At a Glance

Aged Care Monitoring Observations 2021-2024 From the Chief Ombudsman

This *At a Glance* gives a snapshot of what the Chief Ombudsman has seen during his visits and inspections. He has looked at what is working well, along with areas for improvement. This *At a Glance* has been made for residents, and their families/whānau.

The report OPCAT Aged Care Monitoring – Chief Ombudsman's Observations 2021-2024 summarises insights from visits to 148 aged residential care facilities from July 2021 – June 2024. The visits are guided by the Chief Ombudsman's *Expectations for the treatment and conditions of residents of secure aged care facilities*,[1] which are based on international and domestic human rights law and guidance.

Facilities description:

The 148 facilities are mostly urban based, with a small number in rural areas. Of the 148 facilities, 18 provide only secure care, and the rest provide other residential care services as well. There is a mix of small to large facilities with as few as 12 beds or as many as 70 or more secure beds. The facilities are mostly owned by private or not for profit organisations.

What Is Going Well?

Dedicated and Compassionate Staff

- Generally care provided by staff was commendable in their commitment to residents' well-being.
  "The staff who are often flat out consistently show respect, care and love for mum – for which we are truly grateful." – Family/whānau member.
- Many leaders are creating culture changes, improving resident care. For example, shifting from rigid schedules to an approach that encourages a wider range of activities and choice.

Examples of Good Practice

- Most facilities were clean and hygienic.
- Some facilities were doing a good job at creating dementia-friendly environments, including appropriate signage, lighting and colour, and making it easy to identify residents' rooms.

1 To explore the full set of the Chief Ombudsman's Expectations, view the Ombudsman website: https://www.ombudsman.parliament.nz/resources/expectations-conditions-and-treatment-residents-health-and-disability-places-detention

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- Some facilities were making a real effort to provide culturally responsive care. Examples included creating a 'cultural communication manual' for staff, or a 'cultural committee' of staff members from various backgrounds, another had built relationships with outside groups to support them to meet resident's needs. Other examples included culturally responsive signage, spiritual support, and diverse language resources for staff.

Facility Improvements Post-Inspection

- Facility managers have generally responded well to feedback. In some cases, making immediate changes, such as by increasing staff capacity, updating staff training, providing information about complaints processes to residents, and increasing activities.
- Some facilities have decided to adopt new ways of communicating to support residents with dementia, and have also provided more training on caring for people with dementia and those in psychogeriatric units.

What Needs to Improve?

Legal authority to reside in a secure unit needs to be in place for all residents

- Although it is complex issue, a robust process must be in place for checking and recording that there is a legal basis for all residents to be placed in secure aged care facilities. Where legal authority is not in place, there should be a clear plan to obtain it. The Chief Ombudsman has called for national guidance for facilities on how to do this. A clear understanding will help facilities, and families/whānau.

Staffing Pressures

- Staff working in the sector are overstretched. In some cases there is too much reliance on the goodwill of staff to do more. There are many examples of staff working long or double shifts with minimal breaks, and feeling pressured to do so.

Unnecessary Restrictions on Residents

- Some residents are being restricted from going to outdoor areas when they don't need to be.
- There is a lack of consistent staff training and understanding of restraint.
- Some staff need training to help residents maintain their independence, and to support residents to make their own decisions rather than do it for them.

Activity and Social Engagement, and connection with the outside world

- Some facilities lack meaningful activities that support residents' wellbeing, leading to them getting bored and frustrated.
- Some facilities found it hard to give all residents regular time away from the facility. This was because they did not have enough suitable vehicles, or available staff.

Facility Design & Outdoor Access

- Not all environments are dementia-friendly and have confusing layouts for residents.
- Limited access to outdoor areas or spaces that are small or poorly maintained has an impact on each resident's quality of life.

Aged Cared Sector - Looking Ahead

- The Ombudsman will continue regular monitoring of secure aged care facilities.
- Future visits and inspections will track progress on issues raised in this and other reports as well as new challenges.
- By the end of June 2025, the Ombudsman should have visited all secure aged care facilities around the country at least once.

The Chief Ombudsman monitors aged residential care where are people are not free to leave at will – primarily secure dementia level care and/or specialised hospital care (psychogeriatric level care).

To read this report and learn more about the Ombudsman's Aged Care monitoring, go to: **ombudsman.parliament.nz/agedcare**

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