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OPCAT Report

Report on an unannounced follow up inspection of Te Whare o Matairangi Mental Health Inpatient Unit, Wellington Hospital, under the Crimes of Torture Act 1989

August 2020

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Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report of an unannounced follow up inspection of Te Whare o Matairangi Mental Health Inpatient Unit, Wellington Hospital, under the Crimes of Torture Act 1989

ISBN: 978-0-473-53766-1 (PDF)
Published August 2020

Office of the Ombudsman | Wellington, New Zealand | www.ombudsman.parliament.nz

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Foreword

This report sets out my findings and recommendations concerning the treatment and conditions of people detained in Te Whare o Matairangi (the Unit). The Unit is located on the Wellington Hospital Campus, Wellington.

In the Unit, clients receive acute mental health services provided by the Capital and Coast District Health Board's (DHB's) Mental Health, Addictions and Intellectual Disability Service (the Service).

This report has been prepared in my capacity as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA). In 2007, the Ombudsmen were designated one of the NPMs under the COTA, with responsibility for examining and monitoring the treatment and conditions of detained people in the relevant places of detention. My responsibility includes hospital units in which people are detained.

The report examines the Unit's progress implementing the nine recommendations I made in 2017. It also includes findings on the conditions and treatment of clients detained on the Unit at the time of my follow up inspection on 19 – 20 March 2020, resulting in eight recommendations.

I found that four of the nine recommendations I made in 2017 had been achieved, and five had not been achieved.

During the follow up inspection, I found that:

- Maintenance issues in the de-escalation lounge and seclusion rooms had been addressed.
- Seclusion and Restraint policies were up-to-date.
- The women's bathroom had been repaired.
- The Unit was clean and tidy.
- A wide range of activities and occupational therapy was available on the Unit, including on weekends.
- Staff were regularly seen on the Unit and engaging with clients in a professional and respectful manner.
- Staff were complimentary about the Unit's leadership team. Leadership on the Unit was visible, supportive and positive.

The issues that needed addressing were:

- Seclusion rooms, and other non-designated bedrooms, were still being used as bedrooms when the Unit was over occupancy. This amounted to degrading treatment and a breach of Article 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention against Torture').[1]

[1] UN Convention against Torture, Article 16(1): "*Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount*

- Not all staff were up-to-date with mandatory training requirements.
- Clients were not invited to attend their Multi-Disciplinary Team meeting (MDT) and did not receive a copy of their care plan.
- The Unit was regularly over occupancy, which was impacting on the safe management of the Unit.
- Notices detailing the process for entry and exit into and out of the Unit for visitors was not displayed.
- The phone booth in Te Taha Tauira was not made available to clients.
- The Unit did not have a Social Worker, which was placing significant pressure on the Service in sourcing suitable accommodation for long-term clients.
- Safe staffing ratios did not reflect the capacity or acuity levels of the Unit.
- The Unit had employed external security staff to increase staffing numbers, despite not having a formal contract, training or job description.

As a result of my follow up inspection, I make eight recommendations to improve the conditions and treatment of clients. Disappointingly, five of these were repeat recommendations.

I will be assessing the Service's progress in implementing the recommendations in this report with another inspection at a future date.

I acknowledge that this inspection was conducted days before New Zealand entered a nationwide Alert Level 4 lockdown on 25 March 2020 due to the COVID-19 pandemic.[2] I am grateful to the facility staff for supporting my Inspectors in conducting their inspection.

I appreciate that this is a difficult time, and am heartened by the helpful approach taken by management and staff.

Peter Boshier

Chief Ombudsman
National Preventive Mechanism

to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment."

[2] See https://covid19.govt.nz/alert-system/covid-19-alert-system/ for more about New Zealand's COVID-19 alert system.

The facility

Te Whare o Matairangi

Te Whare o Matairangi (the Unit) is a 29-bed[3] acute mental health inpatient service.

The Unit accommodates men and women experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital environment. Clients are referred to the Unit by community teams and wards within the main hospital.

The Service is primarily provided for people in Wellington, Porirua and Kāpiti. However, people can also be admitted from the Wairarapa and wider Wellington region.

