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OPCAT Report

Report on an unannounced inspection of Te Whetu Tāwera Adult Acute Mental Health Unit, Auckland City Hospital, under the Crimes of Torture Act 1989

October 2020

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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Background

Ombudsmen are designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions and treatment of service users[1] detained in secure units within New Zealand hospitals.

Between 19 and 22 November 2019, Inspectors[2] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Te Whetu Tāwera Adult Acute Mental Health Unit (the Unit), which is located in the grounds of Auckland City Hospital, Auckland.

Summary of findings

My findings are:

- There was no evidence that any service user had been subject to torture or other cruel, inhuman or degrading treatment or punishment.
- The Unit was making a concerted effort to reduce seclusion.
- Seclusion and restraint paperwork was detailed and robust.
- All files reviewed contained all the necessary paperwork to detain and treat service users on the Unit.
- Consent to treatment forms for service users were on all files reviewed.
- Progress and handover notes were thorough and kept up-to-date.
- The Unit had separate accommodation areas for women, along with a separate accommodation wing located on Te Whitinga ward, for vulnerable women.
- The physiotherapist was having a positive impact, with service users reducing their use of pain medication for muscular-skeletal issues.
- Volunteers were a positive addition to the Unit.
- There was a comprehensive programme of activities for service users to participate in.
- The recreational officer on Te Tūmanako ward was a welcome addition to the team.

[1] A person who uses mental health and addiction services. This term is often used interchangeably with consumer and/or tāngata whai ora. See Mental Health Foundation.

[2] When the term Inspectors is used, this refers to the inspection team comprising of the OPCAT Manager, Senior Inspector and Inspector.

The issues that needed addressing are:

- The Auckland District Health Board's (ADHB) *Search for Illicit Substances and Hazardous Items - Te Whetu Tawera* policy and practice raised concerns.
- Robust systems were not in place to record and monitor drug testing of service users.
- Service users in seclusion were provided with a cardboard receptacle in which to urinate or defecate. Inspectors noted the receptacle was visible from the seclusion door window and the observation room, which posed a serious risk to service users' privacy and dignity.
- Service users in seclusion and the High Dependency Unit/Arohaina did not have access to fresh air.
- Service users and staff felt unsafe on Te Tūmanako ward.
- The Unit did not have a formal complaint form. The complaints process was not well advertised on the wards. Service users did not know how to make a complaint.
- Consumer Advisors were inaccessible to service users when the corridor doors to the activities area were locked. Service users on Te Tūmanako were limited in their ability to access the Consumer Advisors due to their location in the activities area, coupled with Consumer Advisors not visiting the wards.
- The Unit did not produce care/treatment plans and therefore service users were not given documentation which outlined their planned progression.
- Service users did not attend Multi-disciplinary Meetings (MDT), and staff were unclear as to who was responsible for providing information to the service user from MDT meetings.
- Service users could not lock their bedroom doors.
- Service users on Te Tūmanako had no ability to access hot water independently of staff.
- Service users had restricted access to the activities area when the corridor doors were locked.
- Activities/programmes available to service users in the evening/weekend were limited.
- Service users on Te Tūmanako had restricted access to telephones.
- Service users were required to go to the Emergency Department for medical assessment and treatment.

Recommendations

I recommend that:

1. The ADHB Mental Health Services undertakes a review of its *Search for Illicit Substances and Hazardous Items - Te Whetu Tawera* policy and practice to ensure that the legal basis for all searches is clear and up-to-date, and that service users' privacy and dignity is not compromised.
2. The ADHB Mental Health Services extends its proposed review of the documenting of searching to drug testing to ensure that it has a robust recording system and centralised records in both areas.
3. Measures are taken to ensure that service users in seclusion cannot be viewed when urinating or defecating.
4. Service users in seclusion or the High Dependency Unit area be offered access to fresh air daily. This should be documented, including when this is declined.
5. Senior management investigate why service users feel unsafe on the Unit and address areas of concern.
6. The Unit have a complaint form. The complaints process, including complaint forms, are well advertised and accessible to service users on the Unit.
7. Senior management review the process for service users' access to the Consumer Advisors, particularly on Te Tūmanako ward, in consultation with Kahui Tu Kaha to ensure all service users have access to Consumer Advisors.
8. Service users are given a copy of their treatment plan.
9. Service users are invited to attend their multi-disciplinary team meeting, wherever possible, and are informed of the outcome of those meetings.
10. Service users are able to lock their bedroom doors.
11. Service users in Te Tūmanako ward are able to freely access hot drinks, unless there is an individual risk to doing so.
12. Service users are able to freely access the activities area.
13. A more extensive activities programme is available in the evenings and weekends.
14. Service users in Te Tūmanako have access to a telephone, independent of staff, unless deemed inappropriate for clinical or safety reasons. This should be documented in the service user's recovery plan and reviewed regularly.
15. Service users are not taken to the Emergency Department for medical assessment other than in emergency situations.

Follow up inspections will be made at future dates to monitor implementation of my recommendations.

Feedback meeting

On completion of the inspection, my Inspectors met with representatives of the Unit's leadership team, to outline their initial observations.

Facility Facts

Te Whetu Tāwera Adult Acute Mental Health Unit

Te Whetu Tāwera[3] Adult Acute Mental Health Unit (the Unit) provides assessment, treatment and care for people aged 18 and over who experience overwhelming mental distress which requires a period of acute hospital care.[4] It is the Auckland District Health Board's only dedicated unit for treating acutely ill adults.

Located in the grounds of Auckland City Hospital, the Unit comprises of three wards:

- **Te Tūmanako[5]** is a 12-bed intensive care ward which includes Arohaina, a High Dependency Unit (HDU). This ward is secured to keep people safe during the most difficult times of their recovery.
- **Te Kakenga[6]** is a 23-bed ward which provides 24-hour psychiatric nursing and medical care for service users. Te Kakenga is unlocked during the day and early evening.
- **Te Whitinga[7]** is a 23-bed ward which provides 24-hour psychiatric nursing and medical care for service users. One wing of Te Whitinga is specifically for women who are particularly vulnerable because of what they are experiencing, or past trauma, and for women who wish to be in a gender-specific area for cultural, religious or personal reasons. Te Whitinga is unlocked during the day and early evening.

Te Rama Ora (Auckland District Health Board's marae) is located in the Unit.

[3] 'Te Whetu Tāwera' translates as 'evening star'.

[4] Sourced from *Te Whetu Tāwera - Information for Family, Whānau and Friends*, June 2017.

[5] 'Te Tūmanako' translates as 'hope'.

[6] 'Te Kakenga' translates as 'to climb'.

[7] 'Te Whitinga' translates as 'to cross over'.

Region

Auckland

District Health Board

Auckland District Health Board

Operating capacity

Te Tūmanako – 12 beds (plus two seclusion rooms)
Te Kakenga – 23 beds
Te Whitinga – 23 beds

Last inspection

Unannounced follow-up inspection – March 2017

Unannounced inspection – October 2015

Unannounced inspection – November 2011

The Inspection

Three Inspectors conducted the inspection of the Unit between 19 and 22 November 2019.

On the first day of the inspection, there were 55 service users on the Unit comprising 22 females and 33 males. The average length of stay for the period 1 May to 31 October 2019 was 53 days. As of 20 November 2019, there were six people on the referral list to the Unit.

Inspection methodology

At the beginning of the inspection, Inspectors met with one of the Charge Nurse Managers (CNM), before being shown around the Unit.

