Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced inspection of Haumietiketike Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989

October 2021

.....
Peter Boshier
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an unannounced inspection of Haumietiketike Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989

ISBN: 978-1-99-115511-5 (PDF)

Published October 2021

Contents

Tables

Figures

Executive summary

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 clients[1] detained in secure units within New Zealand hospitals.

Between 14 and 16 July 2020, two Inspectors[2] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Haumietiketike Unit (the Unit), which is located in the grounds of Rātonga-Rua-O-Porirua Mental Health Campus, Porirua. A focused follow up inspection was also carried out on 10 February 2021.

Summary of findings

My findings are:

- Files contained the necessary paperwork to detain and treat the clients on the Unit.
- Clients spoken with felt safe and confirmed that they were treated with dignity and respect.
- The Unit's Morning Hui was a positive initiative.
- Clients' access to leave was well utilised and supported by Unit staff.
- The Unit was clean and tidy.
- Clients had good access to primary health care services.
- Leadership on the Unit was visible.
- Clinical supervision was actively promoted on the Unit and staff were supported to attend.
- The orientation package provided to new staff and student nurses was comprehensive.
- The recently introduced Positive Behaviour Support (PBS) training[3] for staff was well supported by the Unit leadership team.

---

1 A person who uses mental health and addiction services. This term is often used interchangeably with consumer, patient, or tāngata whai ora.

2 When the term Inspectors is used, this refers to the inspection team comprising a Senior Inspector and an Inspector.

3 Delivered by Explore, the PBS framework *'focuses on understanding a person's needs and supporting them and the people around them to experience a better quality of life'* while reducing challenging behaviour. See www.healthcarenz.co.nz/explore-specialist-advice for more information.

The issues that needed addressing are:

- The client previously identified as living in a seclusion[4] room on a permanent basis (in 2014[5] and 2018[6]) had not had a change to their living arrangements at the time of the inspection. A follow-up inspection saw a change in accommodation. During both inspections, the conditions under which Client A was accommodated may have amounted to cruel and inhuman 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').[7]
- Seclusion Room One was not fit for purpose.
- New clients were being admitted into seclusion rooms.
- Night safety procedures[8] were not being recorded as seclusion events and the Night Safety Plan (NSP) paperwork was often a duplicate of the previous plan.
- The complaints process was not well advertised or easily accessible for clients.
- The Health and Disability Service *'Code of Health and Disability Services Consumers' Rights'* posters on display were not all in an accessible format.
- Clients did not routinely receive an up-to-date copy of their care plan.
- Clients were subject to overly restrictive practices and blanket restrictions, including lack of independent access to drinking water, hot drinks, and fresh air.
- Clients' access to Unit activities, religious, and cultural support was limited.
- Clients were not able to use a telephone to contact the District Inspectors (DIs), independent of staff.
- A high proportion of medication errors occurred at the point of administration.
- The Unit had a high and increasing rate of staff turnover.

---

4 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.'* Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Ministry of Health, Wellington, 2010.

5 *Report on an announced visit to Capital and Coast District Health Board's Haumietiketike Unit under the Crimes of Torture Act 1989*. January 2014.

6 *Report on an unannounced visit to Haumietiketike Unit under the Crimes of Torture Act 1989.* April 2018.

7 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 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.'*

8 Night safety procedures are defined as *'the practice of locking a patient in their bedroom overnight for the purposes of safety. The practice has no therapeutic function and constitutes (at the very least) a form of environmental restraint.'* Ministry of Health. *Night Safety Procedures: Transitional Guideline.* Ministry of Health, Wellington, 2018.

Recommendations

I recommend that:

1. As a matter of urgency, Client A is provided with daily access to fresh air, the ability to exercise, and the ability to have meaningful engagement with others. **This is an amended repeat recommendation.**
2. Seclusion Room One is decommissioned urgently.
3. Seclusion rooms are never used as bedrooms.
4. The use of night safety procedures be recorded, reported and treated as seclusion events.
5. Complaint forms are available to clients at all times and the complaint process allows clients to make a complaint independent of staff.
6. Copies of the Health and Disability Commissioner's *Code of Health and Disability Services Consumers' Rights* in Easy Read format should be available throughout the Unit. **This is a repeat recommendation.**
7. Clients should receive an up-to-date copy of their care plan. **This is a repeat recommendation.**
8. Clients have, at a minimum, independent access to drinking water. **This is an amended repeat recommendation.**
9. All clients need to be offered daily access to fresh air. This should be documented, including when they decline. **This is a repeat recommendation.**
10. Clients are provided more opportunities to engage in activities on the Unit. **This is an amended repeat recommendation.**
11. Clients are provided more opportunities to engage with cultural and religious services. **This is an amended repeat recommendation.**
12. Clients are able to make a complaint, and contact the DIs using a telephone, independent of staff. **This is an amended repeat recommendation.**
13. The reasons for the number of medication errors at the point of administration are analysed and, where necessary, appropriate remedial action be implemented.
14. The Unit regularly monitor and analyse the reasons for staff turnover and take action to address any concerning trends.

I intend to monitor the implementation of my recommendations, including conducting follow-up inspections at future dates.

Feedback meeting

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

District Health Board response

The Capital and Coast District Health Board (the DHB) received a copy of my provisional report and were invited to comment. The DHB responded and I have had regard to that feedback when preparing my final report.

The DHB's letter and comments responded to a number of common themes from my inspections of the Unit and three other units in the DHB which were conducted at the same time[9], in particular around the use of seclusion rooms as bedrooms and ongoing reliance on night safety procedures (NSPs).

The DHB emphasised that they considered the reports provided evidence of unmet need within the forensic mental health services. The DHB noted the legal requirement to admit from court and the high acuity of the prison waitlist are such that the bed capacity in the forensic mental health service is continually exceeded. Many of the DHB's responses to the recommendations also highlight significant financial pressure on the DHB and indicate the need for additional funding to achieve the recommendations. While I acknowledge that funding may be a barrier, my role as an NPM is to report on the conditions and treatment for people who are being detained, as they are at the time of the inspection. I intend to highlight my concerns with the Ministry of Health.

I also intend to conduct follow up inspections of all the Units, at which point I will be able to assess whether action to address my concerns has been implemented.

[9] The units inspected at the same time were Rangipapa, Pūrehurehu, and Tāwhirimātea.

Facility facts

Haumietiketike Unit

Haumietiketike Unit (the Unit) is an 11-bed secure, mixed gender, facility. The Unit provides treatment and rehabilitation services for people over the age of 18 with an intellectual disability (ID),[10] who have committed criminal offences, and who demonstrate behaviour that poses a serious risk to themselves or others. Clients may also have a comorbid mental illness.

Clients receive services provided by the Ministry of Health's Regional Intellectual Disability Secure Services (the Service).

Clients admitted to the Unit must be assessed as having an ID as defined under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act). Clients are admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act), or the IDCCR Act.

The Unit consists of four 'clusters' containing 11 bedrooms in total. The de-escalation area contained two seclusion rooms, one of which was operational at the time of inspection and one de-escalation bedroom.

The Unit accepts admissions from the central North Island and South Island.

The Unit is located in the grounds of Rātonga-Rua-O-Porirua Campus, Porirua.

Region

Central North Island and South Island

District Health Board

Capital and Coast District Health Board

Operating capacity

11 (plus two seclusion rooms and one de-escalation/admission bedroom)

Last inspection

Unannounced inspection – November 2017
Announced inspection – January 2014
Announced inspection – September 2008

[10] Intellectual disability is defined in section 7 of the IDCCR Act as: a permanent impairment resulting in significantly sub-average general intelligence, and significant deficits in adaptive functioning, that became apparent during the developmental period of the person.

