SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Åsgårdstrand Nursing Home, Horten Municipality

1st–11th December 2020

National Preventive Mechanism against
Torture and Ill-Treatment

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Innhold

1 Torture and inhuman treatment

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in several international conventions that are binding on Norway.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), adopted in 1984, plays a central role in this connection. The same prohibition is enshrined in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15), and the European Convention on Human Rights (Article 3). Norway has endorsed all these conventions.

People who have been deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2002. Norway endorsed the Optional Protocol in 2013.

2 The Parliamentary Ombudsman's prevention mandate

As a result of Norway's ratification of the Optional Protocol to the UN Convention against Torture in 2013, the Parliamentary Ombudsman was issued with a special mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombudsman has established its own National Preventive Mechanism (NPM) in order to fulfil this mandate.

The NPM regularly visits locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits can be both announced and unannounced.

The Parliamentary Ombudsman has right of access to all places of detention and the right to speak in private with people who have been deprived of their liberty. The Parliamentary Ombudsman also has right of access to all necessary information that is relevant to the conditions for people deprived of their liberty.

The risk of torture or ill-treatment occurring is influenced by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[2] Effective prevention work therefore requires a broad approach that does not exclusively focus on whether the situation complies with Norwegian law.

The Parliamentary Ombudsman's consideration of factors that constitute a risk of torture and ill-treatment is based on a wide range of sources. During its visits, the Ombudsman examines the conditions at the institution through its own observations, interviews and a review of documentation. Private interviews with those who are deprived of their liberty are a particularly important source of information, because they have first-hand knowledge of the conditions at the institution in question. They are in a particularly vulnerable situation and have a special need for protection. Interviews are also conducted with the staff, management and other relevant parties. Documentation is also obtained to elucidate the conditions at the institution, such as local guidelines, administrative decisions on the use of force, logs and health documentation.

After each visit, the Parliamentary Ombudsman writes a report describing its findings and recommendations for preventing torture and other cruel, inhuman or degrading treatment or punishment.

The reports are published on the Parliamentary Ombudsman's website and the institutions visited are given a deadline for informing the Ombudsman about their follow-up of the recommendations. These letters are also published.

In its endeavours to fulfil the prevention mandate, the Parliamentary Ombudsman also engages in extensive dialogue with national authorities, control and supervisory bodies in the public administration, civil society and international human rights bodies.

[1] Section 3 a of the Parliamentary Ombudsman Act.

[2] See the UN Subcommittee on Prevention of Torture (SPT), The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 30 December 2010 CAT/OP/30/6.

3 Summary

The Norwegian Parliamentary Ombuds's National Prevention Mechanism (NPM)visited Åsgårdstrand Elderly Care Home in Horten Municipality in December 2020. Åsgårdstrand is a public care home and is run by the municipality. The facility primarily provides rooms for elderly persons diagnosed with dementia and severe functional impairment as a result of somatic dysfunction. At the time of the visit, the nursing home had 52 rooms divided across three departments and six wards. Our visit focused on wards 1A, 1B and 2D.

Our visit complied with the applicable covid-19 pandemic public health measures at the time of the visit. In addition to an inspection of the premises, the visit also involves conducting telephone interviews and document review.

Residents in care home facilities have the right to be treated with respect and dignity, and to receive adequate services that secure their fundamental needs. The resident has the right to participate in making decisions about their plan of care. Relatives and/or guardians should be systematically involved when developing these care services.

The staff members at Åsgårdstrand had made attempts to create arrangements that would allow the residents to participate in decision making and influence aspects of their everyday lives. The care home appeared to have established a systematic approach for keeping relatives informed. Nonetheless, we found that staff had limited time and capacity to give residents an adequate opportunity to be included in making personal decisions that impacted their daily routine and life.

A majority of the care home residents require help in maintaining mobility and functional movement. A variety of activities that can be adapted to each resident's needs and interests should therefore be available.

We found that there was insufficient capacity to make available physical activities that were adapted to individual residents. The opportunity for residents to spend time outdoors was dependent on the limited capacity of staff, or whether relatives were available. The activities available at Åsgårdstrand were dependent on the municipality's Activities Manager, who was responsible for several care homes and worked on a volunteer basis. Throughout the pandemic, most of the organised activities had been cancelled and the volunteers had significantly limited access to the care home. Even so, we noted that the activities made available to residents was limited even before the pandemic.

A review of documentation indicated that the care home residents received frequent visits from the care home doctors, but that there were shortcomings in documenting important information about the health assessments and follow ups. As example is the assessment done by the medical service when the residents first arrived at the care home. We also noted missing documentation for how medication reviews were conducted, including information about the assessment, findings and whether any follow up measures were necessary. Proper documentation is imperative for ensuring safe use of medication and limiting the risk of harm to patients due to improper use of medication.

There was also limited documentation on how the care home worked systematically to follow up on the nutritional status of individual residents. Many residents were in a general weak mental and physical condition and it is therefore vital that routines and measures are in place that can identify individuals who require necessary care to limit the risk of residents becoming malnourished.

Although not frequent, our findings suggest that residents with behavioral challenges may occasionally act aggressively towards other residents and/or staff members. As a result, we determined there was an increased need for awareness and knowledge in how to handle such incidents. The care home had initiated training on how to prevent and address violent situations. This will be an important measure for providing staff with the skills necessary to prevent violence and aggression, while complying with human rights standards. In order to provide patients with proper care over time, it is also important that staff members have the necessary knowledge and skills to ensure their own safety while at work. Relatives informed us that both they and their family member living at the care home Åsgårdstrand felt safe and well-looked after. Even so, we found that few staff members were aware of the possibility and risk of violence occurring between residents. Staff lacked knowledge of how to proceed if they suspected an incident of violence. Following the Norwegian Parliamentary Ombud's visit, the municipality developed a new procedure for handling such incidents at elderly care homes. Developing solid procedures and training staff in how to implement these procedures are important in ensuring that the care home is in the best position to detect and address elder abuse and neglect.