Inspectors requested the following information during and after the inspection:

- a list of service users and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data from 1 May to 31 October 2019, and the seclusion and restraint policies;
- information on service users' barriers to discharge;
- the contract with the Unit's drug detector dog service provider, the number of searches conducted, and illicit substance finds, from 1 May to 31 October 2019;
- any meeting minutes and reports relating to restraint, seclusion minimisation, and reportable events;
- clinical governance meeting minutes;
- Mental Health and Addictions Directorate's business plan;
- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);[8]
- code orange[9] events data

[8] SPEC training was designed to support staff working within inpatient mental health units 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. Source: www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149

[9] 'Code Orange' is the ADHB's emergency call for assistance to limit or eliminate a risk when staff feel concerned about their own safety, the safety of a patient, others or the environment, or when an incident is impeding or obstructing the provision of clinical care. *Auckland DHB Code Orange Policy*. Updated 29 March 2019

- records of Healthcare Security Officers' Management of Actual or Potential Aggression (MAPA)[10] training;
- Absent Without Leave (AWOL) events from 1 May to 31 October 2019;
- details of all serious adverse events[11] from 1 May to 31 October 2019;
- complaints received from 1 May to 31 October 2019, a sample of responses and associated timeframes, and a copy of the complaints policy;
- service user survey results for 2016 and 2019;
- activities programme;
- information provided to service users and their whānau on admission;
- Nursing Workforce Development Plan 2020-2022;
- nurse orientation booklet;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number);
- data on staff, categorised by profession; and
- assault data from 1 May to 31 October 2019.

Inspection focus

The following areas were examined to determine whether there had been torture or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on service users.[12]

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Unit capacity
- Service users clinically ready for discharge
- Searching and drug testing

[10] MAPA is a programme that teaches management and intervention techniques to staff working in challenging environments to manage escalating behaviour in a professional and safe manner. This programme teaches personal restraint techniques.

[11] Serious adverse events and sentinel events are events that have resulted in, or have potential to result in, serious lasting disability or death, not related to the natural course of the consumer's illness or underlying condition. Source: Auckland District Health Board *Incident Management – Guidelines,* 29 May 2018.

[12] My inspection methodology is informed by the Association for the Prevention of Torture's *Practical Guide to Monitoring Places of Detention* (2004) Geneva, available at www.apt.ch.

- Seclusion facilities
- Seclusion policies and events
- Restraint policies and events
- Restraint training for Unit staff
- Code Orange events and Healthcare Security Officers' MAPA training
- Electro-convulsive therapy (ECT)[13]
- Sensory modulation
- Service users' and whānau views on treatment

Protective measures

- Complaints process
- Family Advisor/Consumer Advisor
- Records
- Incident management – Serious Adverse Events
- Court bailed service users

Material conditions

- Accommodation and sanitary conditions
- Te Tūmanako
- Te Whitinga and Te Kakenga
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes
- Cultural and spiritual support

Communications

- Access to visitors

[13] Electroconvulsive therapy is used mainly in the treatment of severe depressive episodes. It involves the passage of an electric current across the head of a person to produce a convulsion. Source: www.health.govt.nz/publication/electroconvulsive-therapy-ect

- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of managers, staff and service users. Whānau were also spoken with.[14]

Inspectors also reviewed service user records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

[14] For a list of people spoken with by the Inspectors, see Appendix 1.

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any service user had been subject to torture or other cruel, inhuman or degrading treatment or punishment.

Unit capacity

Demand for adult acute mental health services in the Auckland region remains high and the Unit operated at capacity between 1 May and 31 October 2019. However it did not exceed its 58-bed capacity.

There was a robust process in place to ensure the Unit did not go over capacity, including daily occupancy meetings. Daily assessment of potential discharges and admissions were discussed with Community Mental Health Teams. The Auckland District Health Board (ADHB) Adult Mental Health Services had 20 non-governmental organisation (NGO) beds which could be used by the ADHB Adult Mental Health Services as a preventative approach to service users admission to the Unit.

A patient flow project had been implemented, resulting in the Unit and the ADHB's community mental health services taking a joint approach to resolving the complex issue of the Unit regularly being at capacity.

Service users clinically ready for discharge

The Unit did not discharge service users into homelessness. As a result, at the time of inspection, 13 service users who had been identified by treating teams as clinically ready for discharge remained on the Unit. This was due to a lack of suitable, available accommodation in the Auckland area.

Of the Unit's 13 services users who were clinically ready for discharge, three were in Te Tūmanako, four in Te Whitinga and six in Te Kakenga. Five of the 13 service users required hospital-based inpatient rehabilitation, one was waiting on funding for a community package of care, and two were waiting on private accommodation options. The remaining five service users had high and complex long-term needs, coupled with multiple failed former placements, and remained on the Unit. One service user had been in the Unit for 17 months.[15]

[15] As at 19 November 2019.

Table 1: Service users clinically ready for discharge at 19 November 2019[16]

Ward	Service user	Admission date	Date clinically ready for discharge	Number of days
Te Tūmanako	Service user 1	29 September 2019	11 November 2019	9 days
	Service user 2	22 March 2019	19 April 2019	214 days
	Service user 3	18 May 2019	18 May 2019	185 days
Te Whitinga	Service user 1	17 May 2019	29 October 2019	23 days
	Service user 2	1 July 2019	14 October 2019	37 days
	Service user 3	25 July 2019	27 September 2019	54 days
	Service user 4	12 October 2019	11 November 2019	9 days
Te Kakenga	Service user 1	June 2018	7 November 2019	13 days
	Service user 2	10 September 2019	8 October 2019	43 days
	Service user 3	16 April 2019	29 October 2019	22 days
	Service user 4	26 September 2019	31 October 2019	20 days
	Service user 5	11 October 2019	31 October 2019	20 days
	Service user 6	20 September 2019	29 October 2019	22 days

The Unit was aware that the lack of suitable accommodation was a barrier to discharging some service users. The Unit's Directorate Leadership Team was actively seeking to contract a Housing Specialist Coordinator into the Assertive Community Outreach Service team to assist with addressing this ongoing issue.

At the time of inspection, the Unit was actively seeking accommodation for the 13 service users. Mental Health Service Coordination had completed assessments, and referrals had been sent to providers in the Auckland region and other areas. However, a lack of available and suitable housing, as well as strict entry criteria with local service providers, meant these service users were waiting in the Unit for community placements.

Inspectors observed staff interacting with the 13 service users in an engaging, respectful, and caring manner. However, staff expressed frustration and concern at the situation of these service users and their non-therapeutic extended placement on the Unit.

The purpose of an acute mental health inpatient unit is to rehabilitate and reintegrate people experiencing an acute mental illness back into the community. While these 13 service users

[16] Data provided by Unit staff.

were admitted for the purpose of assessment and treatment of a mental illness, they remained in the Unit when clinically ready for discharge.

I consider that the Unit is not suitable accommodation for service users who do not require care in an acute inpatient setting. I am raising this issue with the Ministry of Health.

Searching and drug testing

Unit staff provided my Inspectors with a number of the ADHB's policies relevant to drug testing and searching:

- *Alcohol, Illicit, Psychoactive and Harmful Substances – Te Whetu Tāwera (*dated 7 February 2017). The policy had a review date of 7 February 2020.
- *Search for Illicit Substances and Hazardous Items – Te Whetu Tāwera* (dated 8 February 2017). The policy had a review date of 8 February 2020.
- *Urine Toxicology Specimen Collection in TWT and BRC* (dated 25 May 2018). The policy had a review date of 25 May 2021.

The Search for Illicit Substances and Hazardous Items policy specifically allows for strip searching. To date I have not encountered strip searching policies or practices in any other of my inspections of health and disability facilities.

I consider strip searching to be an inherently intrusive procedure which raises particular issues in a therapeutic setting.

Senior managers at the Unit advised that strip searching did not occur in the facility. However during an Inspector's attendance at an MDT meeting, the option of strip searching a service user on their return from leave was discussed.

When questioned about the appropriateness of a policy that allowed for strip searching in a therapeutic setting, the ADHB advised that it had a duty to provide a safe environment for staff and users, and that users admitted to the acute inpatient unit by definition posed a serious danger to themselves or others. The ADHB further stated that it is not uncommon for service users to have razor blades, items that can be used as weapons, illicit drugs including methamphetamine, needles, methamphetamine pipes and lighters, at the time of admission or after unescorted leave (which is an important part of their recovery to ensure safe discharge). For this reason they consider it essential that staff have an ability to search service users. The ADHB maintained that most inpatient searches involve a brief pat down while the user is fully clothed, that they may include removal of a jacket or hoodie (these have previously been used to hide drugs or razor blades). The ADHB advised that it understands that users in the Unit are not asked to remove underclothing.