The inspection

Two Inspectors conducted the inspection of the Unit between 14 and 16 July 2020. On the first day of the inspection, there were eight clients in the Unit, comprising two females and six males. The ages of those clients ranged from 19 to 50. The average length of stay at the time of inspection was 2117 days.

At the time of inspection, New Zealand was at COVID-19 Alert Level 1.[11]

A focussed follow-up inspection was carried out by two inspectors on 10 February 2021.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Team Leader before being shown around the Unit.

Inspectors were provided with the following information during and after the inspection:

- a list of clients and the legal authority for their detention (at the time of the inspection);
- the seclusion and restraint data from 1 January to 30 June 2020, and the seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events from 1 January to 30 June 2020;
- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);[12]
- complaints received from 1 January to 30 June 2020, a sample of responses and associated timeframes, and a copy of the complaints policy;
- copy of minutes of client group meetings from 1 January to 30 June 2020;
- activities programme;
- information provided to clients and their whānau on admission;
- incident reports relating to medication errors from 1 January to 30 June 2020;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number); and
- data on staff, categorised by profession.

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

[12] 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. See https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149 for more detail.

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 clients.[13]

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Seclusion
- Seclusion policies and events
- Night safety procedures
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Clients' and whānau views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

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

Communications

- Access to visitors

[13] 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.

- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided, Inspectors spoke with a number of managers, staff and clients, and whānau.[14]

Inspectors also reviewed clients' records and additional documents provided by staff, and observed the facilities and conditions.

Recommendations from previous report

The Inspectors followed up on 15 recommendations following an inspection to the Unit in 2017, which were:

a. As a matter of urgency, a more appropriate facility must be sourced for the client living in a de-escalation bedroom room on a permanent basis. **This is a repeat recommendation.**

b. A more robust system for accurately recording seclusion and restraint in the Unit needs to be implemented. Policies and procedures should be up-to-date.

c. Staff training to enhance knowledge and skills for dealing with clients with high and complex needs to be enhanced.

d. The Memorandum of Understanding between the Police and MHAIDS needs to be updated.

e. The complaints process, including the contact details for the District Inspector, needs to be made available in all areas of the Unit.

f. Complaints should be responded to in a timely manner.

g. Copies of the Code of Health and Disability Services Consumers' Rights in Easy Read format should be available throughout the Unit.

h. Clients should receive an up-to-date copy of their care plan in a format they can understand.

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

i. The Unit should be softened to make it more homely. Damaged blinds and soft furnishings should be replaced.

j. The budget for Unit maintenance needs to be increased to ensure damage is repaired in a timely manner.

k. Clients need to be able to freely access water any time of the day and night.

l. All clients need to be offered daily access to fresh air. This should be documented, including when they decline.

m. Clients need greater opportunities to access activities and programmes both on and off the Unit.

n. Clients need increased opportunities to engage with cultural and religious services, particularly during the care planning process.

o. Clients need to be able to make a complaint using a telephone without having to rely on a staff member dialling and connecting them.

The Unit's adoption, or not, of these prior recommendations is referred to in the relevant sections of this report.

Treatment

Torture or cruel, inhuman or degrading treatment or punishment

There was no evidence that any client had been subject to torture, degrading treatment or punishment. However, I found evidence of cruel and inhuman treatment.

Client A

In 2018 I reported on the conditions of Client A, who at the time of the 2017 inspection had lived in a seclusion room for approximately five and a half years. In 2014, my predecessor also reported on Client A's living conditions. Both reports found that Client A's treatment was cruel and inhuman.

At the time of inspection in 2020, Client A's situation remained unchanged. They were still living in the same de-escalation bedroom that they had lived in for approximately eight years.

The de-escalation bedroom was located in the de-escalation area, and Client A spent some time in the area, outside of the de-escalation bedroom. This gave Client A some respite from the confines of the de-escalation bedroom. However, this area, a corridor with a number of rooms leading off it, was not fit for purpose. Line of sight from the nurse's station was poor, so Client A could not be adequately observed when spending time in the space. The de-escalation area was also highly restrictive, so Client A effectively remained secluded.

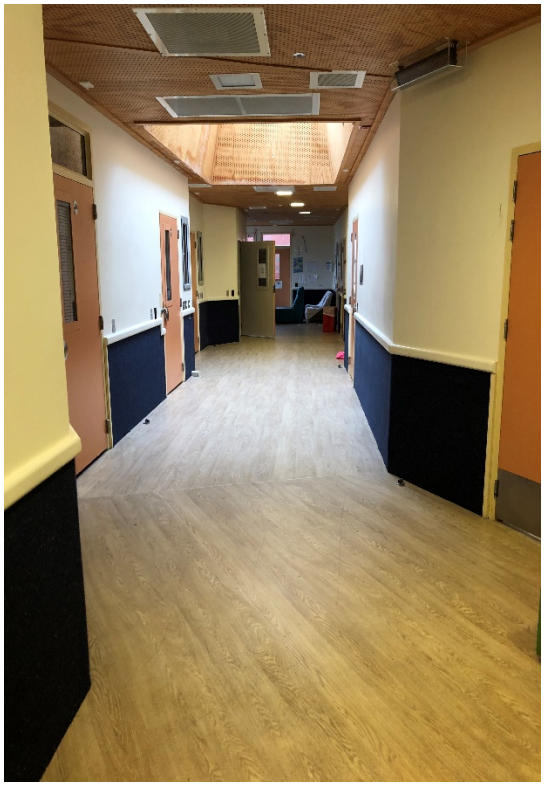

Figure 1: De-escalation area

The de-escalation area was also used for admissions to the Unit and when clients from the Unit required a period in de-escalation. On these occasions Client A was required to return to the confines of their de-escalation bedroom, despite not displaying behaviour that would warrant an episode of seclusion. In these instances Client A would remain in their de-escalation bedroom until the de-escalation area was no longer required, which could be several days, depending on the needs of the other client.

Due to the limitations of the environment, access to fresh air was not guaranteed for Client A. When other clients were in de-escalation, Client A was unable to leave their de-escalation bedroom and therefore not able to access the small outdoor space attached to the de-escalation area. This was noted in Client A's clinical file on a number of occasions.

Client A's clinical file recorded that, when confined to the de-escalation bedroom, they could be 'accepting', 'cooperative', 'frustrated' or 'demanding' especially when asking about leaving the room. Inspectors spoke with Client A who confirmed they enjoyed being in the outdoor area, not locked in their room.

It is my opinion that Client A's treatment was often based on the needs of the Unit, rather than Client A's therapeutic or safety needs.

Client A had no face-to-face contact with staff or other clients other than through a wire fence or door, following two assaults on staff in 2019. Staff confirmed that Client A had not left the de-escalation area since November 2019. This reduction in face-to-face contact resulted in limited opportunities for Client A to participate in therapeutic programmes and activities. Inspectors' review of the clinical file and interviews with Unit staff indicated that Client A's living conditions at the time of the inspection were having a detrimental impact on their well-being.