At the time of the visit, the care home had residents who were subject to use of force on the basis of necessity, in accordance with the *Patient and User Rights Act, Chapter 4A*. The municipality had clear and consistent routines that contributed a distinct placement of responsibility for various aspects of the procedure for using force. Regular meetings at the municipality level were established to review the use of force decisions and to provide guidance for issues involving non-conformance. It appeared that staff at the care home had a high level of awareness regarding the importance of building trust and that they consistently documented which trust-building measures had been attempted before decisions to use force were made. The staff also showed they were capable of a high level of professional and ethical reflection regarding use of force. However, many seemed uncertain about how to manage practical use of force situations. There appears to be a need for more training about the legislative requirements with a focus on how to record use of force decisions. Our review found that several decisions did not fulfill the legal requirements for use of force against elderly care residents.

In some situations, a decision on health care had been made and provided to a patient despite lack of consent, without the decision fulfilling the legal requirements. In several cases the reasoning for this was a misinterpretation and lack of understanding about the criteria in *the Patient and User Rights Act, Chapter 4A.* Staff were under the impression that the legislative requirements did not apply for incidents when force was applied for short periods of time. Limited time during the incident for staff members to comply with the requirements was also one explanation given by staff.

Our finding highlights the importance of emphasizing that the legal requirements always apply when making a decision against a care home resident who is not giving consent to the specific treatment. In the event where time does not allow for the decision to be recorded in writing prior to exercising force, the decision may be recorded after the incident has occurred, with an explanation for the reasons why force was deemed necessary.

The resident rooms had sensor alarm installed on the doors which alerted staff when a resident left their room. It was primarily used for residents who had difficulties with orientation or who were at risk of falling, in order to prevent them from being injured.

We found examples of the sensor alarms turned on without notifying the residents. In other cases, residents were informed of the sensor alarm being activated, but the decision to restrict the resident's movement in this manner was lacking. Similarly, there was a lack of assessment on whether the resident had given consent to activate the sensor alarm.

Some staff members justified the use of sensor alarms during the evenings and nights. This practice is not legal.

A smaller number of residents were subject to the legal decision to be detained in accordance with the regulations under *the Patient and User Rights Act, Chapter 4A*. However, our findings indicated that the care home's routines and staffing resulted in residents for which decisions regarding detention were not applicable, were in practice also prevented from leaving. Several residents experienced locked doors to be particularly restrictive. Many residents relied on staff members' assistance in order to go outdoors, and some only received the opportunity to go outside when aided by staff or their relatives. We noted that the opportunities for staff to accompany the residents outside of the care home were particularly limited, especially in the afternoons and evenings. Overall, our findings revealed that, in practice, the existing routines and available staffing at the care home posed a risk of residents being prevented from leaving the care home without the legal requirements being fulfilled.

3.1 Recommendations

Contributions from relatives

- The elderly care home must involve relatives and/or guardians of each patient when developing measures aimed at creating trust in order to prevent coercion and use of force when providing healthcare services to the resident.

Activities

- The elderly care home must ensure that all residents who would like the opportunity to go outdoors in fresh air have that option available to them.
- The elderly care home must improve the list of activities offered and ensure that activities are tailored to each individual resident, including physical activities.

Use of medicines

- The elderly care home must implement measures that ensure that systematic medication reviews are carried out and that the assessments, findings and measures are documented in each patient's journal. Deviations from the national guidelines regarding the use of medication must be justified in writing with adequate reasons recorded in the journal.

Follow-up on the nutritional status of residents

- The elderly care home must ensure that systematic follow-up procedures are in place regarding the nutritional status of each patient, and that this work is recorded in each patient's journal.

Good practices for recording rights

- The elderly care home must improve procedures for regularly recording how each patient's fundamental needs and rights are being addressed and ensured.

Protection and safety

- The elderly care home must ensure there are procedures in place for both preventing and handling incidents of violence, threatening behaviour and assaults towards residents and staff members, and that these are sufficiently detailed and that all staff members are familiar with the procedures.
- The care home must implement measures to increase staff members' awareness and knowledge of elder abuse, so that they are prepared to recognise and address incidents.
- The care home must ensure that adequate guidance and systematic procedures exist to assist staff members after difficult incidents.

Knowledge of coercion in healthcare

- The municipality and elderly care home must implement measures to ensure that all members of staff have the necessary knowledge regarding coercion in healthcare, including how decisions need to be written in order to document that the legislative conditions for using force are met.

Decisions regarding coercion in healthcare

- The municipality and elderly care home must ensure that each patient's ability to consent is continuously assessed, specifically in relation to the relevant healthcare they are receiving, and that these assessments are documented.
- The municipality and care home must ensure that decisions regarding coercion in healthcare include adequate reasons and are explained in a manner that gives an opportunity for oversight.

Coercion in healthcare without a decision

- The elderly care home must implement measures to ensure that the healthcare services it provides fulfil the conditions in Chapter 4A, and that a decision is made in accordance with the legislative requirements.
- The care home must secure that it improves its practise on the use of door alarms, ensuring that door alarms are only activated upon the patient's informed consent, or, in situations where the patient is unable to give consent, after an individual assessment on whether the legislative requirements are fulfilled.
- The elderly care home must ensure that residents are not prevented from leaving the nursing home due to lack of staff, but only after an individual assessment of the conditions laid out in Chapter 4A have been met.

Necessity and the right of self-defence

- The care home must ensure that intervening emergency measures to protect the patient or others are thoroughly documented (in the patient journal and in the deviation system).

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