The ADHB considers that the Search and Surveillance Act (Part 3, subpart 4) empowers staff in the Unit to conduct strip searches if there are reasonable grounds to believe that the person has an item that could be used to harm a person. It acknowledged that the legislative references in the policy were out of date that it intended to review the policy, including

providing more detailed guidelines regarding the conduct of searches. The ADHB noted that any search 'would need to be justified in its inception and reasonable in its execution'.

The ADHB had a contract with a drug detector dog service provider[17] to perform random searches of the Unit, and on request when ADHB staff considered there were reasonable grounds to suspect the presence of illicit substances on the Unit.

Information provided by Unit staff stated that between 1 May and 31 October 2019, five random detector dog searches occurred and no illicit drugs were found during these searches.

Inspectors reviewed data from the Unit's online incident reporting system regarding illicit substances found by staff over the same period. Of the 10 incidents recorded between 1 May and 31 October 2019, four involved the finding of illicit drugs (cannabis).

The Unit had a policy of urine drug testing service users on admission, or when there was a change in the service user's mental state based on clinical assessment and judgement, or as requested by the responsible clinician, or delegate, as part of the treatment plan. Data on urine toxicology was not available for Inspectors to analyse; my inspectors were advised that this would require the Unit to complete a paper count search through hundreds of individual clinical records.

My inspectors noted possible issues with respect to record keeping relating to both strip searches and urine toxicology. Clear records of both, including aggregate numbers, are important to monitor and address issues and trends. This is important given the apparent number of attempts by users to bring weapons and drugs (including methamphetamine) into in the unit. The ADHB has agreed to review its documentation in relation to searching.

Seclusion

Seclusion facilities

The Unit had two seclusion[18] rooms located in the Arohaina/High Dependency Unit (HDU) area of Te Tūmanako. Both seclusion rooms were stark, with no direct access to water or toilet facilities. There was a cardboard receptacle provided in each room for service users to urinate or defecate in. There was a toilet in the HDU which service users in seclusion did not routinely have access to.

A large observation panel allowed staff in an adjacent room to observe the service user in seclusion. The observation window was in need of repair or replacement. Inspectors noted that service users would be visible from the seclusion door window and the observation room when urinating or defecating. While observation of service users in seclusion is responsible, observation of service users urinating or defecating can and should be avoided.

[17] Contract for Services between Auckland DHB (ADHB) and a contracted drug detector dog service provider, dated 17 May 2011.

[18] 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.

The ability to view service users in seclusion urinating or defecating poses a serious risk to their privacy and dignity. Any such viewing would likely amount to degrading treatment and a breach of Article 16 of the Convention against Torture.

The seclusion rooms had a means of raising an alarm. A small window set up high in the wall provided the only natural light and there was no access to fresh air. Service users had access to the time via a clock, but had no ability to know the day or date.

There was a lounge area outside the two seclusion rooms in the HDU. The lounge was stark and sparsely furnished. There was a toilet and shower in this area. There was no access to the outdoors or to fresh air. Staff told Inspectors that new furniture for the HDU lounge area was on order, and funding for wall decals[19] depicting nature scenes to go on the HDU lounge walls was currently under discussion with the Clinical Governance team.

I consider that the seclusion rooms and HDU communal areas are in need of refurbishing. The facilities are stark, unwelcoming and not conducive to the mental wellbeing of the service users accommodated in them.

No service users were in seclusion at the time of the inspection.

Figure 1: Seclusion room

Figure 2: Arohaina/High Dependency Unit

Seclusion policies and events

Unit staff provided my Inspectors with the ADHB's *Seclusion in Mental Health Policy* (dated May 2015). The policy was due for review in May 2018 and was out of date at the time of the inspection.

The Unit demonstrated a commitment to reducing the use of seclusion. There were plans to decommission one of the seclusion rooms in late November 2019. The Unit was looking to

[19] A picture or design printed on special paper, that can be put onto another surface, such as metal or glass. https://dictionary.cambridge.org/dictionary/english/decal

repurpose this room into a sensory space, and include a bed. Painters began repainting this area during the course of inspection.

Senior management interviewed by Inspectors recalled three seclusion events between 1 May and 31 October 2019, and Inspectors reviewed the documentation for these three events. Documentation provided by the Unit staff further recorded there had been 20 seclusion events, involving 15 service users, in those six months. This is broken down as follows:

Table 2: Seclusion events 1 May – 31 October 2019[20]

Month	Events	Service users	Hours	Average hours
May	6	5	72.8	12.13
June	8	5	63.5	7.94
July	4	3	39.2	9.8
August	0	0	0	0
September	1	1	5.8	5.8
October	1	1	0.6	0.6
Total:	**20**	**15**	**181.9**	**6**

Of the seclusion files reviewed, notes were thorough, with a clear rationale for seclusion provided. Regular reviews had occurred and service users were released from seclusion as soon as possible.

It is encouraging to note that while seclusion event numbers remained at a relatively similar number to the previous 2015 full inspection,[21] the average duration of seclusion events had decreased significantly.

Staff told my Inspectors that sometimes, for safety reasons, they would lock the door between Te Tūmanako's main ward area and the HDU. They would do this when there was a service user of concern in the HDU area. This was done to maintain staff and service user safety. When the door was locked, staff would observe the HDU service user from the office base. Staff said these occurrences were not being recorded as seclusion events. I consider this practice to be a seclusion event that must be recorded appropriately.

[20] Data provided by Unit staff.

[21] Sixteen seclusion events with the average length of time for each seclusion event during this reporting period being just over 13 hours. *COTA Report on an unannounced visit to Te Whetu Tāwera Adult Acute Mental Health Unit under the Crimes of Torture Act 1989*, October 2015.

Restraint

Restraint policies and events

Unit staff provided my Inspectors with the ADHB's *Restraint Minimisation and Safe Practice in Mental Health Policy* (dated January 2016). The policy was due for review in January 2019 and was out of date at the time of the inspection.

Data supplied by Unit staff showed there were 182 events of restraint, involving 78 service users, between 1 May and 31 October 2019— an average of close to 30 restraint events a month. All restraint events were recorded as personal restraint.[22] This is broken down as follows:

Table 3: Restraint data (exclusive of seclusion data) 1 May – 31 October 2019[23]

	May	June	July	August	September	October
Total restraint events	27	42	38	14	36	25
Total service users restrained	13	15	11	9	16	14
Personal restraint	All	All	All	All	All	All
Number of males	6	8	9	3	8	8
Number of females	7	7	2	6	8	6
Youngest person restrained (years)	18	22	24	23	20	20
Oldest person restrained (years)	56	61	63	60	79	60
Shortest restraint events (minutes)	1	1	1	1	1	1
Longest restraint event (minutes)	45	20	25	60	30	25
Average restraint event (minutes)	9.3	14.3	8.1	13.9	7.6	6
Number of restraint events resulting in seclusion	6	8	4	0	1	1

[22] Personal restraint is when a service provider(s) uses their own body to limit a service user's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[23] Data provided by Unit staff.

Restraint training for Unit staff

Information provided by Unit staff showed that 66 of 84 Unit staff were up-to-date with SPEC training. Of the 19 staff who were out-of-date, seven were on maternity leave, long-term sick leave, or had a medical certificate excusing them from SPEC. The remaining 12 staff were scheduled for an annual refresher course. Inspectors were not provided with course dates.

Code Orange events and Healthcare Security Officers' MAPA training

Healthcare Security Officers (HSOs) assisted the Unit by responding to Code Orange[24] call outs from the Unit.

Unit staff provided my Inspectors with the ADHB's *Code Orange Policy* (updated March 2019).

Data supplied by Unit staff showed that between 1 May and 31 October 2019, HSOs were called to the Unit 178 times for Code Orange events. Of the 178 events, 138 were managed without restraint occurring. This is broken down as follows:

Table 4: Code Orange Events 1 May – 31 October 2019[25]

	May	June	July	August	September	October
Number of Code Orange call outs	22	29	18	10	50	49
Number of physical restraints by security staff	4	5	9	3	11	8

Unit staff told Inspectors that they were happy with the response rate of the security team and felt they were a positive addition to the Unit.