During the inspection, my Inspectors were told that a campus wide security system failure resulted in Client A being unable to leave their de-escalation bedroom for two days. Inspectors reviewed Client A's clinical file, which showed that staff did not enable access to the de-escalation area during the malfunction. There were multiple file notes from Unit staff over the two days reiterating Client A could not leave their room due to the system failure, such as: '*Unfortunately due to a malfunction of the duress system [Client A] is unable to leave to exit [their] room for the time being'* and *'[Client A] accepts the need to be patient, and hopefully will be able to come out later'.* Notes confirmed that Client A remained in the de-escalation bedroom for two days.

Following a query from Inspectors, a retrospective reportable event record was completed by Unit staff. The reportable event documentation did not refer to the impact the malfunction had on Client A's ability to leave the de-escalation bedroom.

I raised this issue with the Chief Executive of the DHB following the inspection.[15] The DHB responded that '*at no time were staff unable to use swipe cards or backup key over-rides'.*

The DHB said that not allowing Client A to leave their bedroom was a clinical decision, not the result of the system failure. The DHB also confirmed that staff were able to access Client A's

[15] My inspectors also raised this issue with Unit staff during the inspection.

bedroom to provide food and medication. The DHB acknowledged that the clinical notes could have been clearer on this issue.

The Unit's leadership team told Inspectors an area within one of the Unit clusters had been repurposed to accommodate Client A and was close to completion. Inspectors saw the near completed area during the inspection.

While acknowledging this progress, my concerns regarding Client A remain. Improvement in Client A's living conditions had not been progressed over a number of years despite repeated recommendations. I consider it unacceptable that Client A remained in conditions that were not fit for purpose. This may amount to cruel and inhuman treatment, and a breach of Article 16 of the Convention against Torture.

Immediately following the inspection, I wrote to the DHB, and sought an assurance that Client A's planned move would occur, and occur in a timely manner. The response confirmed Client A had moved to the repurposed cluster area in the weeks after the inspection. I asked my Inspectors to undertake a follow up visit to Client A.

Follow-up inspection – Client A

In February 2021, my Inspectors visited the Unit to examine the changes to Client A's living conditions and spoke with Client A. Client A had been living in the newly repurposed cluster since August 2020.

Client A's new living space was more spacious and attractive than the de-escalation area. There was a bedroom with storage facilities, a living area, and an activities room. There was a bathroom in the cluster, but no en-suite from the bedroom. An enabler belt had been introduced to facilitate contact with staff.

The key improvement in Client A's treatment is that the space was no longer shared. There was no restriction in Client A's movement when another client needed a period of de-escalation.

My Inspectors saw several matters in need of attention.

- Although the new accommodation was more spacious and attractive than the de-escalation area, Client A was still effectively in seclusion. Client A remained alone, in a locked area, and unable to leave.[16]
- The area had no direct access to fresh air. To access fresh air, a staff member was needed to escort Client A through the main Unit, after all other clients are moved away from the escort route. Client A was then able to spend time in the courtyard and vegetable garden, before being escorted back to the cluster. My Inspectors reviewed documents stating that Client A had passed *'large patches'* of time, spanning consecutive days, without access to the outdoors. In the de-escalation area, Client A could access an outdoor area independently of staff during the day, unless another client was in the de-escalation area.

[16] Consistent with the Ministry of Health definition of seclusion, set out in footnote 4 above.

- The lack of en-suite bathroom, combined with ongoing use of a night safety plan (see below) means Client A could use the bathroom during the day independently of staff, but overnight, Client A needed to ring a call bell for a staff member to give access. In the de-escalation area, Client A had access to an en-suite bathroom at all times.

Following the inspection, the DHB raised the matter of variance in the use of the term seclusion compared to other restrictive practices. The DHB considered that its seclusion practice was consistent with Ministry of Health monitoring requirements, including reporting.

However, the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* define seclusion 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'*.[17] Perhaps the key element of this definition that distinguishes it from restrictive practices, such as environmental restraint, is the deprivation of company.[18] The fact was that Client A was placed alone in a room from which they could not freely exit is not in dispute. In my view, this treatment clearly meets the definition of seclusion and should be understood as such.

I intend to raise the differing interpretations with the Ministry of Health.

I consider Client A remained in conditions that were not fit for purpose, and which may amount to cruel and inhuman treatment, and a breach of Article 16 of the Convention against Torture.

Client B

In 2018 I also reported on the conditions of Client B. Client B shared a cluster unit with another client, but due to Client B's mental state, was effectively secluded at most times. What engagement Client B had with staff and visitors to the cluster was facilitated by use of an enabler belt (discussed on page 18).

At the time of inspection in 2020, significant work had been undertaken by Unit staff to enhance the quality of engagement with Client B. Client B no longer shared a cluster space with other clients, allowing them free movement throughout the area during the day.

Activities and leisure activities for Client B now included leave off the Unit with staff. Client B's participation in therapeutic programmes and the morning Hui occurred via Zoom.

My Inspectors saw Client B participating in a face-to-face music session with two members of staff, and were told this was a regular, weekly event. Client B appeared to be enjoying this session and was positively engaged. Following my 2018 report, the Unit had also developed a process which enabled Client B to access fresh air daily in the main courtyard.[19] Client B's access to fresh air was documented in their clinical notes, along with instances when they declined this. Inspectors saw Client B accessing the courtyard each day of the inspection.

---

[17] New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[18] Mental Health (Compulsory Assessment and Treatment) Act 1992, section 71.

[19] Other Unit clients did not access the courtyard space at these times.

I commend the Unit staff for the effort made to improve conditions for Client B.

Seclusion facilities

The Unit had two seclusion rooms in operation at the time of inspection. Inspectors were told that the operating seclusion room (Seclusion Room One) was in the process of being decommissioned because it was no longer fit for purpose. The room was basic and stark. The only furnishing was a mattress on the floor. Graffiti was scratched in to the paint on the floors and walls. There was no natural light as the window had been blocked out due to construction work. Clients in Seclusion Room One had no way of orientating to time and date.

Seclusion Room One did not have an en-suite. An adjacent bathroom was available for clients in seclusion. Inspectors reviewed documentation that showed clients in seclusion could access the bathroom, dependent on individual risk assessment.

New admissions to the Unit were admitted into Seclusion Room One. The Ministry of Health seclusion guidelines state *'seclusion should not occur as part of a routine admission or therapeutic procedure, or be administered as discipline, or as a replacement for adequate levels of staff or resources'*.[20] I agree. It is inappropriate that new admissions were routinely admitted into Seclusion Room One.

My Inspectors were told Seclusion Room One was due to be decommissioned soon after completion of my inspection. My Inspectors saw the nearly completed, refurbished, replacement seclusion room at the time of the inspection.

When my Inspectors visited again in February 2021, they asked for an update on the use of Seclusion Room One. Staff told them the new room was not conveniently located, and management confirmed the old room was still in use.

The DHB provided additional information after the inspection, confirming that Seclusion Room One was still to be decommissioned. However, the DHB also noted that they are waiting on the remodelling of Seclusion Room Two to include an en-suite bathroom. This was occurring along with the build of the ISU [21]and refurbishment of the de-escalation area. The DHB informed me that Seclusion Room One would then be decommissioned and remodelled into a kitchenette for the de-escalation cluster 1B areas.

[20] Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Ministry of Health, Wellington, 2010.

[21] Intervention Support Unit presently under construction behind Haumietiketike.