The Unit is located in the grounds of Wellington Hospital Campus, Wellington. It has three main accommodation areas for clients:

- Te Taha Tauira – secure ward
- Whakatau Wairua – low stimulus/seclusion area
- Te Taha Manaaki – open ward

Operating capacity

Te Taha Tauira – 18 beds

Whakatau Wairua – 2 beds (seclusion rooms)

Te Taha Manaaki – 12 beds

District Health Board

Capital and Coast District Health Board

Region

Wellington, Porirua and Kāpiti

Last inspection

The facility was previously inspected on:

Unannounced inspection – August 2017

Unannounced inspection – May 2013

Announced informal visit – August 2009

[3] While the Unit has 30 physical beds, it is only funded and resourced for 29 beds. Seclusion rooms are not counted in the operating capacity.

Occupation at time of inspection

On 19 March 2020, the first day of the inspection, the Unit was at 110 percent capacity with 32 clients, comprising 15 men and 17 women. Three clients were on leave at the time of inspection.

Of the 32 clients on the Unit at the time of the inspection:

- 28 were detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).
- 4 were voluntary clients.[4]

[4] A voluntary client (sometimes called an 'informal patient') is someone who has been admitted as an inpatient to a psychiatric unit but is not detained under the MHA. This means that the client has agreed to have treatment and has the right to suspend or stop that treatment. The client has the right to leave the facility at any time.

The inspection

Between 19 and 20 March 2020, Inspectors — whom I have authorised to carry out visits to places of detention under COTA[5] on my behalf — made an unannounced two-day follow up inspection of Te Whare o Matairangi (referred to in this report as 'the Unit').

The inspection team (the Team) comprised two Inspectors.[6]

Methodology

The Team inspected the following areas of the Unit, assessing:

- Treatment of clients
- Clients' material conditions
- Clients' activities and communications
- Staff.

The Team looked for progress in implementing the recommendations I made in 2017[7], and identified any additional issues that need addressing.

During the inspection, the Team met with the Acting Team Leader (ATL), and spoke with a number of staff, managers, and clients.[8]

The ATL provided Inspectors the following information:

- Data on all current clients and the legislative reference under which they were being detained at the time of the inspection;
- A copy of the Unit's seclusion and restraint policies;
- Data on the number of staff trained in Safe Practice Effective Communication (SPEC),[9] and reasons for any training being out-of-date; and
- Staff data including gender, age, and ethnicity, sickness levels, and turnover from 1 September 2019 to 29 February 2020.

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5 See page 22 for more detail about my function as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA).

6 Inspectors have various expertise and backgrounds in mental health and disability, social work, aged care, and prison operation and management.

7 See *OPCAT Report on an unannounced inspection to Te Whare o Matairangi (Capital and Coast District Health Board) under the Crimes of Torture Act 1989*, for my 2017 findings and recommendations.

8 See page 21 for a list of the people the Team spoke with during the inspection.

9 SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. See https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149 for more detail.

The Team also viewed a random sample of health records and additional documents, provided on request, during the inspection.

Feedback meeting

The Team met with representatives of the Unit's leadership team at the end of the inspection, outlining initial observations and any corrections of fact or clarifications.

Treatment of clients

Implementation of 2017 recommendations

Seclusion

In 2017 I recommended:

> Minor maintenance issues in the de-escalation lounge and seclusion rooms should be addressed.

I found that my recommendation was **achieved**:

- Minor maintenance issues in the de-escalation lounge and seclusion[10] rooms had been addressed.
- The de-escalation lounge and seclusion rooms had undergone extensive renovations in 2018 as a result of an incident on the Unit.

In 2017 I recommended:

> The Seclusion Policy should be reviewed and updated.

I found that my recommendation was **achieved**:

- Inspectors received a copy of the Seclusion Policy for the Unit.
- The Seclusion Policy (1.227) had been reviewed and updated. The policy had a review date of September 2020.

In 2017 I recommended:

> Seclusion rooms should remain dedicated for emergency use only.

