

(Office of the
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 **Ombudsman**

Fairness for all

OPCAT COVID-19 report

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

June 2021

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Tari o te Kaitiaki Mana Tangata

Executive summary

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

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

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

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

Health and safety

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

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

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

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

²⁰ The same recommendation was made to two different Facilities.