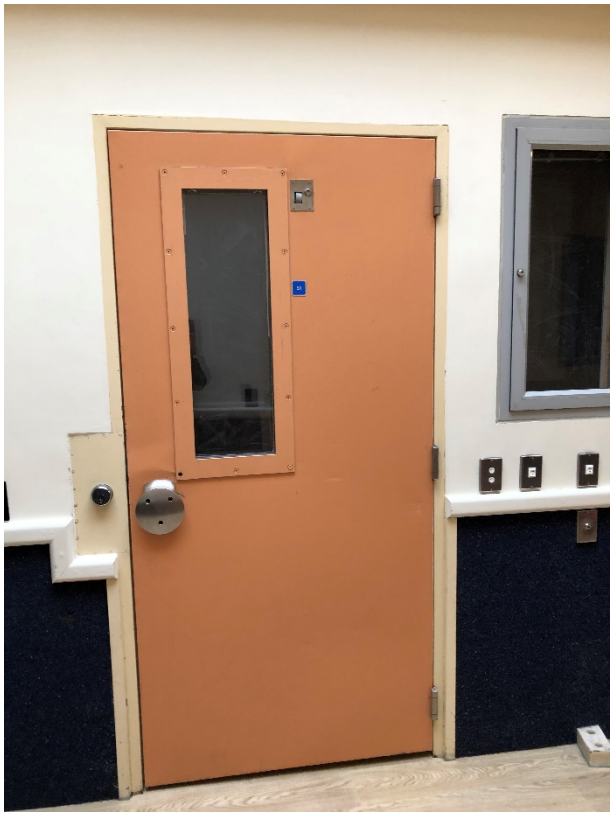

Figure 2: Seclusion room entrance

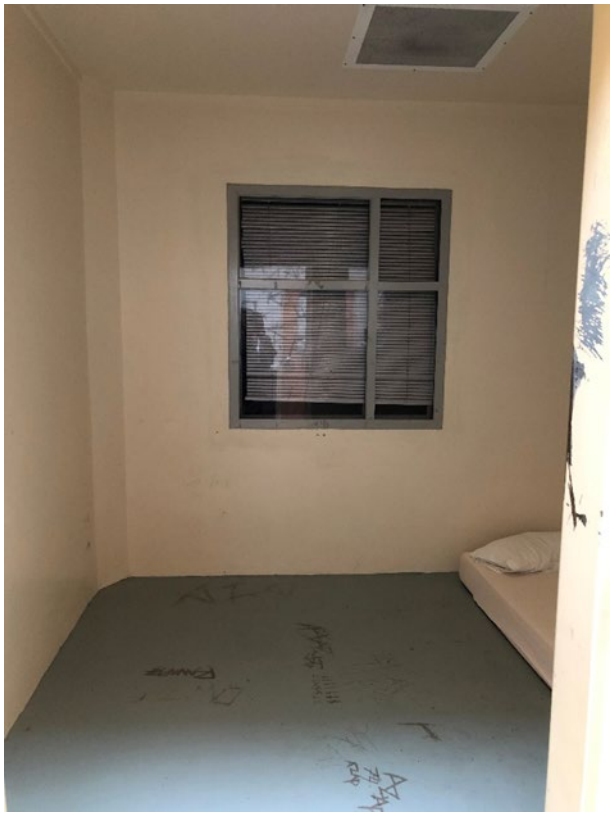

Figure 3: Seclusion room/admission room

Seclusion policies and events

The DHB provided Inspectors with its *Seclusion* Policy, dated 2015, with a review period of five years. The Policy was current at the time of inspection.

Data provided by the Unit indicated that, from 1 January to 30 June 2020, there were 24 seclusion events. As in my 2018 report, the recording of Client A's time in seclusion was inaccurate. Client A was effectively in seclusion at all times. Although sometimes able to leave the de-escalation bedroom to spend time in the de-escalation area (for approximately four hours each day, unless someone was using the de-escalation area), this time continued to meet the definition of seclusion, but these periods were not recorded as such. Also, the Unit did not record Client A's confinement overnight, every night, as seclusion. Rather this confinement was recorded as a 'Night Safety Plan'. Hence, the number of seclusion events recorded did not match the time spent in seclusion.

Table 1: Seclusion events 1 January – 30 June 2020[22]

Month	Events	Client numbers	Hours	Average hours
January	2	2	300 and 15 minutes	150
February	2	2	278 and 15 minutes	139
March	8	2	403 and 10 minutes	50
April	4	2	322 and 20 minutes	80
May	6	2	347 and 10 minutes	57
June	2	2	267 and 35 minutes	133
Total:	**24**	**12**	**1917**	**101.5**

The Unit had improved its recording of seclusion events, using a primary, comprehensive register. All seclusion paperwork was inputted into a spreadsheet and submitted as a reportable event. At the time of inspection, seclusion recording was contained in individual folders for each client.

Night safety procedures

The DHB provided Inspectors a copy of its *Night Safety Procedure* (dated October 2018). The procedure had a review period of three years.

Night safety procedures are defined by the Ministry of Health as '*the practice of locking a patient in their bedroom overnight for the purposes of safety'.* The Ministry of Health has advised the use of night safety procedures *'is no longer fit for purpose'* and, in 2018 issued a transitional guideline to assist in phasing out the use of night safety procedures.[23]

The procedure stated that Night Safety Plans (NSPs) differ from seclusion in certain crucial aspects. One key difference was that, under an NSP, '*the person is entitled to exit their room at any time unless this would immediately jeopardise the safety and/or security of the person or*

[22] Data as provided by the Unit.

[23] Ministry of Health. *Night Safety Procedures: Transitional Guideline.* Ministry of Health, Wellington, 2018.

others.' Another is that clients subject to NSPs require hourly observations, however, for clients in seclusion '*the longest interval between recorded observations shall be 10 minutes'*.[24]

At the time of my inspection three clients on the Unit were subject to NSPs. Inspectors viewed the NSPs for each of the three clients. All three NSPs were current and signed by the Responsible Clinician or Care Manager and the Forensic Director of Area Mental Health Services (DAMHS).

Client A was in seclusion during the day and subject to an NSP by night. A second client had been subject to an NSP for a number of years. A third client had been transferred from an acute adult forensic unit, and their NSP followed them.

Client A's conditions remained unchanged regardless of the time of day or night. He was not able to leave the de-escalation bedroom room under the NSP. The only practical distinction between seclusion and the NSP for Client A was the level of documented observations, which were required every ten minutes during the day but reduced to hourly observations overnight under the NSP. I am not satisfied that a client who is subject to a seclusion event and the requirements of care associated with seclusion should be subject to a lower standard of care (including reduced observations) simply because an NSP comes in to effect at night.

While NSPs for each client were current, the NSPs that had been reviewed were largely identical to previous NSPs. This indicated little or no meaningful consideration of the client's needs as part of the review process, as was the case in my 2018 report.

The Unit did not record the use of NSPs as a seclusion event. In discussion with Inspectors, the DAMHS acknowledged that locking a client in their room overnight under an NSP equates to seclusion and should be recorded as such. I welcome improvement in this regard.

I agree with the Ministry of Health that the use of NSPs is no longer fit for purpose. Further, not recording these events as seclusion does not accurately represent the reality of confinement for clients.

Restraint

Inspectors were provided with the DHB's *Restraint Minimisation and Safe Practice Policy* (the Restraint Policy) (dated May 2020). The policy had a review date of November 2023.

Data provided by the Unit showed that 27 clients were subject to 141 restraint events[25] between 1 January and 30 June 2020. Of the 141 events, 46 were recorded as personal

[24] Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Ministry of Health, Wellington, 2010.

[25] One client accounted for the 59 mechanical restraint events.

restraint,[26] 35 environmental restraint,[27] and 59 mechanical restraint (enabler).[28]

It is encouraging to note a 21 percent reduction in the use of personal restraint on the Unit from the time of my 2018 report.