I found that my recommendation was **not achieved**:

- On the first day of inspection, four clients were accommodated in Whakatau Wairua. Two clients were sleeping in the designated seclusion rooms, but not subject to a period of seclusion, while the other two clients were sleeping on mattresses on the floor in the TV room and seclusion lounge.
- Staff informed my Inspectors that one client had been placed in the seclusion lounge due to her vulnerable state and lack of other appropriate de-escalation areas. The lack of de-escalation spaces, compounded with over occupancy pressures, meant that Whakatau Wairua, a low stimulus seclusion area, was regularly over occupancy (see page 9).

[10] Seclusion is defined as: '*Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit*'. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

- Both Unit staff and senior management advised that chronic over occupancy on the Unit had meant that seclusion rooms were regularly being used to accommodate clients, despite them not being subject to formal seclusion.
- Seclusion rooms, which are unfurnished apart from a mattress, are meant to be used to nurse clients in isolation for a short period if they are a risk to themselves or others. Section 71(2)(a) of the MHA states:

  > *Seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients.*

- The Service's Seclusion Policy also states that *'seclusion should only be considered as a last resort after a range of other possible options for intervention have been considered'*.
- The practice of accommodating clients in seclusion rooms, despite them not being subject to seclusion, has the potential to cause significant physical and psychological impacts on clients, as well as compromise the dignity and wellbeing of those using the Service.
- I consider the ongoing use of seclusion rooms, and other non-designated bedrooms, as bedrooms when the Unit was over occupancy amounted to degrading treatment and a breach of Article 16 of the Convention against Torture.

Restraint

In 2017 I recommended:

> The Restraint Policy should be reviewed and updated.

I found that my recommendation was **achieved**:

- Inspectors received a copy of the Restraint Policy for the Unit.
- The Restraint Minimisation and Safe Practice Policy (1.772) was reviewed and updated in August 2019. The policy had a review date of August 2021.

Mandatory staff training

In 2017 I recommended:

> All staff should be up-to-date with mandatory training requirements.

I found that my recommendation was **not achieved**:

- A number of Unit staff were not up-to-date with mandatory training requirements at the time of inspection.

- Two staff members were 'due to update' their SPEC training, one staff member had not received training for more than 18 months, 10 staff were 'critically overdue to update', and six staff were due for training in February 2020.[11]
- Inspectors were advised that due to the impacts of COVID-19, SPEC training had been temporarily suspended and COVID-19 related training, such as Personal Protective Equipment training, had been prioritised.
- While I acknowledge the limitations regarding COVID-19, I reiterate that it is imperative all staff are up-to-date with mandatory training requirements.

Clients' views on treatment

In 2017 I recommended:

> Clients should be invited to attend their MDT and receive a copy of their care plan.

I found that my recommendation was **not achieved**:

- Staff and management told Inspectors that clients were not invited to attend their MDT, and did not receive a copy of their care plan. Inspectors were advised that this was due to time restrictions and logistical issues in the coordination of MDTs.
- Effective, multi-disciplinary based care in mental health services should enable clients to determine their level of involvement in decision making and ensure clients have a clear understanding of their care plan.
- While I am encouraged to see that clients are invited to attend complex case reviews on a case-by-case basis, I suggest that the Service consider options for involving clients in their MDT, where appropriate.

Findings of 2020 inspection

In addition, I found that:

Over occupancy

- Over occupancy had become a significant issue on the Unit and was having a detrimental effect on the health of staff and clients, as well as reducing the staff's ability to provide optimal nursing care to clients.
- At the time of inspection, the Unit was at 110 percent capacity (including clients on leave). From 1 September 2019 to 29 February 2020, the Unit was at an average 109 percent capacity.
- Throughout the inspection, Inspectors observed seclusion rooms, and other non-designated bedrooms, being used inappropriately as bedrooms (see page 7).

[11] Data as provided by the Service (1 February 2020).

