SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Høyås Residential and Rehabilitation Centre, Nordre Follo Municipality

October 2020

National Preventive Mechanism against Torture and Ill-Treatment

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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 Ombud's National Prevention Mechanism (NPM) visited Høyås Residential Elderly Care and Rehabilitation Centre, Nordre Follo Municipality in October 2020. Høyås is a public facility and run by the municipality. Nordre Follo Municipality was established on 1st January 2020, when the municipalities of Oppegård and Ski were merged. The process of merging the municipalities was still ongoing at the time of the visit and thus impacted both the municipality and the elderly care home. As did the Covid-19 pandemic.

At the time of the visit, the care home had the capacity for 111 patients, organized into four separate sections. We visited the section referred to as the basement section, which had 31 rooms reserved for patients with dementia. This section was divided into four residential units. Two of these were so-called sheltered units. Our visit complied with the applicable Covid-19 pandemic public health measures at the time of the visit.

Elderly residents in long-term care and nursing homes have the right to be treated with dignity and respect while receiving adequate services that address their individual and fundamental needs. It is imperative that residential care homes can accommodate persons with dementia in a manner that, to the greatest extent possible help maintain their personal autonomy. As example every resident must have the opportunity to participate to the extent possible in the development and implementation of the care plan. In addition, there needs to be a clear process and practice of information sharing and dialogue with the resident's family or designated decision-maker.

During the visit, we observed several examples of arrangements being made for the residents to participate in decision making, and where the care home interacted with relatives. A majority of the relatives and residents we spoke with expressed that they were being well-looked after. However, we found a lack of a systemic approach and several missed opportunities for including residents and their relatives in the decision-making process.

A review of the non-conformance issues reported by the basement section from the end of May to October 2020 revealed periods with insufficient staff. This was reported to have impacted staff members' abilities to follow up on the residents in a responsible manner. As example, there were several cases where temporary staff had not been hired to cover for permanent staff on sick leave. Lacking sufficient and professional staff had contributed to difficult working conditions and lack of adequate abilities to provide care and treatment for residents.

Most of the elderly care home residents require help to maintain their mobility and functional movements. Adapted physical activity and the opportunity to go outdoors can help residents be more self-sufficient and also provide them with a better everyday quality of life. This is crucial to promoting self-awareness, reducing pain, preventing injuries caused by falling and avoiding complications. The care home offered limited activities that were individually adapted for residents, as well as limited opportunities to spend time outdoors in fresh air. We found that the basement section in general had limited opportunities for physical activity. Many of the residents had physical activity included as a goal in their action plan, but the plans did not contain information or any description of how this goal would be achieved. Neither did we find information concerning this issue in the nursing records.

There was a significant variation in the quality of the residents' individual action plans. In several cases, the action plan goals were missing, as were the descriptions of how these actions would be implemented. The nursing records had limited information on whether or not, and how, actions and

treatments had been followed up on a daily basis. This made it difficult to assess whether actions, goals and procedures had been addressed and implemented for each individual resident.

It later became evident that staff members working in the basement section were not provided with systematic training on how to prevent and handle aggressive behaviour, even though they frequently encountered such situations when interacting with residents. There was also no systematic follow-up or guidance procedures in place for staff who had experienced difficult or serious incidents. In order to provide residents with proper care over time, it is important that staff members receive psychosocial support and have the necessary knowledge and skills to ensure their own safety while at work.

We found that there was a lack of adequate knowledge in using force when providing health services to residents. This included uncertainty about the definition of force, in what situations staff have the legal permission to use force, and when it is required to make a legal decision for situations where force is necessary. There was also a lack of understanding about who was responsible in the use of force decision making process, including who had approval authority, and how the decision should be formulated. Both staff and management considered these issues complicated and time consuming

Lack of adequate knowledge concerning the legal requirements for use of force constitutes a high risk of elder abuse and the illegal use of force, , either because the conditions for using force are not present or because the decision to use force is not being documented. Knowledge and awareness of the legislative requirements for using force is crucial in order to correctly assess whether the resident/patient is providing consent, whether the force is necessary in the given situation, and whether the force is proportionate considering the given circumstances.

The staff seemed to use a significant amount of time on motivational work and trust-building measures so to give residents an opportunity to voluntarily consent to their care and necessary assistance. Even so, our findings demonstrated that health services had been provided to residents without consent and without making a legal decision in accordance with the legislative requirements.