Enabler

In my 2018 report I discussed the use of an enabler belt for Client B. The enabler was introduced as a means of managing the risk of assault to other clients and staff in the Unit. The enabler also allowed Client B to safely participate in activities and enjoy face-to-face contact with others.

The enabler remained in use for Client B at the time of inspection. The enabler, a leather belt, was applied and secured through the back of a chair, to the wall, by Client B. Client B was able to remove the enabler by unfastening the carabiner at the front (which took approximately three minutes). The enabler allowed Client B some movement while reducing the risk of assaults to staff and visitors.

Restraint training for staff

Eleven of 34 Unit staff were either overdue or due to update their Safe Practice Effective Communication (SPEC) training at the time of inspection. Inspectors were told that the reason for some staff being out-of-date was the result of COVID-19 affecting the provision of training, specifically during the higher alert levels.

Eight of the eleven staff were booked to attend their training in the coming months.

While I understand the COVID-19 pandemic has caused disruption to the Unit it is my expectation that all staff involved with the use of restraints are up to date with SPEC training.

Police assistance

As identified in my 2018 report, Police assistance is occasionally required to assist with clients who are exhibiting violent or threatening behaviour.

Inspectors requested and were provided with the Memorandum of Understanding (MOU) between the New Zealand Police (Wellington District) and the Mental Health, Addictions and

[26] 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

[27] Environmental restraint is where a service provider(s) intentionally restricts a service users' normal access to their environment, for example where a service users' normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

[28] '*Enablers are equipment, devices or furniture voluntarily used by a consumer following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety.*' CCDHB *Restraint minimisation and safe practice* policy. Document no. 1.772. May 2020.

Intellectual Disability Service (dated April 2014). The MOU had not been updated since my previous recommendation of 2018 and was now several years out-of-date.[29] Inspectors were told by senior Unit staff that the Unit intended to develop an individual MOU agreement with the Police. A timeframe was not provided for this.

After the inspection, the DHB stated that "*the Unit was not looking to develop an individual MOU with the Police because the DHB has an overarching MOU*". The DHB noted that it has set up meetings with the local Porirua Police to strengthen familiarity at a leadership level and ensure frontline officers understand the most appropriate ways in which to respond to situations involving their client group.

Electro-convulsive therapy

There were no clients undergoing Electro-convulsive therapy (ECT)[30] at the time of the inspection.

Sensory modulation

The Unit had one Sensory Modulation Room.[31] At the time of the inspection, the room was locked and clients had to locate a staff member to facilitate its use. Inspectors saw that the room was used for storage, and did not see the Sensory Modulation Room used by clients during the inspection.

As mentioned in my 2018 report, there was no information on the Unit about the Sensory Modulation Room or how to access it. Equally, the Unit did not monitor the use of sensory modulation, or track its use against seclusion and restraint events.

This resource could be more effectively utilised as a means of therapeutic intervention for clients and a tool toward seclusion and restraint reduction.

Clients' and whānau views on treatment

Clients' views on their treatment on the Unit were generally positive. A number of clients said they felt they were treated with respect by staff and that they felt safe on the Unit. Whānau spoke of a team of staff that generally provided compassionate and thoughtful care. Inspectors observed respectful, positive, and warm interactions between clients and staff.

Three times a week a Morning Hui was held on the Unit for clients and staff. Inspectors were told by staff the Morning Hui began as a result of COVID-19, as a forum for sharing information

[29] The MOU was intended to be reviewed yearly.

[30] 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.

[31] *'Sensory modulation uses a range of tools to help individuals get the right amount of sensory input. In mental health settings, sensory modulation can be used to assist distressed service users to regain a sense of calm'*. Te Pou o te Whakaaro Nui. *Sensory modulation in inpatient mental health: A summary of the evidence.* Te Pou o Te Whakaaro Nui, Auckland, 2011.

with clients. These meetings were successful and it was agreed they would continue indefinitely.

My Inspectors attended a Morning Hui. There was a high level of client involvement in, and ownership of, the Morning Hui. Clients were supported to take responsibility for chairing the Hui and opening and closing of the meeting with a karakia. Hui meeting minutes indicated a broad range of topics discussed, including arranging a boil up, obtaining Netflix on the Unit, the new menu ordering system, group van rides, queries around Unit routines, the Unit newsletter, regular updates on the client advocate and Kaimanaaki vacancies, the Positive Behaviour Support training, and COVID-19 information sharing. Minutes indicated issues and ideas raised were followed up at later Hui.

Recommendations – treatment

I recommend that:

1. As a matter of urgency, Client A is provided with daily access to fresh air, the ability to exercise, and the ability to have meaningful engagement with others. **This is an amended repeat recommendation.**
2. Seclusion Room One is decommissioned urgently.
3. Seclusion rooms are never used as bedrooms.
4. The use of night safety procedures be recorded, reported and treated as seclusion events.

Haumietiketike comments

The DHB accepted recommendations 1, 2 and 3.

The DHB did not accept or reject recommendation 4.

The DHB's response included the following comment regarding recommendation 4:

> *CCDHB follows current advice as set in our contracts and advice by MOH.*
>
> *CCDHB are not in a position to accept or reject this statement. This issue needs addressing with the MOH*

Ombudsman response:

I acknowledge that Ministry of Health *Night Safety Procedures: Transitional Guideline* suggest that NSPs constitute, at the very least, environmental restraint and should be recorded as such. However, Ministry of Health guidance and the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* define seclusion 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'.[32] Perhaps the key element of this definition that distinguishes it from environmental restraint is the deprivation of company.[33]

The practise of locking clients in their bedrooms overnight, alone, and without the ability to freely exit, by definition constitutes seclusion. I consider that it should be recorded as such.

[32] New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[33] Mental Health (Compulsory Assessment and Treatment) Act 1992, section 71.

Protective measures

Complaints process

A copy of the DHB's *Consumer Complaints, Advocacy and Code of Rights* Policy (the Complaints Policy) (dated November 2016) was provided to Inspectors. The policy had a review period of three years and was out-of-date at the time of the inspection.

On the first day of inspection, my Inspectors noted the complaints process was not advertised on the Unit. When my Inspectors brought this to the attention of senior staff it was remedied the same day. However, the information was not in an accessible form for clients living with an intellectual disability. Complaint forms, however, were in Easy Read format.

To make a written complaint, clients needed to ask staff for a form and hand the completed form back to staff, to be placed in a box in the staff-only reception area. Clients should be able to make a complaint without staff involvement.

Despite the lack of a well-advertised complaint process, clients who spoke with my Inspectors said they knew how to make a complaint and had done so when required.

The Unit's records showed that there had been four complaints between 1 January and 30 June 2020. Inspectors reviewed all complaints and responses and found that the responses were courteous in tone, individualised, and addressed the issues raised in detail.

Review of all complaints received was a standing agenda item on the Intellectual Disability Service Clinical Governance Group meeting.

District Inspector (DI) contact details were visible on the Unit, and clients were able to tell Inspectors where this information was located. However information on the role and functions of the DI was not displayed.

The Health and Disability Commissioner's '*Code of Health and Disability Services Consumers Rights*' was displayed throughout the Unit, although, as noted in 2018, not in Easy Read format.

Records

Of the eight clients on the Unit on the first day of the inspection, two clients were detained under the MHA, two clients were detained under the IDCCR Act, and the remaining four clients were detained under the Criminal Procedure (Mentally Impaired Person) Act 2003 (CPMIP Act). All eight files had the necessary paperwork for clients to be detained and treated on the Unit.