MAPA[26] training was introduced at ADHB in April 2018 and had a two-year recertification cycle. HSOs attend annual refresher training. HSOs' identification badges showed a refresher date for MAPA training. Information provided by Unit staff showed that all 81 HSOs were up-to-date with MAPA training.

Information provided by Unit staff showed that HSOs as well as some clinical staff were trained in MAPA.

[24] See previous footnote page 6.

[25] Data provide by Unit staff.

[26] See previous footnote page 7.

Electro-convulsive therapy

There was one service user undergoing electro-convulsive therapy (ECT)[27] in the Unit at the time of the inspection. Consent had been obtained and was recorded on the service user's file.

Sensory modulation

The Unit had a designated Sensory Modulation Room[28] located off the corridor between Te Whitinga and Te Kakenga. The room was comfortable but not well equipped. Staff actively supervised service users who were using the Sensory Modulation Room. Inspectors observed the room used for both individual and small group sessions. Te Whitinga and Te Kakenga each had comfort rooms[29].

Service users' and whānau views on treatment

Inspectors spoke with a number of service users and whānau during the four-day inspection, and noted:

- Service users were positive about the unlocked door policy on Te Whitinga and Te Kakenga.
- Some service users reported feeling unsafe on the Unit, particularly in Te Tūmanako.
- There was a perception by some service users that being placed in Te Tūmanako was a 'punishment'.
- Some service users felt vulnerable, in particular women, as they were not able to lock their bedroom door. They told Inspectors that some male service users were intimidating, in particular those who had been on the Unit for a long period of time.
- Service users on all wards did not know how to make a complaint. One service user had found it difficult to get the information from staff about how to make a compliment.
- Several service users did not know whether or not they were under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). Service users stated that MHA paperwork was not provided in a timely manner.

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[27] Electroconvulsive therapy is used mainly in the treatment of severe depressive episodes. It involves the passage of an electric current across the head of a person to produce a convulsion. https://www.health.govt.nz/publication/electroconvulsive-therapy-ect

[28] A room in which sensory modulation is practised. Sensory modulation is an approach which utilises sensory input to promote emotional regulation, grounding and encourage adaptive ways of performing simple and complex purposeful activities. *Sensory Modulation in Mental Health & Addictions Guideline.* Auckland DHB. February 2016.

[29] A 'comfort room' is a space designed to provide a safe and comfortable space for a service user to relax, regroup and practice self-nurturance and skills for self-soothing.

- All service users spoken to did not know what their care plan was, have a copy of their care plan, or know what their discharge plan was.
- Several service users spoke of not attending Unit activities as they spent their time waiting outside the nurses' station to speak to a nurse or Doctor when they visited the ward.
- A common theme among service users' views was a lack of activities on the Unit, particularly in the evenings and weekends.
- Service users were highly complimentary about the input of the Occupational Therapy (OT) team.

Inspectors reviewed the ADHB's *Consumer Leadership and Advocacy Services Consumer Surveys* for 2016 and 2019. In general, feedback from the surveys was positive, however service users expressed their desire to be central to their care planning process. They wanted clarity, and access to information about their treatment, leave and discharge.

Service users also expressed a desire for increased opportunities for social activities and the fostering of prosocial relationships between staff and service users in daily practice. They sought greater access to the OT area during the weekends and evenings, increased capacity of the OT department (including within Te Tūmanako), and greater access to outdoor areas with more recreational activities.

Whānau said they were easily able to visit service users, and visits took place in private areas within the Unit's wards.

Recommendations – treatment

I recommend that:

1. The ADHB Mental Health Services undertakes a review of its *Search for Illicit Substances and Hazardous Items- Te Whetu Tawera* policy and practice to ensure that the legal basis for all searches is clear and up-to-date, and that service users' privacy and dignity is not compromised.
2. The ADHB Mental Health Services extends its proposed review of the documenting of searching to drug testing to ensure that it has a robust recording system and centralised records in both areas.
3. Measures are taken to ensure that service users in seclusion cannot be viewed when urinating or defecating.
4. Service users in seclusion and the High Dependency Unit area be offered access to fresh air daily. This should be documented, including when this is declined.
5. Senior management investigate why service users feel unsafe on the Unit and address areas of concern.

Te Whetu Tāwera comments

The ADHB accepted recommendation 1.

The ADHB rejected recommendation 2.

Recommendation 2 response:

> *Urine toxicology results are a standard aspect of individual patient care, as they are in the provisional of physical health care. ADHB does not consider that creating centralised documentation of patient urine toxicology results in order to enable analysis of aggregate results would be practicable to achieve, nor would it be useful from a mental health management perspective.*

Ombudsman response:

Given the level of concern expressed about the use of illicit drugs and their impacts, I remain of the view that having clear records of drug testing and the results is important to monitor and address emerging issues and trends.

The ADHB partially accepted recommendations 3, 4 and 5.

Recommendation 3 response:

> *Bathrooms in Te Whetu Tawera are private.*
>
> *The ensuite doors in Te Tumanako have been removed because they are a ligature risk but service users cannot be viewed from the bedroom door while they are in the*

ensuite. These ensuite doors will be replaced with ligature proof doors as part of anti-ligature environmental changes currently being planned in Te Tumanako.

It appears that this recommendation relates to visibility of a service user while they are in the seclusion room. In response to the Covid-19 pandemic, a negative pressure room with an ensuite bathroom (a toilet and sink) has been created within Te Whetu Tawera, which can be used as a seclusion room. This will allow staff observing the service user in seclusion to see that they are in the ensuite bathroom (which is necessary for safety reasons) but not to view them urinating or defecating.

Ombudsman response:

I have consistently been of the view that the observation of people in detention urinating or defecating would constitute degrading treatment. The only exception would be where, in a particular case, it was clinically necessary to do so. In my view, that is likely to be rare.

I welcome the information that a bedroom with ensuite bathroom has been created which will allow service users the ability to use a toilet, with a degree of privacy. My understanding of the response is that following completion of the room it will be the only place of seclusion (this is not explicit in the response); any continued seclusion in the rooms that enable service users to be viewed urinating and defecating would remain of significant concern.

Recommendation 4 response:

Seclusion is an intervention of last resort used for safety reasons, for example when a service user is demonstrating a high level of aggression to others. In most cases, it would not be safe or appropriate to take the service user out of seclusion to give them access to fresh air.

Episodes of seclusion in Te Whetu Tawera as for as short a duration as necessary, based on clinical assessment. Episodes of seclusion of longer than 12 hours would be a rare occurrence in Te Whetu Tawera.

The recommendation regarding offering access to fresh air to someone being nursed in the High Dependency Unit is accepted and will be followed up by the Nurse Unit Manager. The exception to this would be if someone was in isolation in the High Dependency Unit due to suspected or confirmed Covid-19.

Ombudsman response:

I acknowledge that secluding a service user is a tool of last resort and is a decision not taken lightly by Te Whetu Tawera. However, it is important to ensure that regular access to fresh air is granted where feasible. While I acknowledge there may be situations where it would not be safe to provide a service user in seclusion access to fresh air, I do not accept this as a general rule.

Recommendation 5 response:

Service users engage with clinical staff frequently and are encouraged to talk to staff if they are feeling unsafe at any time.

The recommendation regarding the ability of service users to lock their bedroom doors is accepted.

The ADHB has further advised that service users' perceptions of feeling unsafe will be raised with the Kahui Te Kaha Leadership team to consider *'what steps can be taken to investigate the causes of this and whether, for example, there are particular themes that can be addressed.'*

Protective measures

Complaints process

Unit staff provided my Inspectors with the ADHB's *Consumer Complaint Management Policy* (dated 20 February 2017). The Policy had a review date of 20 February 2020.

