaty	Te Tiriti o Waitangi | The Treaty of Waitangi
Ngā paerewa Health and disability services standard NZS 8134:2021	Standards	
New Zealand Disability Strategy 2016-2026	Strategy	NZDS
New Zealand Disability Action Plan 2019-2023	Action plan	NZDAP

Table 2: International treaties, standards and guidelines

Full title	Type	Abbreviation
UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Treaty	'Convention against Torture' or 'the Convention'
UN Optional Protocol to the Convention Against Torture and other Cruel, Inhuman, and Degrading Treatment	Treaty	OPCAT
United Nations Universal Declaration of Human Rights	Treaty	UDHR
UN International Convention on the Elimination of All Forms of Racial Discrimination	Treaty	CERD
UN International Covenant on Civil and Political Rights	Treaty	ICCPR
UN International Covenant on Economic, Social and Cultural Rights	Treaty	CESCR
UN Convention on the Rights of Persons with Disabilities	Treaty	Disability Convention
UN Convention on the Elimination of All Forms of Discrimination against Women	Treaty	CEDAW
UN Declaration on the Rights of Indigenous Peoples	Declaration	UNDRIP
UN Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment	Principles	BOP
UN Principles for Older Persons	Principles	
Yogyakarta Principles and Yogyakarta Principles plus 10	Principles	
Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Protocol	The Istanbul Protocol
Institutional Treatment, Human Rights and Care Assessment (2010)	Guidance	The ITHACA Toolkit
Practice Guide to Monitoring Places of Detention (2004) – Association for the Prevention of Torture	Guidance	APT guidelines
World Health Organisation QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities (2012)	Guidance	WHO QualityRights Tool Kit
World Health Organization Freedom from Coercion, Violence and Abuse: WHO QualityRights Core Training: Mental Health and Social Services (2019)	Guidance	WHO QualityRights Tool Kit