- Unit staff advised that they were often directed by senior management to move clients into the low stimulus area, Whakatau Wairua, to allow for new admissions on the Unit. In most cases, these clients' primary beds were not reserved as they would be 'backfilled' with new clients.
- One female client, with high and complex needs,[12], was being nursed in the seclusion lounge in Whakatau Wairua, as she was considered *'highly vulnerable'* and required high levels of observation and care. This client was sleeping on a mattress on the floor and could be observed from the external seclusion courtyard area.
- The use of de-escalation spaces as accommodation had placed significant pressure on Unit staff in managing more '*vulnerable or at risk'* clients and had also resulted in higher tension and agitation amongst clients due to lack of available low stimulus areas or access to private spaces.
- Unit staff also raised concerns that staffing numbers did not reflect the high occupancy or acuity levels on the Unit, and staff were under increasing pressure as a result (see page 15).
- Occupancy pressures were further exacerbated as there were a number of long-term clients[13] on the Unit who could not be discharged due to a lack of available supported accommodation in the Wellington region. Issues regarding lack of housing and supported accommodation for clients with high and complex needs is not unique to the Service, and is an issue I have raised with the Ministry of Health.
- While I acknowledge the high demand in providing care in an acute inpatient setting, the issue of over occupancy is not only unsustainable, but unsafe for clients and staff. If not addressed, it could amount to degrading treatment and a breach of Article 16 of the Convention against Torture.

Recommendations

As a result of my 2020 follow up inspection, I recommend the following actions be taken to improve the treatment of clients:

[12] *'People with "high and complex needs" are a small and unique group of people with disabilities at the high end of the support needs spectrum. This group of disabled people includes those with multiple disabilities such as sensory disabilities, physical disabilities, severe intellectual disability, and serious and ongoing medical conditions. These individuals require support with self-care and basic activities of daily living. They tend to also have behaviours that require a very high level of support.'* Te Pou o Te Whakaaro Nui (2013). Valuing and supported disabled people and their family/whānau. Te Pou o Te Whakaaro Nui.

[13] As at 19 March 2020, three clients had been on the Unit for over five months.

Treatment of clients

1. Seclusion rooms, and other non-designated bedrooms, are never used as bedrooms. **This is a repeat amended recommendation.**
2. All staff are up-to-date with mandatory training requirements. **This is a repeat recommendation.**
3. Clients are invited to attend their MDT and receive a copy of their Wellness plan, where appropriate. **This is a repeat amended recommendation.**
4. The issue of over occupancy be addressed as a matter of urgency.

Te Whare o Matairangi comments

The DHB accepted recommendations 2 and 4.

The DHB partially accepted recommendation 1.

The DHB rejected recommendation 3.

Recommendation 1 response:

> *At times we are faced with the predicament of weighing up the risk of admitting a person into this area against the risk of the person remaining at a less safe environment, for example the emergency department, police station or other uncontained community setting.*
>
> *We are experiencing very high demand on our high acuity secure resources. The high occupancy in inpatient units is also related to lack of adequate alternative community options for those clients who no longer require an inpatient stay. MHAIDS is actively working on addressing these issues. There is also an acute crisis continuum working group looking at alternatives to admission for those that could be cared for in lesser acute areas. This group involves funders, clinical staff and managers as well as NGO providers.*

Ombudsman response:

I acknowledge that work is currently underway to address the issue of over occupancy on the Unit and I support the Service's development of the Acute Crisis Continuum Working Group.

However, as indicated by my repeat recommendation, I remain concerned that the Service has not prioritised addressing over occupancy and the use of seclusion rooms as bedrooms. I reiterate that I make my recommendations based on the conditions and evidence found at the time of inspection. My Inspectors' observations, and the information provided by the Service, identified high occupancy levels and the use of seclusion rooms as bedrooms at the time of inspection, and also that this has been an ongoing issue.

I am further concerned that this is a repeat recommendation from my 2017 report, which was previously accepted by the Service.

My expectation is that seclusion rooms, and other non-designated bedrooms, should never be used as bedrooms for clients. The degrading nature of this treatment is a key part of my finding that there had been a breach of Article 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Recommendation 3 response:

> *In MHAIDS we do not have care plans but clients do have Wellness Plans, which they receive a copy of.*
>
> *The issue of clients attending their MDT is complex, as the standard MDT is a large meeting and can be perceived as overwhelming to some clients. There are, however, planning meetings and discharge meetings between the client, whānau, inpatient and community staff.*

Ombudsman response:

I am pleased that staff endeavour to give feedback to clients in the form of planning and discharge meetings, as well as providing copies of clients' Wellness Plans.