The complaints process was not well displayed, or was absent, on all wards. There were no complaint forms available on any of the wards. Staff told Inspectors the Unit did not have a written complaints form for service users to complete. Staff informed Inspectors that service users could speak directly with a staff member or write their complaint on a piece of paper. This process for making a complaint was set out in the Information for Service Users Welcome Pack.

An additional means for service users to make a complaint was to phone the Consumer Liaison department, however the telephone number was not displayed in the Unit's phone booths. The ADHB also advised that complaints could be made by email, and that this is the most common way in which complaints are received. In the situation where service users in Te Tūmanako did not have unrestricted access to telephones (and by extension email), I consider complaint forms should be available.

Although copies of the ADHB's '*Your Rights'* brochure and posters[30] were located in the reception area of the Unit, my staff did not observe them in the wards over the four days of inspection. Service users who did not have leave or who were in Te Tūmanako ward could not access the reception area. In its response to my provisional report, the ADHB advised that the brochures were located in Te Tūmanako ward, on the window of the Nurses station.

The Unit received 23 complaints between 1 May and 31 October 2019. One complaint remained open at the time of inspection. The complaint had been raised on 21 October 2019. Inspectors reviewed a sample of complaints. The sample responses reviewed were courteous in tone, individualised, and addressed the complaints in detail and within the ADHB's *Consumer Complaint Management Policy* timeframes.

District Inspector (DI) contact details were displayed in the telephone booth on Te Kakenga, and at the nurse's station in Te Whitinga, but were not displayed in Te Tūmanako. Inspectors observed that the DI maintained a strong presence on the Unit. The DI reported having good

[30] The brochure and posters outlined how to make a complaint or a compliment.

access to service users. Service users spoken with generally knew who the DI was and what their role entailed.

The Health and Disability Commission Code of Rights was not well displayed on the Unit. Staff in Te Whitinga stated that service users took posters and information in the Unit off the walls and as a result, this information was not in the Unit at the time of inspection.

The Unit did not have service user meetings.

Family Advisor/Consumer Advisors

A Family Advisor was available to assist and support whānau. The Family Advisor sat on the Clinical Governance meetings. Inspectors did not have the opportunity to speak with the Family Advisor.

The ADHB had four Consumer Advisors[31] who covered both the Unit and the community mental health teams. A dedicated office had been provided for the team within the Unit. Consumer Advisors were members of the Clinical Governance meetings and Team Quality meetings. They reported a good relationship with senior management, but relationships with nursing staff were strained.

Inspectors saw the Consumer Advisors' information displayed in Te Kakenga ward, but were unable to locate it in the other wards.

Consumer advisors were a part of the Te Whetu Tāwera Recovery Programme and provided sessions for service users on Monday and Wednesday afternoon held in the OT area. Service users in Te Tūmanako were not able to attend, and therefore access to the Consumer Advisors was limited for this group of service users.

The Consumer Advisor reported to Inspectors that they were not a part of debriefs following a seclusion or restraint event and that access to speak with service users in these circumstances was difficult.

I am concerned that service users were not able to easily access the Consumer Advisors, in particular those service users in Te Tūmanako.

Records

There were 55 service users in the Unit on the first day of the inspection. Fifty four service users were detained under the MHA and one service user had voluntary status.[32]

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[31] Kahi Tu Kaha provide Consumer Leadership & Advocacy to Auckland DHB Mental Health & Addiction Services. https://kahuitukaha.co.nz/consumer-leadership-advocacy/

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

The Unit had a dedicated staff member for maintaining full copies of legal paperwork. Each ward additionally held copies of the service user's detaining paperwork. Inspectors reviewed a sample of files during inspection. All files reviewed contained the necessary paperwork to detain and treat service users on the Unit. Case notes were thorough and easy to follow. Consent to treatment and Second Health professional documentation[33] was present.

Inspectors reviewed MHA paperwork for a sample of service users detained at the time of inspection. There were a number of service users whose legal status had been reviewed 1-2 days early. I am concerned this resulted in service users progressing to the next stage of compulsory assessment or treatment earlier than is intended under the MHA. There was evidence of service users having more than one Responsible Clinician identified on section papers, or a Responsible Clinician being named with an additional 'or delegate' Responsible Clinician, and one MHA document was not dated. Inspectors were not able to confirm the consultation/engagement of whānau in some service users' documentation as required under the MHA.[34] Some service users reported to Inspectors they were not provided with a copy of their MHA documentation in a timely manner.

There were no recorded treatment plans for service users. Staff advised that the Unit had shared care plans but they were not completed by staff.

Allied health staff[35] documentation was recorded throughout the clinical notes but there was no capacity to collate information about service users' formal and informal supports or other social history information of note in one readily accessible document. This resulted in information being difficult to find. Social workers needed to gather this information repeatedly from a range of sources each time a service user was discussed.

Inspectors attended a MDT meeting. Service users and key nurses were not involved in the MDT, and Inspectors could see no clear mechanism in place for outcomes from these meetings to be fed back to service users. My inspectors spoke with a number of service users during the inspection. None of the service users spoken with had attended their MDT or were aware of the outcome.

[33] A second health professional report is completed by a health professional with knowledge of the patient who has had involvement in their treatment. The report is provided to the judge of the Family Court overseeing the Compulsory Treatment Order hearing. The health professional may be asked by the judge to speak to their report during the hearing.

[34] Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 requires a medical practitioner or responsible clinician to consult with family or whānau during the compulsory assessment and treatment process unless it is not in the best interest of the patient or proposed patient, or it is not reasonably practical. See *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health. 2008.

[35] Social workers and social worker assistants.

Incident Management – Serious adverse events

Unit staff provided my Inspectors with the ADHB's *Incident Management – Guidelines* (dated 29 May 2018).

There were three reportable events[36] for the period 1 May to 31 October 2019, including two deaths of service users while off the Unit, and one event of alleged serious harm on the Unit. Events were rated using the Severity Assessment Code[37] (SAC). Two events were assessed as SAC 1 events and one as a SAC 2 event.

Inspectors reviewed documentation provided by Unit staff. Documentation reviewed was clear, robust and the ADHB's *Incident Management – Guidelines* were followed. Initial recommendations and findings for one of the SAC 1 events had been tabled for discussion across the Unit. The remaining two serious adverse event reviews were still in progress as at the time of the inspection.

Court bailed service users

Senior staff informed Inspectors that the courts were directing an increasing number of service users directly to the Unit. The Unit was bound to take court ordered service users. This concern had been raised by senior management with the Director of Mental Health.

Recommendations – protective measures

I recommend that:

6. The Unit have a complaint form. The complaints process, including complaint forms, are well advertised and accessible to service users on the Unit.
7. Senior management review the process for service users' access to the Consumer Advisors, particularly on Te Tūmanako ward, in consultation with Kahui Tu Kaha to ensure all service users have access to Consumer Advisors.
8. Service users be given a copy of their treatment plan.
9. Service users are invited to attend their multi-disciplinary team meeting, wherever possible, and be informed of the outcome of those meetings.

[36] Mandatory external reporting to the Health Quality and Safety Commission (HQSC) is required for all SAC 1 and 2 events.

[37] Severity Assessment Code (SAC) – A numerical rating allocated to an event based on the type of event, the actual outcome or consequences of the event and the likelihood or recurrence of a similar event. Auckland District Health Board, *Incident Management – Guidelines* May 2018. SAC contains 4 levels of severity rating from SAC 1 to SAC 4.

Te Whetu Tāwera comments

The ADHB accepted recommendation 8.

The ADHB partially accepted recommendations 6, 7 and 9.

Recommendation 6 response:

> *Te Whetu Tawera follows the ADHB-wide complaints process, which is explained in the Information for Service Users welcome pack provided to all service users upon admission to the unit. Complaints can be accepted in any form, including by email or by telephone to ADHB's Consumer Liaison Service. Most complaints are transmitted to ADHB's Consumer Liaison Service by email, which appears to be the mode accessible to most people.*
>
> *ADHB Mental Health Services does not consider that a specific complaint form is necessary.*
>
> *ADHB Mental Health Services agrees that the complaints process should be made more visible to service users and this will be followed up with the Te Whetu Tawera Charges Nurses.*

Ombudsman response:

I acknowledge that the complaints process is explained in the Information for Service Users welcome pack. However I do not consider that this alone is sufficient. I remain of the view that Te Whetu Tawera should have a specific complaint form that is readily available to service users.