I recommended in 2018 that clients receive a copy of their care plan. However, review of client files showed the majority of care plans did not record whether clients had received a copy of their plans. My Inspectors reviewed a selection of clients' clinical notes and inpatient care plans. Clinical notes were thorough and up-to-date. However, documentation routinely had no client signatures, nor was it documented whether a client had accepted or declined a copy of their plan.

There was evidence of communication with whānau in treatment plans and clinical documentation, however this was inconsistent. There was no record of discussion with whānau in the development of more complex treatment plans.

Care plans were generally thorough, individualised, and up-to-date. However, staff had difficulty directing Inspectors to where the plans were located.

The DHB stated that their " *Model of Care is an overarching clinical framework that incorporates the Good Lives model of offender rehabilitation, a comprehensive risk assessment structure, Positive Behaviour Support approaches to direct care, and a formal staff supervision and education programme*". The *Good Lives* model[34] looks at a client's internal and external strengths and obstacles in order to determine what primary needs are required for a good life. Treatment plans were formulated following interviews with the client, their whānau, and members of their care team, which fed in to the planning and review processes. Inspectors reviewed examples of the resulting formulations and found they were considered and individualised to the client.

Recommendations – protective measures

I recommend that:

5. Complaint forms are available to clients at all times and the complaint process allows clients to make a complaint independent of staff.
6. Copies of the Code of Health and Disability Commissioner's *Code of Health and Disability Services Consumers' Rights* in Easy Read format should be available throughout the Unit. **This is a repeat recommendation.**
7. Clients should receive an up-to-date copy of their care plan. **This is a repeat recommendation.**

Haumietiketike comments

The DHB accepted recommendations 5, 6 and 7.

[34] https://www.goodlivesmodel.com/

Material conditions

Accommodation and sanitary conditions

The Unit, which opened in 2004, was generally clean and tidy. Some maintenance issues were apparent and the Unit appeared dated in areas. However, damage to the Unit was not evident, in contrast to my finding in 2018 where there were a number of repair works outstanding.

The Unit compromised three separate 'clusters'. Each cluster had capacity for between three and four clients. Each cluster contained a TV and sofas, and natural light through a sky light. One cluster had been repurposed, and separated in two. One half, comprising two bedrooms, was dedicated for use by the two female clients living on the Unit. The other half of the cluster was the nearly completed, purpose built space for Client A.

Bedrooms were spacious, with adequate storage, natural light and a means of contacting staff via a call bell. Clients had unique swipe cards allowing independent access to their bedrooms. Bedroom spaces were personalised.

The Unit had two large communal areas. One was a lounge space which had a cross-trainer machine and a table tennis table available for client use, and access to the courtyard. The other communal area contained the TV lounge.

Figure 4: TV lounge

Figure 5: Dining room

Food

Clients were able to choose their own meals from the neighbouring Kenepuru Hospital menu. The menu catered to a range of dietary requirements and preferences. Breakfast was self-serve with staff supervision. Lunch was delivered from around 12pm, and dinner around 5pm.

Once a week, clients had a takeaway meal on a night of their choosing. Most clients would have leave off the Unit, with staff, to buy their takeaways. A number of clients told my Inspectors they enjoyed this outing.

There was one communal dining area where clients could have their meals. The adjoining kitchen was locked and clients were unable to access the kitchen without staff accompanying them. As a result, clients were unable to access drinking water, snacks, or hot drinks independent of staff. Inspectors were told this was because staff needed to monitor clients' water intake, and hot water or kitchen equipment could be used as a weapon.

The blanket restriction on access to the kitchen adversely impacted on clients' ability to access drinking water, hot drinks and refreshments. At a minimum, clients should have access to drinking water without relying on staff.

I acknowledge the view that there is a safety rationale behind the restriction on access to hot water. However, the current process disadvantaged all clients as it applied to everyone irrespective of safety risk. Access to hot drinks should be facilitated based on individual risk and subject to regular review. My Inspectors noted that clients attending programmes at Te Maara (discussed below) were able to make themselves hot drinks without staff assistance, but could not do so when they returned to the Unit.

I consider it unacceptable that clients on the Unit require staff assistance to access drinking water which, is a basic human necessity.

Recommendations – material conditions

I recommend that:

8. Clients have, at a minimum, independent access to drinking water. **This is an amended repeat recommendation.**

Haumietiketike comments

The DHB accepted recommendation 8.

Activities and programmes

Outdoor exercise and leisure activities

All clients had leave from the Unit, with the exception of Client A. Inspectors observed clients using leave off the Unit throughout the inspection.

Client leave from the Unit took a number of forms. Clients were given leave to attend programmes, visit whānau, attend sporting events, and go shopping. During the inspection, a client attended a transition visit, out of region and facilitated by staff, to assist with the settling-in process at their new accommodation.

Access to the courtyard was made by request to staff. Clients who spoke with Inspectors said that the courtyard was opened when they asked, except at night time. In 2018 I recommended that all clients needed to be offered daily access to fresh air and that this should be documented, including when clients declined. Inspectors' review of the clinical documentation did not show that clients were consistently offered access to fresh air.