However, I do not consider the Unit has provided a clear reason for not including clients in their MDT. The fact that these meetings have to date been attended only by staff is not a sufficient basis for the status quo to remain.

My Inspectors' observations are that, where clients are invited to their MDT, this further facilitates the development of ongoing, individualised care and support for the client. Indeed, a blanket decision by the Service to not invite clients to attend their MDT because it could be 'overwhelming for some' suggests an approach that does not support clients to decide their level of involvement in their own care, and that contravenes the client's right to being treated with dignity and respect.

Clients' material conditions

Implementation of 2017 recommendations

In 2017 I recommended:

> The women's bathroom should be repaired.

I found that my recommendation was **achieved**:

- The women's bathroom had been repaired at the time of inspection.
- Staff and management confirmed that the bathroom was repaired in 2018.

Findings of 2020 inspection

In addition, I found that:

- Overall the Unit was clean and tidy. The Unit felt spacious and open, with plenty of natural light. The Unit had a number of open communal areas and outdoor spaces, including a women's only courtyard, which gave it a calm, therapeutic feel.

Recommendations

I have no further recommendations to make in relation to clients' material conditions.

Clients' activities and communications

Implementation of 2017 recommendations

In 2017 I recommended:

> Notices detailing the process for entry and exit into and out of the Unit for visitors should be displayed in prominent areas, including the Unit entrance.

I found that my recommendation was **not achieved**:

- Notices detailing the process for entry and exit into and out of the Unit for visitors were not displayed at the time of inspection.
- While staff noted that this process was explained verbally to clients and visitors, clients my Inspectors spoke with did not have a clear understanding of how to enter and exit the Unit.

In 2017 I recommended:

> The phone booth in Te Taha Tauira should be made available to clients.

I found that my recommendation was **not achieved**:

- The phone booth in Te Taha Tauira was not available to clients at the time of inspection.
- Staff advised that telephones were removed from Te Taha Tauira in 2018, as the external telecommunications provider refused to reinstall phones due to repeated damages.
- Staff advised that clients could either use their personal phones or request to use handheld phones, which were kept in the nurses' station.
- While this information was available in the induction booklet, there was no information available on the Unit regarding how to access the handheld phone.

Findings of 2020 inspection

In addition, I found that:

Social worker vacancy

- At the time of inspection, there was no dedicated Social Worker on the Unit.
- While the Service had been recruiting for a Social Worker position, senior management advised that they had been unable to fill the role.
- Staff and management noted that the lack of resource on the Unit had placed additional pressures on Registered Nurses (RNs) and Occupational Therapists (OTs) to complete social work functions, such as sending referrals and seeking community placements.
- Consequently, there were a number of long-term clients on the Unit who were awaiting referrals for suitable accommodation and housing.
- The lack of resource for discharge planning, family and whānau liaison, and community services support, had also impacted on clients' recovery and successful transition into the community.
- While I acknowledge that the Service has been actively seeking to fill this position, it should consider other options to provide interim support until the vacancy is filled.

Occupational Therapy engagement

- My Inspectors were pleased to observe a wide range of activities and programmes available to clients on the Unit.
- The Unit had employed two full-time equivalent (FTE) OTs and two FTE OT Support Workers.
- The Unit had a full and varied programme of activities, which was well advertised on the Unit and also available during evenings and weekends. Activities included music therapy, art workshops, cooking, sewing, gardening, SPCA visits, meditation, educational programmes and peer support groups, among others.
- While I note that some externally provided activities had been limited due to COVID-19, I was pleased to see that clients were provided with a variety of therapeutic and constructive activities on the Unit.

Recommendations

As a result of my 2020 follow up inspection, I recommend the following actions be taken to improve clients' activities and communications:

Clients' activities and communications

5. Notices detailing the process for entry and exit into and out of the Unit for visitors be displayed in prominent areas, including the Unit entrance. **This is a repeat recommendation.**
6. Information on how to access the phone be made readily available to clients in Te Taha Tauira. **This is a repeat amended recommendation.**

Te Whare o Matairangi comments

The DHB accepted recommendations 5 and 6.