Recommendation 7 response:

> *Your recommendation regarding service users' access to "Consumer Advisors" will be raised with the Kahui Tu Kaha Consumer Leadership team.*
>
> *Kahui Te Kaha Consumer Leaders will now be conducting weekly meetings with service users in the Te Tumanako ward, which will facilitate access to the Consumer Leaders for those service users in Te Tumanako.*

Ombudsman response:

I am pleased to hear that there has been progress made on implementing this recommendation and look forward to seeing improvements in service users' access to Consumer Advisors in my follow-up inspection.

Recommendation 9 response:

> *Meetings of a service user's treating team in order to plan or review care are usually attended by the service user, and their whanau where possible. In situations where the service user does not wish to attend this meeting, he or she is informed of the outcome of the meeting.*

Some multi-disciplinary team meetings, such as handover and multi-disciplinary team reviews, are for clinical staff only.

Ombudsman response:

My Inspectors were informed by a number of service users and staff that service users were not invited to their MDT. Service users spoken with by my Inspectors were not aware of the outcome of their MDT or the plan for their ongoing care and treatment. I am of the view that service users should be invited to their MDT wherever possible.

Material conditions

Accommodation and sanitary conditions

The Unit comprised of three wards: Te Tūmanako, a locked intensive care ward and Te Whitinga and Te Kakenga, both open wards. A central corridor area between Te Whitinga and Te Kakenga contained spaces for the Occupational Therapy, Physiotherapy, Psychologist, Sensory Room and activities areas.

Te Tūmanako

Te Tūmanako had two bedrooms with en-suites, and four bathrooms to service the remaining ten bedrooms. The ward was clean and tidy, but sparsely furnished. The Unit had two courtyards, with the larger courtyard having limited fixed metal furniture and beanbags. Both courtyards were dirty, with cigarette butts on the ground, and mould on the walls of the larger courtyard.

Furnishing were old and worn and needed replacing, and the walls in Te Tūmanako were stark.

Figure 3: Te Tūmanako bedroom

Figure 4: Te Tūmanako large courtyard

Service users in Te Tūmanako were unable to lock their bedroom doors at night, or when they left their bedrooms during the day. Staff locked and unlocked bedroom doors on request.

Laundry facilities were available on Te Tūmanako; however, service users were not able to use the laundry facilities without supervision. Locked linen stores on Te Tūmanako required service users to make a request for linen by speaking with staff.

Te Whitinga and Te Kakenga

Te Whitinga and Te Kakenga had a similar layout. One wing of Te Whitinga was specifically for women who were considered particularly vulnerable because of what they were experiencing, or past trauma, and for women who wished to be in a gender-specific area for cultural, religious, or personal reasons.

Whilst these wards were clean and tidy, with sufficient bathrooms for the number of service users, furnishing were old, worn, and needed replacing. The flooring in one of the shower rooms in Te Kakenga needed replacing.

The bedrooms in the Unit were single occupancy, with a small number of double occupancy rooms. Staff informed Inspectors that service users rarely had to share bedrooms as the Unit had additional bedrooms above their funded occupancy. Service users were unable to lock their bedroom doors at night or when they left their bedrooms. Privacy screening on a service users' bedroom windows in Te Kakenga needed replacing as their room was visible from the small courtyard on the ward.

There were several lounges and quiet spaces for service users to use. Both wards had a small outdoor courtyard area.

Laundry facilities were available on both wards. Service users were able to use the laundry facilities without supervision. Service users could access linen when required in both wards.

The Unit had a programme to replace worn furnishings and staff advised Inspectors that wall decals depicting nature scenes were currently under discussion with the Clinical Governance team and funding was being sought to install the decals in all three wards.

Figure 5: Typical bedroom

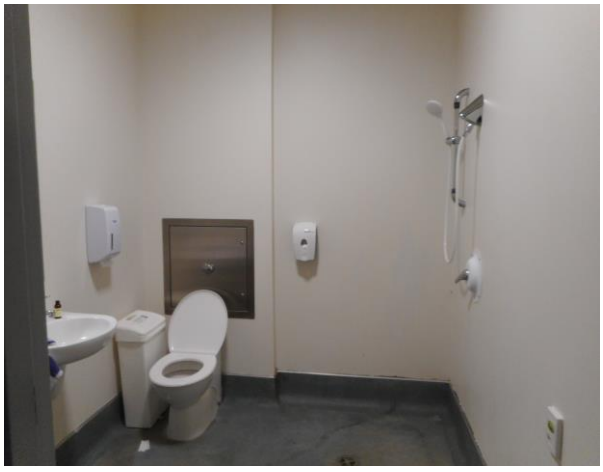

Figure 6: Shower/toilet

Food

Staff prepared a self-service breakfast in the servery area attached to the dining room for service users. Lunch and dinner were prepared in the hospital kitchen and transported to the Unit in a trolley with a heated side and a chilled side. The menu operated on a four-weekly cycle. Special dietary requirements were catered for. The menu provided various selections from halal, vegan, vegetarian to standard menu choices. Service users selected their meals the day prior. There were two options for both lunch and dinner.

Inspectors observed the lunch meal, and the quality and quantity of the food appeared good. Service users spoken to by Inspectors enjoyed the meals and felt there was sufficient quantity and choice.

Service users were encouraged to have their meals in the dining area. On weekdays, breakfast was between 8am and 8.30am, lunch at 12.30pm and dinner at 5.30pm. Morning and afternoon tea including a selection of fruit was readily available to service users in the dining room throughout the day and evening in all wards.

There was a vending machine in the Unit's reception area where service users could purchase snacks. Uber Eats and takeaways could be ordered by service users and delivered to the Unit.

Service users in Te Whitinga and Te Kakenga could freely access hot and cold drinks. Staff provided hot drinks to service users in Te Tūmanako ward.

Recommendations – material conditions

I recommend that:

10. Service users are able to lock their bedroom doors.
11. Service users in Te Tūmanako ward are able to freely access hot drinks, unless there is an individual risk to doing so.

Te Whetu Tāwera comments

The ADHB accepted recommendation 10.

The ADHB rejected recommendation 11.

Recommendation 10 response:

> *It is not currently possible for service users to lock their bedroom door [for safety reasons].*[38]
>
> *Scoping for [doors which service users will be able to lock] has been completed and a business case is in the process of being submitted to obtain the necessary funding.*

[38] The full comment by ADHB was redacted for safety reasons.

The ADHB has further agreed to consult other DHBs regarding possible interim solutions in the meantime.

Recommendation 11 response:

> *This recommendation is rejected on safety grounds.*
>
> *All of the service users on Te Tumanako ward are acutely mentally unwell and allowing them access to boiling water – which could be used to harm themselves, other patients or staff – would involve an unacceptable safety risk. There have been multiple instances of hot liquids being thrown at staff and other service users in Te Tumanako, most of which were not predictable. The current system, whereby service users can request hot drinks from staff, permits an individual risk assessment to be conducted by staff to determine whether it is safe for the service user to have a hot drink provided to him or her at that time, given his or her mental state.*

Ombudsman response:

I acknowledge Te Whetu Tawera's safety concerns and the practical realities of what is needed to keep service users and staff safe. However the value of staff making an individual risk assessment every time a service user wants a hot drink is not clear to me, in light of the advice that such incidents are not predictable. The current policy on the Ward disadvantaged all service users as it applied to everyone irrespective of safety risk. I continue to consider that free access to hot drinks should be available for all service users unless deemed unsafe based on a risk assessment for the particular individual.

Activities and programmes

Outdoor exercise and leisure activities

Te Tūmanako had two outdoor courtyard areas. Both areas had seating and shade available to service users. Neither courtyard provided any leisure or exercise equipment.