At the time of our visit there were no patients in the basement section that were registered as subject to the legal decision to be detained in accordance with the regulations under the *Patient and User Rights Act, Chapter 4A*. Even so, we noted that, in reality, it was difficult for residents of this section to leave the care home without assistance from staff. Practical opportunities for the staff to accompany the residents outside of the care home appeared to be particularly limited. During the visit, we observed various physical obstacles that limited the residents' opportunities to move around freely. Restrictions on freedom of movement can only be made if the criteria outlined in the *Patient and User Rights Act, Chapter 4A*, have been fulfilled and this decision must include adequate reasons that justify why it is necessary in that specific situation for that specific individual. A general decision to limit freedom of movement that applies to all residents cannot legally be made, as example, locking all doors at the care home or all doors in one section. Overall, we found that there was a risk that residents were restricted from leaving the care home without the legal conditions being fulfilled.

There was also an extensive use of the sensor alarms in the basement section. No legal decisions on restricting freedom of movement had been made in any of these situations. It was also not clear whether the alarms had been used with the residents' consent, whether they had been informed that the sensor alarms were activated or what assessments were made in regards to the individual resident.

In the period 2019/2020 two decisions to use force had been made in the section. Both of these decisions were evoked by the County Governor due to errors and omissions. The care home did not have a process for quality assurance when it came to review of use of force decisions. Such quality assurance was also missing on the municipality level. In accordance with the law the municipality must have an 'Overall Specialist Manager' who must receive a copy of all decisions concerning use of force. The municipality of Nordre Follow did not have anyone in the position as an "Overall Specialist Manager" and as such, there was no oversight of the use of force at the care home.

3.1 Recommendations

Recommendation: The resident's right to participate

- The care home should systematically accommodate a process that ensures the resident's participation in making decisions about their care and life.

Recommendation: Participation of the resident's family or designated decision-maker

- The care home should establish a process and routine that ensures information sharing and dialogue with the resident's family or designated decision-maker, also in situations where use of force is necessary.

Recommendation: Staffing and capacity

- The municipality and care home should ensure that all units are adequately staffed so that staff members have the capacity and ability to provide proper care that ensures the fundamental needs of the residents.

Recommendation: Physical activities

- The care home should ensure that all residents who desire have a realistic opportunity to spend time outdoors in fresh air on a daily basis.
- The care home should strengthen the activity offers and ensure that there are activities available that are based on the individual needs of the residents.

Recommendation: Documentation in nursing records

- The care home must ensure that all activity plans include updated information about the resident, which activities are necessary to provide the required care, and how the activities will be implemented (specific procedures for care).
- The care home must ensure that the nursing records include documentation on follow-up of activities and procedures relating to care of the resident.

Recommendation: Procedures for preventing violence

- The municipality must ensure that there is a process in place for preventing and managing violence, threats and abuse against residents (elder abuse) and staff members, and that information and awareness about these processes are made available to all staff.
- The municipality and care home should ensure that all staff receive training in how to prevent and manage challenging behaviour.

Recommendation: Staff welfare

- The care home should ensure staff receive guidance and follow-up on a routine basis following difficult incidents.

Recommendation: Review of use of force

- The care home should establish a process for quality control for decisions on the use of force.

Recommendation: Municipality's oversight and follow-up

- The municipality should designate an Overall Specialist Manager to ensure oversight and review of the use of force decisions in the municipality.

Recommendation: Knowledge of forced health services

- The municipality and the care home should ensure that all staff have solid knowledge in the requirements for providing health services without consent (Chapter 4A), including the practical skills in drafting decisions on the use of force.
- The municipality and the care home should ensure that training is made available to staff on a regular basis on the criteria for providing health services without consent.
- The municipality and the care facility should ensure that all staff are familiar with the roles and responsibilities when providing health services without consent.

Recommendation: Resisting health services and care

- The care home should implement procedures to ensure that health services and care is not provided with the use of force unless a legal decision that fulfils the legislative requirements is made.

Recommendation: Detention and limitations of movement

- The care home should ensure that the resident's freedom of movement is not limited more than the legislation allows.

Recommendation: Use of sensor alarm

- The care home should ensure that location- and alarmtechnology is not used without a legal decision made that fulfils all legislative requirements.

Office address: Akersgata 8, Oslo
Postal address: P.O. Box 3 Sentrum, NO-0101 Oslo
Telephone: +47 22 82 85 00
Free of charge: +47 800 80 039
Fax: +47 22 82 85 11
Email: postmottak@sivilombudsmannen.no
www.sivilombudsmannen.no