Staff

No recommendations were made in 2017.

Findings of 2020 inspection

I found that:

Safe staffing ratios

- Minimum staffing levels were a critical issue on the Unit. Staff raised concerns that the minimum staffing levels were not sufficient to provide safe and optimal care to clients. My Inspectors assessed that this was exacerbated by the ongoing high occupancy levels on the Unit.
- Staff reported often working double shifts to cover gaps in staffing, and this was observed during the inspection. Staff also commented that night staffing levels were insufficient to safely deal with crisis calls, and that burnout had resulted in a number of recent staff departures and an increase in sick leave.
- Information provided to my Inspectors indicated that the Unit had vacancies for three FTE RNs and three FTE Mental Health Support Workers (MHSWs).
- Nursing staff worked a three-shift roster, with a designated staffing level on each shift. The morning shift ran from 7am to 4pm with 10 RNs and six MHSWs, the afternoon shift from 3pm to 11.30pm with 10 RNs and five MHSWs, and the night shift from 11pm to 7.30am with four RNs and four MHSWs.
- However, staff reported to my Inspectors that the designated staffing levels were often not met, due to sickness and short staffing.

- In order to provide evidence of their concerns to senior management, Unit staff had been recording 'safe staffing' as a reportable event[14]. Between 1 September 2019 and 29 February 2020, there were 49 reportable events regarding 'safe staffing'.[15]
- The Service had employed external security staff to increase staffing ratios when the Unit was over occupancy, or depending on acuity levels. However, these staff did not receive any training such as SPEC, or have relevant mental health experience to provide support to staff on the Unit.
- However, despite these staffing pressures, Inspectors observed that staff were regularly on the Unit and engaging with clients in a professional and respectful manner.
- Staff were also complimentary about the Unit's leadership team, and leadership on the Unit was visible, supportive and positive.

Security staff

- At the time of inspection, the Unit had employed security staff through an external provider. Security staff had been working on the Unit since 2018 and were employed through an agreement between the external security firm and the Service.
- Inspectors requested copies of the service contract as well as job descriptions for security staff members. However, they were advised that these were not available.
- Inspectors were advised that security staff had been employed to increase staffing ratios and as a means of improving safety for staff and clients on the Unit. Security staff did not wear uniform on the Unit.
- Security staff were not permitted to restrain clients, and received an induction to the Unit from an RN or MHSW. Senior management advised that the security firm had a selection process to find suitable staff to work on the Unit. Some security staff had previous experience working in health and disability services, but this was not a requirement.
- Inspectors were told that security staff were only present on the Unit to assist RNs and MHSWs in general observations, and to provide a sense of security for staff and clients on the Unit.
- A number of Unit staff raised concerns that security staff did not receive adequate training, and, in some instances, had issues with boundaries. Staff were also concerned that having security staff on the Unit added additional pressures for RNs and MHSWs.

[14] The definition of 'reportable events' is broad enough to require employees to report events that have resulted in harm to consumers, visitors and employees, and that are discovered upon entry to the service, or occur during service provision; or serious harm suffered by employees, visitors or contractors as defined in the Health and Safety in Employment Act 1992. *Reportable Event Guidelines*. Ministry of Health. 2001. See: https://www.health.govt.nz/system/files/documents/publications/reportableevents.pdf

[15] Data as provided by the Service.

- On one occasion, a security staff member attempted to remove a client from a period of seclusion, without consulting Unit staff. Unit staff and management also raised instances where security staff had questioned certain clinical decisions, such as whether clients should be taking their prescribed medication, or questioning other clinical opinions.
- I have significant concerns that security staff may be working on the Unit without appropriate training or an adequate understanding of the nature of the environment in which they are working.

Recommendations

As a result of my 2020 follow up inspection, I recommend the following actions be taken to improve staffing issues:

Staff

7. Senior management address the safety concerns relating to staffing levels.
8. The Unit develops a policy and formal job description for security staff, which includes a detailed induction and training specific to mental health care.

Te Whare o Matairangi comments

The DHB accepted recommendation 8.

The DHB partially accepted recommendation 7.