Te Whitinga and Te Kakenga had multiple small outdoor areas. Staff locked the smaller courtyards at times during the day as service users were using these courtyards for smoking. Service users who had leave were able to access the adjacent Auckland Domain[39] for fresh air and exercise.

Te Kakenga had a television which had been broken for approximately one year, and an X-box which was redundant because of this.

[39] Auckland Domain is a 75 hectare park located in the suburb of Grafton, Auckland. https://en.wikipedia.org/wiki/Auckland_Domain

Service users were concerned about a lack of activities, particularly during the evenings and weekends. A lack of activities was predominantly a concern for service users on Te Tūmanako. This particularly affected service users who had been on the Unit for an extended period.

Kia Atawhai[40] provided opportunities for activities in Te Rama Ora for service users from Te Whitinga and Te Kakenga, however, these activities were not identified on the Te Whetu Tāwera Recovery Programme.

Figure 7: Small outdoor courtyard – Te Kakenga

Figure 8: Activites area between Te Whitinga and Te Kakenga

Programmes

The activities area located between Te Whitinga and Te Kakenga contained art and craft equipment, plants, exercise equipment, games, puzzles, and a selection of books.

The activities area was well utilised by service users, however during the inspection the doors to this area were locked for extended periods. This significantly affected service users' ability to use the activities area.

The Unit had three full time OTs, and one Occupational Therapy Assistant (OTA). The OT team worked Monday to Friday 8am to 4.30pm. The OT team were aware of the need to offer activities and programmes in the evenings and weekends, but initiatives had not progressed. The OT team provided both group and individual assessments and programmes for service users.

Te Whetu Tāwera Recovery Programme was in place across Te Whitinga and Te Kakenga wards. Groups included drug and alcohol, smoke free support, hearing voices, coping skills, and meditation and wellness groups. A number of activities were available to service users during the day Monday to Friday. These included art and craft, gym sessions, games, puzzles, books and gym equipment including a treadmill and rowing machine. The psychologist also ran group sessions during the day. An evening yoga session was available in Te Rama Ora and two

[40] Kia Atawhai are the cultural support team in the Unit.

evening alcohol and other drug support group sessions were available to service users in Te Whitinga between 7pm and 8pm.

Figure 9: Activities area between Te Whitinga and Te Kakenga

Figure 10: Activities area between Te Whitinga and Te Kakenga

A Recreational Officer based in Te Tūmanako worked alongside the OT team and Kia Atawhai to provide activities to service users in Te Tūmanako. Te Tūmanako had daily sessions of Te Roopu Whakarongo (listening group) which was open to all service users and staff. This group session was a part of the ADHB's commitment to talking therapies[41] to assist with a service user's journey to wellness.

The Unit had a volunteer coordinator employed three days a week. The volunteer coordinator had sixteen volunteers at the time of inspection. Volunteers spent their time on the Unit engaging with service users by playing musical instruments or board games in lounge areas, or talking to service users. Volunteers also had therapy dogs which were brought into the Unit on a regular basis for service users to engage with. The volunteer coordinator had a recruitment and supervision process to ensure the volunteers were appropriately screened, including police checked, and supervised. The volunteer coordinator also coordinated Te Whetu Clothesline, a clothing and shoe service. A range of clothing donated by manufacturers, clothing stores and the public was available for service users to choose from.

Cultural and spiritual support

Inspectors met with the Kaumātua and Kai Atawhai services for the Unit. The Kai Atawhai team consisted of four Kai Atawhai. Each ward on the Unit had the presence of a Kai Atawhai. The Kai Atawhai team operated a 24-hour on-call service for any new admissions of Māori service users to the Unit. Kai Atawhai were engaged with 15 service users at the time of inspection.

[41] Te Pou o te Whakaaro Nui – Talking therapy initiative. https://www.tepou.co.nz/initiatives/talking-therapies/54

The Kai Atawhai provided cultural expertise and support to new arrivals with karakia, a whakatau and/or other cultural interventions. Kai Atawhai made contact with service users after they had settled onto the Unit.

The Kai Atawhai led daily karakia and were active in providing cultural support to the Unit, whānau, and service users. This included providing input into the therapeutic programme, recreational programme in Te Tūmanako, and MDT meetings.

Kai Atawhai sent invitations to service users they were engaged with to attend a monthly group in Te Rama Ora. Service users could attend yoga sessions in Te Rama Ora on Monday evenings at 7pm.

Four ecumenical chaplains provided services across Auckland City Hospital. Church services and Mass were facilitated each Sunday in the main hospital chapel. Service users with leave could attend this service if they wished.

Chaplains were part of the Te Whetu Tāwera Recovery Programme and were available every Tuesday afternoon for an hour in the OT area. They provided a drop in visit to the wards every Thursday to meet with any service users who wished to see them.

Recommendations – activities and programmes

I recommend that:

12. Service users be able to freely access the activities area.

13. A more extensive activities programme is available in the evenings and weekends.

Te Whetu Tāwera comments

The ADHB partially accepted recommendation 12 and 13.

Recommendation 12 response:

> *The activities area between the two open wards is only accessible when staff are present because of ligature risks and other risks in this area. The unit is not staffed to have this area available in the evenings. It is available for part of the weekends.*

Ombudsman response:

During the inspection my inspectors observed the corridor that linked the two open wards to the activities area was locked for extended periods while staff were present. They were informed that this was due to the risk of service users without leave absconding. The locked corridor significantly impacted on service users' ability to access activities throughout the day. Steps should be taken to ensure that service users can freely access the activities area when staff are present.

Recommendation 13 response:

ADHB Mental Health Services intends to review its Occupational Therapist staffing at Te Whetu Tawera in the evenings and at weekends with a view to extending the activities programme to include evenings and weekends, if possible.

Ombudsman response:

I look forward to seeing progress in this area in my follow-up inspection.

Communications

Access to visitors

The Unit's visiting hours were Monday to Friday 4pm to 8pm. At weekends and public holidays visiting hours were 12pm to 8pm. Te Tūmanako restricted visits to half an hour, with a maximum of two visitors. These visits were by appointment. Visits outside the designated times were at the discretion of staff.

Te Tūmanako visits could take place in a private quiet space on the ward. Whānau spoken to visiting a service user in Te Tūmanako were appreciative of staff facilitating a private, quiet space for their visit.

Te Whitinga and Te Kakenga also had a number of private quiet spaces for visits to take place and a dedicated whānau room for visitors with children to visit. The majority of service users had leave and were able to go out with their whānau when they visited.

Access to external communication

Te Tūmanako had two telephone booths, however on the first day of inspection only one telephone was available. Staff informed Inspectors that telephones were regularly removed from the booths due to the risk of damage. Service users were provided with telephones by staff on request. Service users on Te Tūmanako were unable to retain their own mobile phones due to concerns about them making external communications whilst acutely unwell. Staff assessed on an individual basis whether service users could be supervised to use their own phones in a private area of the ward.

Te Whitinga and Te Kakenga had two telephone booths in the ward, which were freely accessible to service users. They could make local or Freephone calls independently. Staff connected cell phone and toll calls on request. Service users on these two wards were able to retain their own mobile phones.

Service users had no concerns about access to visitors or telephones on Te Whitinga and Te Kakenga wards.

Recommendations – communications

I recommend that:

14. Service users in Te Tūmanako have access to a telephone, independent of staff, unless deemed inappropriate for clinical or safety reasons. This should be documented in the service user's recovery plan and reviewed regularly.

Te Whetu Tāwera comments

The ADHB rejected recommendation 14.

Recommendation 14 response:

> *Access to a telephone for service users on Te Tumanako ward needs to be overseen by staff. There may be a risk of these service users – while they are acutely unwell – breaching protection orders, causing distress to others (for example by making abusive telephone calls to family members) and of causing harm to their interests in some other way if they are permitted to have access to a telephone independently of staff (for example if there was a telephone freely accessible to service users on the Te Tumunako ward).*
>
> *The decision to give service users on the Te Tumunako ward access to a telephone is a clinical decision, based on an assessment of the potential risk involved and whether it would be detrimental to the interests of the service user and to his or her treatment. An assessment as to the appropriateness of the service user having access to a telephone may change from day to day or during a day based on the service user's clinical presentation and mental state. Access will be recorded in the clinical record by the responsible clinician and regularly reviewed.*

Ombudsman response:

I remain of the view that service users should be able to access a telephone unless there a specific clinical or safety reasons not to allow this. I do not accept that the use of the telephone for all service users in Te Tumanako needs to always be supervised.