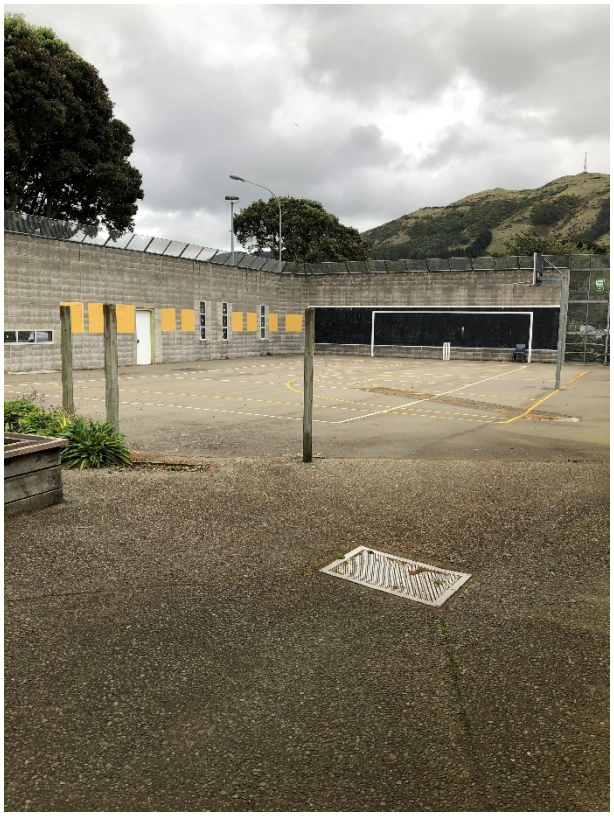

Figure 6: Courtyard

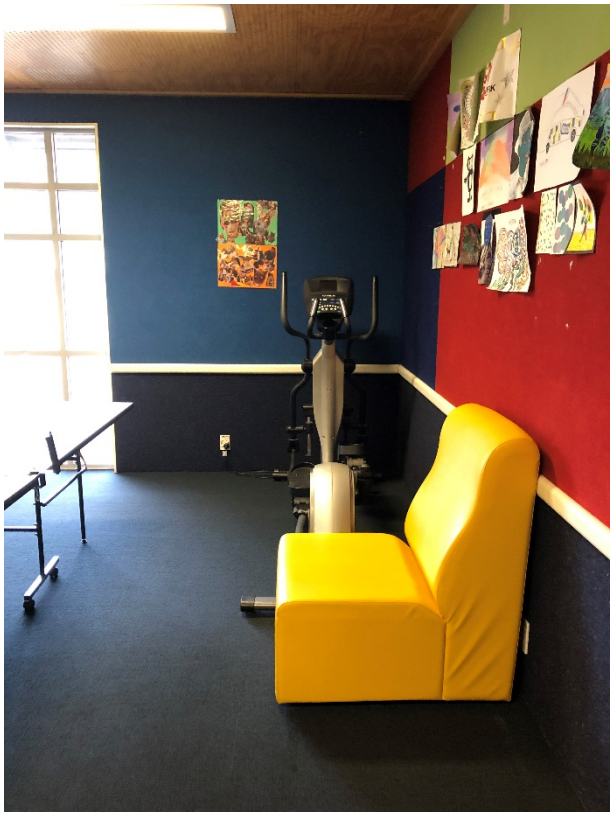

Figure 7: Common room – cross trainer in background

The Unit had an activities room, which remained locked throughout the inspection. Inspectors did not see the activities room in use, except on one occasion when a client was asleep on a chair next to a staff member.

Inspectors reviewed clients' activity schedules. These schedules showed a number of activities occurring off the Unit. However, activities on the Unit were limited, as identified in 2018. Clients mostly watched TV. Inspectors were told the Unit was in the process of recruiting for an Occupational Assistant. The role was to cover early evenings and weekends to support clients to utilise the art room and activities on the Unit. I look forward to hearing of an appointment to this role.

Te Maara is the Service's external centre for activities and programmes. Te Maara was located a short walk from the Unit. The centre had two classrooms, two tunnel houses, vegetable gardens and a lawn area. Stepping Stones, Life Skills, Art Group and recreational programmes were offered at Te Maara, in addition to horticulture and music.

Programmes

At the time of the inspection, the Unit employed two full time equivalent (FTE) and three part-time Clinical Psychologists. Each client had a psychologist allocated to their care and attended either individual psychology sessions or group programmes.

The Stepping Stones[35] therapeutic programme was well established in the Service. Clients engaged in the Stepping Stones programme completed a series of modules targeting emotion regulation, distress tolerance, relationships, problem solving and skills for living in the community. Clients attend one two-hour session per week at Te Maara. The Stepping Stones Chain Analysis and Coping Skills Toolkit provided Service-wide structures for the review of incidents and the development of emotion regulation skills. Staff were trained to deliver the programme to clients and provided daily support in implementing and reinforcing the new skills learnt. The programme was overseen by a psychologist.

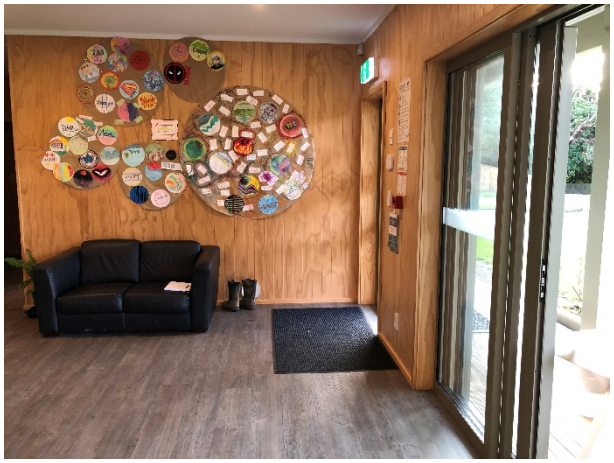

Figure 8: Te Maara

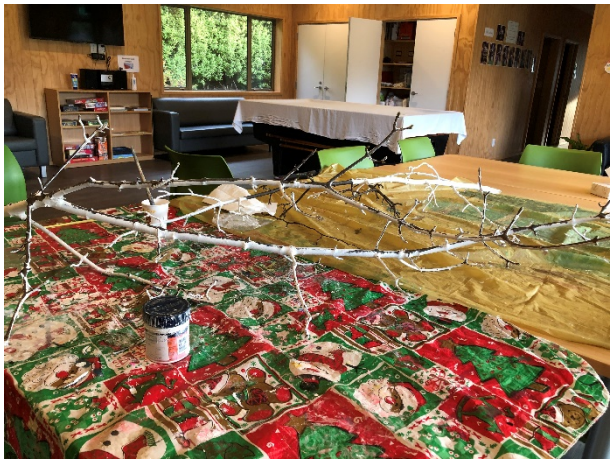

Figure 9: Activity in Te Maara

[35] Stepping Stones is a comprehensive emotion regulation, communication and social skills group therapy programme designed for offenders with an intellectual disability. See www.tepou.co.nz/news/stepping-stones-programme-teches-emotion-regulation-to-intellectually-disabled-adults/258

Cultural and spiritual support

The Service employed two Spiritual Pastoral Therapists, who worked across the Service, and the Hospital Chaplaincy Team was also available to clients, which could be requested through staff. Staff told Inspectors that one client received regular visits from a hospital chaplain.

Ruamoko, a Māori cultural centre, provided assessment, treatment, programmes and support to tāngata whai ora. Vaka o le Pasifika, a Pasifika facility, similarly provided cultural support to tagata pasifika. The Ruamoko programme supported Māori clients in strengthening their cultural identity to support their recovery and well-being. The Ruamoko programme had recently recommenced after closing as a result of COVID-19 alert level restrictions.

The Unit's Kaimanaaki role had been vacant for five months prior to my inspection. Inspectors saw evidence that showed the Unit had been active in attempting to fill the role. At the time of inspection the Unit was commencing a new round of advertising.

There was limited evidence that the two clients on the Unit, who identified as Māori, had access to cultural support.

Recommendations – activities and programmes

I recommend that:

9. All clients need to be offered daily access to fresh air. This should be documented, including when they decline. **This is a repeat recommendation.**
10. Clients are provided more opportunities to engage in activities on the Unit. **This is an amended repeat recommendation**.
11. Clients are provided more opportunities to engage with cultural and religious services. **This is an amended repeat recommendation.**

Haumietiketike comments

The DHB accepted recommendations 9, 10 and 11.

Communications

Access to visitors

Visits to the Unit could take place seven days per week, and more than once per day. Bookings and pre-approval were required through the clients' care team. Children were welcome to visit, subject to individual risk assessment. Inspectors saw children visiting at the time of the inspection.

Visits were supervised by Unit staff, however privacy was provided. Inspectors saw a visit taking place with a staff member situated outside the room, with line of sight maintained.

Visits were held in the Unit's dedicated visits room. The adjacent whānau room was available for use if needed. Both rooms were located at the entry to the Unit. The visits room was welcoming with facilities for making hot drinks and a microwave provided. The visits room had access to an outdoor space and toilet facilities.

There was a flexible approach to allowing Client A and Client B to receive visitors, despite their living arrangements.

Clients did not raise any concerns with Inspectors about their access to visitors.

Access to external communication

The Unit had one operational phone booth at the time of inspection, which provided privacy for clients when making phone calls.

Clients could not access the phone without staff. Cell phones were not permitted on the Unit. In my 2018 report, I recommended clients should be able to make a complaint using a telephone without having to rely on a staff member dialling and connecting them. At the time of this inspection, clients were still required to ask staff permission for a phone call, including to the DI's. If the call was approved, staff would connect the number and transfer the call to the clients' phone booth.