Recommendation 7 response:

> *The staffing rostered numbers are based on historical agreements and set at 10:10:6. In fact the actual day-to-day staffing levels are consistently higher than this as there has been a relatively low threshold for the team leader and coordinator to roster extra staff. Therefore the day-to-day rostered staffing can be relatively high, with up to 16 RNs/MHSWs rostered on a shift. This is also complemented by non-rostered MDT staff, including medical, allied, a coordinator, team leader and clinical nurse specialist. However at times to reach the levels of requested staffing there has been an over reliance on overtime.*
>
> *MHAIDS is well engaged with the Care Capacity Demand Management programme (CCDM). TrendCare is part of this programme and will assist in determining actual required staffing based on demand.*
>
> *Senior nursing leaders are currently developing a MHAIDS escalation plan and considering how redeployment could progress in MHAIDS.*

Ombudsman response:

I acknowledge your response, however, I reiterate that recommendations relate to the conditions and evidence my Inspectors found during the time of inspection.

My Inspectors identified that staffing levels had become a significant safety concern on the Unit and that security staff had been brought onto the Unit to support staffing ratios.

I remain of the view that senior management address the safety concerns relating to staffing levels.

Appendix 1. Implementation of 2017 recommendations

Listed below are all the recommendations I made in 2017, the Unit's response at that time to my recommendations, and my 2020 findings regarding the implementation of those recommendations:

2017 recommendation	2017 response[16]	2020 finding[17]
1. Minor maintenance issues in the de-escalation lounge and seclusion room should be addressed.	Accepted	Achieved
2. The Seclusion Policy should be reviewed and updated.	Accepted	Achieved
3. Seclusion rooms should remain dedicated for emergency use only.	Accepted	Not achieved
4. The Restraint Policy should be reviewed and updated.	Accepted	Achieved
5. All staff should be up-to-date with mandatory training requirements.	Accepted	Not achieved
6. Clients should be invited to attend their MDT and receive a copy of their care plan.	Rejected	Not achieved
7. The women's bathroom should be repaired.	Accepted	Achieved
8. Notices detailing the process for entry and exit into and out of the Unit for visitors should be displayed in prominent areas, including the Unit entrance.	Accepted	Not achieved
9. The phone booth in the male wing (Te Taha Tauira) should be made available to clients.	Accepted	Not achieved

[16] Accepted, Partially accepted, or Rejected

[17] Achieved, Partially achieved, or Not achieved

Appendix 2. Recommendations

Listed below are all my recommendations following the 2020 inspection of Te Whare o Matairangi:

Recommendation	Repeat	Unit's response
1. Seclusion rooms, and other non-designated bedrooms, are never used as bedrooms.	Repeat	Partial
2. All staff are up-to-date with mandatory training requirements.	Repeat	Accept
3. Clients are invited to attend their MDT and receive a copy of their Wellness plan, where appropriate.	Repeat	Reject
4. The issue of over occupancy be addressed as a matter of urgency.		Accept
5. Notices detailing the process for entry and exit into and out of the Unit for visitors be displayed in prominent areas, including the Unit entrance.	Repeat	Accept
6. Information on how to access the phone be made readily available to clients in Te Taha Tauira.	Repeat	Accept
7. Senior management address the safety concerns relating to staffing levels.		Partial
8. The Unit develops a policy and formal job description for security staff, which includes a detailed induction and training specific to mental health care.		Accept

Appendix 3. List of people who spoke with Inspectors

Table 1: List of people who spoke with Inspectors

Managers	Unit staff	Others
Service Manager	Acting Team Leader Clinical Co-ordinator Associate Charge Nurse Manager Mental Health Act Administrator Acting Clinical Nurse Specialist Registered Nurses Mental Health Support Workers Consultant Psychiatrist Occupational Therapist	Clients External security firm staff

Appendix 4. Legislative framework

In 2007 the New Zealand Government ratified the *United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – health and disability facilities

Section 16 of COTA defines a "place of detention" as:

> *"…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(d) a hospital*
>
> *(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003…"*

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM's functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
  - for improving the conditions of detention applying to detainees;
  - for improving the treatment of detainees; and
  - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and
- choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on his behalf.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read his reports online: ombudsman.parliament.nz/opcat.