SIVILOMBUDET
Norwegian Parliamentary Ombud

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Stovnerskoghjemmet Nursing Home, Oslo municipality

16–17 March 2022

National Preventive Mechanism against
Torture and Ill-Treatment

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Summary

In December 2021, Oslo Municipality was informed that a visit would be carried out to Stovnerskoghjemmet Nursing Home over the course of 2022. The visit was carried out on 16–17 March 2022.

At the time of the visit Stovnerskoghjemmet had capacity for 148 patients, organized into six different sections. Our visit was carried out to the section reserved for patients with dementia (1B), which had capacity for 19 patients and was at full occupancy at the time of the visit. The section was a so-called sheltered unit and the only section in the nursing home that had locked doors. Ten of the places in the section was so-called reinforced, reserved for patients with dementia and challenging behaviour.

During the visit, we examined four thematic areas at the crux of our mandate: restrictions on movement, use of coercive measures when providing health care, risk of inadequate medical care, as well as the nursing home's efforts to protect the residents against violence and abuse.

Restrictions on movement and barriers to exiting

A general decision to limit the freedom of movement that applies to all residents cannot legally be made, as example, locking all doors at the nursing home or in one section. 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. For example, this may be relevant if residents, due to disorientation or cognitive impairment, risk getting lost or going missing or being seriously harmed in traffic.

At the time of the visit, two of the residents in the nursing home's secluded section were subjected to a legal decision to be detained. The two decisions were justified individually, in a manner that documented fulfilment of the statutory requirements.

To execute the restriction on movement for these patients the section was locked from the inside. It is not contrary to the legislative framework for the exit door of a nursing home to be locked if one or more of the residents are subjected to a decision to be detained. However, it is important that this does not generally prevent the residents from exiting.

At the time of the visit, none of the residents were in possession of key cards and were all in need of assistance from the personnel in order to exit. The findings during the visit indicated that the department followed up individually with residents who wished to leave the department.

Overall, our findings showed that the nursing home's routines, practices in the section and the high level of awareness among staff members regarding the residents' right to freedom of movement, reduced the risk of residents being subjected to restrictions of movement without the statutory requirements being met.

Use of coercive measures to implement health care

At the nursing home, generally, and on the secluded department, in particular, many patients have illnesses and conditions that may affect their capacity to consent to health care. Therefore, situations

will often arise where residents refuse to receive necessary health care without understanding the consequences of such a refusal and there may be a risk of considerable harm if care is not provided.

At the time of the visit, two residents in section 1B were subjected to a legal decision entailing that care could be implemented against the patient's will. The decisions were justified individually and fulfilment of the conditions for using coercive measures were accounted for pursuant to the *Patient and User Rights Act, Chapter 4A.*

During the visit, information emerged regarding a patient who, for periods of time, was incapable of displaying resistance due to said patient's health condition. No legal decision concerning care had been made pursuant to Chapter 4A. A review of documentation also revealed that the patient had resisted care during periods in which said patient was capable of doing so. The Parliamentary Ombud notes that a legal decision concerning the use of coercive measures to implement health care should have been made for these situations.

Prevention of coercive measures

It appeared that good efforts were being made in the section in terms of confidence building measures and prevention of coercive measures. The staff members appeared to be well acquainted with the residents and relatives were actively used to ensure good treatment. The culture at the department was characterised by collegial guidance, an interdisciplinary approach and active use of collective reflection regarding specific challenges in the workday. This appeared to result in a high level of awareness and confidence in the understanding of what constitutes resistance and what is experienced and defined as coercion.

At the same time, it appeared that many staff members were uncertain about the regulatory framework on the use of coercive measures. There was an unmet need for training in the legislation relating to the use of coercive measures. However, the culture and the systematic knowledge transfer in the secluded section at Stovnerskoghjemmet seemed to limited the risk linked to inadequate formal training in the regulatory framework.

Oslo Municipality was informed of the scope of decisions made concerning the use of coercive measures and had held several meetings with the nursing home over the course of the year. However, the Municipality did not have a comprehensive overview of how many or how large a share of the nursing homes' decisions concerning use of coercive measures had been overturned by the County Governor or returned with remarks regarding errors or omissions. This resulted in Oslo Municipality not having the possibility to identify differences in quality of decisions between the nursing homes in the Municipality.

Medical follow-up

At nursing homes, medication errors represent a risk of serious patient harm or fatalities. Patients admitted for long-term stays in Norwegian nursing homes are to be offered systematic medication reviews upon admission and at least once a year.

The secluded section had weekly visits by a physician and otherwise had good access to a physician. Our findings indicate that the nursing home had sound systems for medication review. Medication review was carried out twice a year and documentation of the medication reviews offered good

descriptions of both physical and mental health matters, results from blood tests, medications and possible changes to medications, as well as plans for changes.

Staff members at all levels stated that they perceived it as being their responsibility to notify and discuss suspicions of medication errors with a physician.

Protection from violence and abuse

Residents at nursing home are especially vulnerable to violations, violence and abuses because they are often entirely dependent on assistance due to their health condition.

The majority of relatives of residents in the secluded department at Stovnerskoghjemmet explained that both they and their relative felt safe and well looked after at the nursing home. However, there was an acknowledgement among staff members and management that the staffing situation could limit possibilities for safeguarding the residents. In particular, this was a risk during the night when the secluded department was staffed with only one auxiliary nurse, despite the fact that the department was divided into three separate wings. In light of the residents' needs and behavioural expressions, the low staffing levels in the night appeared to pose a risk of the night shift being unable to safeguard the residents.

At the time of the visit, Oslo Municipality had a number of routines in place for preventing and handling threats and violence directed at and among residents. We found that there was some awareness among staff members regarding the risk of violence and sexual abuse among residents.

The risk of abuses and violations perpetrated by staff members was a less discussed topic. The applicable routines and procedures for such situations were not well known among the staff members. Therefore, the Parliamentary Ombud recommends that measures be implemented to strengthen staff members' awareness of this risk.

I. Recommendations

Restrictions on movement and barriers to exiting

- The Nursing Home should ensure that the section is not routinely locked irrespective of the composition of residents. All restrictions on freedom of movement must be justified individually in accordance with the criteria outlined in the Patient and User Rights Act, Chapter 4A.

Compulsory healthcare

- The Nursing Home must ensure that the healthcare is not provided through coercive means without the conditions in Chapter 4A having been met, and that a legal decision has been made regarding this.
- The nursing home should implement measures to ensure that decisions concerning the use of compulsory healthcare include clear descriptions of the coercive measures that are to be performed.
- The Nursing Home should implement measures to ensure that, when coercive measures are used, it is documented in the patient's medical records which specific coercive measures were performed.

Prevention of coercive measures

- The Municipality and the Nursing Home should implement measures to ensure that all staff members have the necessary knowledge in the legislation relating to the provision of health care thorough the use of coercive measures.
- The Municipality should consider initiating measures that provide comprehensive knowledge regarding the quality of decisions across the nursing homes in the Municipality.

Protection from violence and abuse

- The Nursing Home must ensure that the Municipality's procedures for both preventing and handling incidents of violence, threatening behaviour and assault toward residents are familiar to all members of staff.
- The Nursing Home should ensure staffing during the night, which, in practice, enables staff members to protect the residents from violence or abuse.

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