Health care

Primary health care services

The Unit's House Officer conducted physical examinations of service users at the time of admission.

A treatment room was available on each ward for physical examinations. A separate medication room stored medications. These rooms were tidy and well organised.

Service users who had a deterioration in their physical health that necessitated further assessment and intervention were taken to the Auckland City Hospital's Emergency Department accompanied by mental health staff. I am concerned that adequate medical assessment was unable to be provided on the Unit. Patients in a general hospital setting would not be required to attend the Emergency Department for assessment and intervention. Such an approach other than in an emergency would appear to draw a distinction between mental health service users and other ADHB patients solely on the basis of disability.

I consider that the ADHB should, as a priority, review its approach to the provision of physical health care to the service users on the Unit.

The Unit's pharmacist was actively involved in the MDTs and met with service users to explain medication uses and side effects. Service users appeared to have a good understanding of the medications they were taking and the side effect profiles. One service user commented that after their consultation with the pharmacist they now understood the purpose of the medication and intended to continue to take the medication once discharged.

A dietician visited the Unit on Thursdays for three to four hours and service users could attend in small groups.

The Unit employed a physiotherapist for 20 hours a week. The physiotherapist reviewed service users on referral from the House Officer for muscular-skeletal issues to reduce the need for pain medications. The physiotherapist undertook relaxation classes and massage, working closely alongside the OT team. The physiotherapist developed individual exercise programmes for service users, including seated exercise.

Recommendations – health care

I recommend that:

15. Service users are not taken to the Emergency Department for medical assessment other than in emergency situations.

Te Whetu Tāwera comments

The ADHB rejected recommendation 15.

Recommendation 15 response:

> *Routine or non-urgent medical assessments are conducted in Te Whetu Tawera by the House Officers, including the on call House Officers after hours. At times, a Medical Consultant from Auckland City Hospital will come to the unit to review a service user. The Auckland City Hospital Emergency Department is accessed for emergency situations, such as acute injuries and chest pain.*

Ombudsman response:

I remain of the view that the practice of Unit staff accompanying acutely unwell mental health service users to await non-emergency medical assessment in the Emergency Department should be avoided. Service users admitted to an inpatient mental health unit should expect to receive seamless medical assessment and treatment in line with patients within the wider hospital.

Staff

Staffing levels and staff retention

At the time of inspection, the Unit had vacancies for 3.5 FTE RNs, 5 FTE MHAs, 0.5 Nurse Unit Manager, 1 after hours Clinical Charge Nurse, 0.6 Psychologist, and 1 Psychiatrist. The vacant Psychiatrist position had been particularly challenging for the Unit to recruit, and the vacancy had been open for two years.

Nursing staff worked a three-shift roster, with a designated staffing level on each shift. Day shift and afternoon shift on Te Whitinga and Te Kakenga had four RNs and one MHA. Te Tūmanako had five RNs and one MHA. Night shift on Te Whitinga and Te Kakenga had two RNs and one MHA. Te Tūmanako had two RNs and two MHA. In addition to the rostered staff was an admissions coordinator rostered Monday to Friday 9am to 5pm, an afternoon shift and weekend day and afternoon shift clinical charge nurse and on night shift a supernumerary shift coordinator.

Staff were often working overtime to fill the roster, with some shift vacancies remaining unfilled. Inspectors observed staff working double shifts during the inspection. Staff spoken to by Inspectors identified feeling pressured at times to work overtime and cover shifts when the wards were under-staffed. The Unit had access to temporary contract staff, known as 'agency staff'[42], however these staff were often not familiar with the wards.

Data provided by Unit staff showed that between 2017/2018 and 2018/2019, staff turnover had decreased from 11.9 percent to 11.6 percent. There had been a 27.4 percent turnover in Senior RN roles in 2018/2019. The average sickness rate for the Unit for the 2018/2019 period was 3.75 percent. Forty-five percent of RNs had a length of service of five years or more, with 18 percent having less than one years' service.

There had been a number of changes in the senior leadership team over the two years prior to inspection that staff had found destabilising. Inspectors were advised that staff retention had been difficult and the Unit had a culture of bullying. Several managers had now completed the 'Just Culture Certification Course'.[43] Despite this training some staff reported to Inspectors that

[42] Agency staff means staff who are employees of a labour hire agency. They may provide either short term or long term personnel as required by the DHB.

[43] Excerpt from Just Culture website: ""Just Culture" is the system we use to implement organizational improvement, presenting a set of design laws that influence our ability to create the societal outcomes we desire. Our five-skill model is designed to help change an organization's culture by placing less focus on events,

they still felt unable to approach their direct managers with their concerns. Inspectors raised this with senior management at the time of the inspection. Senior management were aware of the concerns and were actively working to address the issues. They had a plan to implement staff rotation, inclusive of management across the Units. Senior management were working closely with the Public Service Association union (PSA) and jointly reviewing the concerns of staff at weekly meetings. Staff spoken with felt that senior management were listening and responding to their concerns.

Staff spoken with identified feeling unsafe on the Unit, particularly on Te Tūmanako. Data provided by Unit staff identified 120 assaults recorded for the period 1 May to 31 October 2019, 78 of these being assaults on staff. The Unit had an agreement with the PSA to provide extra staff when needed in line with the number of acute admissions. Staff on the wards did not have personal alarms.

Senior hospital management had implemented a specific rapid response team to support code orange call outs across the hospital when staff felt concerned for their own safety or the safety of a patient or other patients in the hospital. Unit staff had told Inspectors they felt safer when this dedicated team were present and were happy with the response rate from this team. The Leadership Team had weekly meetings to discuss staffing levels, staff issues, and service users with high and complex needs and associated risks. Management had agreed to provide extra staffing when required due to acuity and had developed an escalation plan.

Recommendations – staff

I have no recommendations to make.

Acknowledgements

I appreciate the full co-operation extended by the Unit's Clinical Director, Charge Nurse Managers and staff to the Inspectors during their inspection of the Unit. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

errors and outcomes, and more focus on risk, system design and the management of behavioral choices. We do this by defining three manageable behaviors based on the choices of those in the system – human error, at-risk behavior and reckless behavior – and we strongly encourage the creation of an environment of free and open reporting within process systems. This helps to build a culture which encourages coaching and honesty at all levels, in order to bring about the best possible outcomes." https://www.outcome-eng.com/david-marx-introduces-just-culture/

Appendix 1. List of people who spoke with Inspectors

Table 5: List of people who spoke with Inspectors

Managers	Ward staff	Others
Director Area Mental Health (DAMHS) Service Clinical Director/Nursing Unit Manager Child & Family Unit Operations Manager	Charge Nurse Managers Registered Nurses Mental Health Assistants Lead Psychiatrist Consultant Psychiatrists Occupational Therapists Physiotherapist Social Workers Social work assistants Medical Officer Special Scale (MOSS) House Officer Pharmacist Security Acute admissions coordinator	Service users District Inspector Whānau Chaplain Complaints co-ordinator Consumer Advisor Kai Atawhai Kaumatua Volunteer coordinator PSA Representative Reception staff Peer Support Worker

Appendix 2. 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…"*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

The *New Zealand Gazette* of 6 June 2018 sets out in further detail the relevant places of detention:

> *"…in health and disability places of detention including within privately run aged care facilities; …"*

Carrying out the NPM's functions

Under section 27 of COTA, an NPM's functions, in respect of places of detention, 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.

Under 28 – 30 of COTA, NPMs 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 designated places they want to visit and the people they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

- require the production of any information, documents, papers or things that, in the Ombudsmen's opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
- at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman's NPM function, inspection powers, and read his reports online: ombudsman.parliament.nz/opcat.