All clients had an individualised phone plan and phone logs were maintained. Throughout the inspection, Inspectors saw clients making calls. One client told Inspectors their 15 minute allocated phone calls were *'not long enough'* but stated that there were no problems receiving calls in to the Unit.

Client A, despite being subject to a number of restrictions, was supported by the Unit to utilise a variety of tools to communicate with whānau and the outside world. An iPad was provided for emailing, online grocery shopping, and phone and video calls.

Clients did not raise any concerns with Inspectors about their ability to send and receive mail.

Recommendations – communications

I recommend that:

12. Clients are able to make a complaint, and contact the DIs using a telephone, independent of staff. **This is an amended repeat recommendation.**

Haumietiketike comments

The DHB rejected recommendation 12.

The DHB's response included the following comment regarding recommendation 12:

> This was addressed in the last report where this recommendation was made.

Ombudsman response:

For completeness, the response to my previous recommendation was as follows:[36]

> *It is acknowledged that there is a tension in secure ID services between providing direct access to a phone and ensuring that phone use happens in a safe and appropriate way. A number of our clients are not able to make phone calls themselves, or dial numbers they did not mean to dial, are not supposed to dial or are prohibited from dialling. Some clients may use the phone constantly and in an inappropriate manner.*
>
> *For these reasons, in order to access a phone, a client is required to make a request to do so. We note that access is only denied if clients try ringing people who they are prohibited from contacting, or if the intended contact is otherwise inappropriate. Clients are supported in exercising their rights to make telephone calls at reasonable times and reasonable intervals. Further, once the call has been connected to the intended recipient, the client is left to conduct the conversation in private.*

In my opinion, the recommendation has not been addressed.

I acknowledge that there are concerns around privacy and safety which must be considered in relation to how clients access the telephone. I acknowledge also that it will not appropriate for every client to have unsupervised or unrestricted access to a telephone.

However, the Unit was applying a blanket approach which disadvantaged all clients regardless of their individual circumstances. In my opinion, any restriction on independent access to the telephone should be based on an individual risk assessment. I therefore remain of the view that there should be practical ways of mitigating the issues identified by the DHB while also ensuring independent access to the telephone.

[36] *Report on an unannounced visit to Haumietiketike Unit under the Crimes of Torture Act 1989.* April 2018.

Health care

Primary health care services

The quality of physical health assessment and monitoring was robust and thorough.

Clients routinely received a physical assessment on admission to the Unit. This included obtaining a medical history, taking routine blood tests, and addressing any physical concerns.

Review of clinical notes demonstrated good access for clients to medical assessment and treatment in circumstances when a deterioration or concern was identified.

Clients did not raise any concerns with Inspectors regarding access to primary health care.

There were nine documented medication errors between 1 January and 30 June 2020. My Inspectors reviewed each reportable event form relating to the errors. Eight errors were administration errors, for example: the wrong dose, the wrong client, the wrong route, or the wrong medication.

The Health and Disability Commissioner has identified that *'when medication errors do occur they have the potential to cause significant harm'*.[37]

I am concerned by the number of medication errors occurring on the Unit, specifically at the point of administration.

Recommendations – health care

I recommend that:

13. The reasons for the number of medication errors at the point of administration are analysed and, where necessary, appropriate remedial action be implemented.

Haumietiketike comments

The DHB accepted recommendation 13.

[37] The Health and Disability Commissioner. 2018.

Staff

Staffing levels and staff retention

Data provided by the Unit showed a multi-disciplinary staff complement (excluding medical staff) of 15 Registered Nurses (RNs), 24 Mental Health Support Workers (MHSWs), one Enrolled Nurse, a 0.5 FTE Social Worker, a Clinical Nurse Specialist, Associate Charge Nurse Manager, and a Team Leader.

The Unit had vacancies for 10 RNs and two MHSWs, according to information provided to Inspectors.

Nursing staff worked a three-shift roster, with a designated staffing level on each shift. The morning shift ran from 7am to 4.05pm with nine staff,[38] afternoon shift from 2.30pm to 11.05pm also with nine staff, and the night shift from 10.45pm to 7.20am with one RN and three MHSWs.

Data showed that between 2017/18 and 2018/19, RN turnover decreased from 20 percent to 11 percent. However, between 2018/19 and 2019/20 this increased to 25 percent. Further, the turnover rate for MHSWs on the Unit increased from seven percent to 20 percent between 2017/18 and 2019/20.

Data provided by the Service indicated that between 2017/18 and 2019/20, staff sickness levels remained relatively stable between 5 and 4 percent.

The use of overtime on the Unit was high. Staff said they often worked extensions to cover gaps in staffing, and this was observed during the inspection. On one day of the inspection five staff were working extended shifts as a result of shortfalls in the roster.

The majority of staff had worked on the Unit for over five years. Three RNs had joined the Service within the last year.[39]

Staff were generally complimentary of the leadership and management of the Unit. Staff spoke positively about the support from the Unit leadership team enabling staff to attend supervision. Access to supervision was also extended to the MHSW team. Inspectors were told supervision continued to be provided to Unit staff during the COVID-19 Alert Level 4. Supervision at the time of Alert Level 4 was facilitated through Skype, Zoom meetings and phone calls.

A form of group supervision called '*Coffee, Cake, Chat*' was introduced in 2013 and ran on a fortnightly basis. The group supervision was facilitated by the Service's two Consultant Clinical Psychologists. There was an open invitation to Unit staff to attend the group session if they

[38] The nine staff rostered on to the shift were a mixture of RNs, ENS and MHSWs. At the time of the inspection one client was being nursed on a two-to-one watch.

[39] 10 RNs and 13 MHSWs had worked on the Unit for over five years, three RNs and nine MHSWs had worked on the Unit between one and five years.

wished to do so. Several staff told Inspectors they appreciated the support from the Unit leadership team to attend.

In 2018, I recommended enhancement of staff training to develop knowledge and skills for dealing with high and complex needs. At the time of this inspection the Unit and the forensic ID service was a Dedicated Education Unit (DEU). Fortnightly in-service teaching sessions were offered to staff.

The orientation package provided to new staff and student nurses was comprehensive and user friendly. Inspectors were told it was a challenge releasing staff from the floor to attend training. Training was timed to coincide with nursing shift handovers with the hope of increasing staff attendance.

Alongside the mandatory core competencies, all staff in the forensic ID Service were receiving formal training in Positive Behaviour Support (PBS), facilitated by experts from Explore.[40] . At the time of inspection, the Service also had trained nine nurses and support workers as advanced PBS Coaches. The training was provided across all disciplines and was funded externally by Te Pou o te Whakaaro Nui.[41]

Recommendations – staff

I recommend that:

14. The Unit regularly monitor and analyse the reasons for staff turnover and take action to address any concerning trends.

Haumietiketike comments

The DHB accepted recommendation 14.

[40] Explore is a specialist provider contracted by the Ministry of Health to deliver disability support services.

[41] Te Pou o te Whakaaro Nui is a national centre of evidence based work force development for the mental health, addiction and disability sectors.

Acknowledgements

I appreciate the full co-operation extended by the Team Leader 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

Appendix 1. List of people who spoke with Inspectors

Table 2: List of people who spoke with Inspectors

Managers	Unit staff	Others
Service Manager	Team Leader Registered Nurses Clinical Director Occupational Therapists Social Worker Mental Health Support Workers House Officer	Clients Whānau District Inspector Cultural Advisor Family Advisor Chaplains

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…"*

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.