Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced inspection of He Puna Wāiora Mental Health Inpatient Unit, North Shore Hospital, under the Crimes of Torture Act 1989

August 2020

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Tari o te Kaitiaki Mana Tangata

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Background

In 2007, the Ombudsmen were designated 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 November 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 He Puna Wāiora Mental Health Inpatient Unit (the Unit), which is located in the grounds of North Shore Hospital Campus, Auckland.

Summary of findings

My findings are:

- There was no evidence that service users had been subject to torture or other cruel, inhuman or degrading treatment or punishment.
- The Unit had a robust process for recording who has been offered use of sensory modulation,[3] and what service users' sensory preferences were.
- Service user and whānau views on the Unit were generally positive.
- Up-to-date contact details for District Inspectors (DIs) were visible in each of the wards and the DIs had an active presence on the Unit.
- Files contained all the necessary paperwork to detain and treat service users on the Unit.
- Consent to treatment forms were available for most, but not all, service users subject to a compulsory treatment order.
- Court sittings are regularly scheduled and service users' have access to legal representation.
- The Unit was generally clean, tidy and well maintained.

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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 website, https://www.mentalhealth.org.nz/home/glossary/

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

3 '*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 (2011). Sensory modulation in inpatient mental health: A summary of the evidence. Auckland. Te Pou o Te Whakaaro Nui.

- Service users had free access to the courtyards and fresh air throughout the day.
- Service users had their own bedrooms and a unique electronic bracelet to unlock the door to their room.
- The Unit offered activities and programmes during the week, after hours and in the weekend.
- The Unit had relationships with a range of cultural services and employed a Cultural Advisor on the Unit.
- Inspectors observed whānau visiting service users regularly and noted that staff treated whānau with respect.
- Service users' had access to primary health care services.

The issues that needed addressing are:

- 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.
- There was an unpleasant musty odour in the seclusion room, reportedly due to problems with the pipes.
- Seclusion paperwork had inconsistent levels of detail and was often incomplete.
- The District Health Board's (DHB) *Door Locking: Egress of Adult Inpatient Unit Doors Policy* was out-of-date and needed to be updated to accurately reflect the status of voluntary service users.[4]
- Leave restrictions and the lack of information detailing the process for entry and exit into the Unit had the potential to arbitrarily detain voluntary service users.
- There was no information about the complaints process on display on the Unit, including on the role of the DIs.
- Service users were not invited to their Multi-Disciplinary Team (MDT) meetings and did not regularly receive feedback on the outcomes of these meetings.
- The courtyards in the High Care Areas required cleaning due to birds roosting in the area.
- The removal of the en-suite doors had a significant impact on service users' privacy and dignity.

[4] 'Voluntary' means that the service user has agreed to have treatment and has the right to suspend that treatment. If the service user is being treated in hospital, they have the right to leave at any time.

- There was more demand for cultural competency, support, guidance and facilities than the Unit currently provided.
- Tāngata whai ora[5] were transferred to other facilities at short notice and without involvement of cultural support.
- If service users did not have a cell phone, they were dependent on staff to provide access to a portable phone.
- Staff morale on the Unit was extremely low and there had been very high turnover over the past three years (the period for which information regarding staff turnover was requested).

[5] People with experience of mental illness, who are seeking wellness, or recovery of self. Usually used in reference to Māori service users. See Mental Health Foundation website, https://www.mentalhealth.org.nz/home/glossary/

Recommendations

I recommend that:

1. Measures are taken to ensure that service users in seclusion cannot be viewed when urinating or defecating.
2. The toilet in the de-escalation area be accessible by service users in seclusion, unless this would pose a serious risk of harm to the service user or staff. If an individual service user is not allowed to access the toilet, the reasons are recorded and reviewed.
3. Measures are taken to eliminate the unpleasant musty odour in the seclusion area.
4. All seclusion paperwork is fully and accurately completed.
5. The *Door Locking: Egress of Adult Inpatient Unit Doors Policy* be reviewed, and updated to accurately reflect the status of voluntary service users.
6. The Unit address the risk of arbitrarily detaining voluntary service users by prominently displaying the process for entry and exit into the Unit, including in the Unit entrance. **This is an amended repeat recommendation.**
7. Information on the complaints process should be easily visible and accessible to all service users, including information on the role of the District Inspectors. **This is an amended repeat recommendation.**
8. Service users be invited to attend their Multi-Disciplinary Team meeting, wherever possible, and routinely informed of the outcome of their review. **This is an amended repeat recommendation.**
9. The High Care Area courtyards are cleaned regularly.
10. The replacement of en-suite doors with 'stable doors', or a suitable safe alternative, takes place as a matter of priority to ensure service users' privacy.
11. The level of cultural support on the Unit be increased and appropriate spaces are designated to welcome tāngata whai ora and staff with a pōwhiri or mihi whakatau.
12. The garage is not used as an entrance to the Unit unless other options are deemed unsafe based on individual risk assessment.
13. Cultural advice informs decisions on transferring or discharging tāngata whai ora.
14. Service users have access to a telephone, independent of staff, unless deemed unsafe based on individual risk assessment.
15. The Unit takes action to rebuild staff morale and address the high turnover rate.

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.

Consultation

A provisional report was forwarded to the DHB for comment as to fact, finding or omission prior to finalisation and distribution.

Facility Facts

He Puna Wāiora Mental Health Inpatient Unit

He Puna Wāiora Mental Health Inpatient Unit (the Unit) is a 35 bed acute adult inpatient unit, providing assessment, treatment and stabilisation of service users experiencing acute mental health issues, who are unable to be cared for safely in a community environment.[6]

Service users receive acute mental health services provided by Waitematā District Health Board's (DHB's) Adult Mental Health Services (the Service).

The Unit is a locked facility with separate areas for male and female service users. The Unit consists of two wards, Rongoa and Rerewai; each with 13 beds. Each wing includes a High Care Area (HCA) (male and female) with nine beds in total. The Unit is located in the grounds of North Shore Hospital Campus, Auckland.

Admission to the Unit is by referral from the Emergency Care Centre or a Community Mental Health Team.[7] Service users can be admitted to the Unit either as a voluntary service user or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

Region

North Shore, Rodney and Waitakere

District Health Board

Waitematā District Health Board

Operating capacity

35 (plus one seclusion room)

Last inspection

Unannounced inspection – February 2016

6 www.healthpoint.co.nz

7 Adult Mental Health Services, Waitematā District Health Board. *Adult Mental Health Services information pamphlet.*

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 35 service users on the Unit, comprising 14 females and 21 males. Another service user was on leave from the Unit. The average length of stay for the preceding six months was approximately 19.5 days.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (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;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events;
- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);[8]
- service user absent without leave (AWOL) events from 1 May to 31 October 2019;
- details of all sentinel events[9] 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;
- copy of minutes of consumer and service user group meetings for the previous three months;
- activities programme;
- information provided to service users and their whānau on admission;
- incident reports relating to medication errors from 1 May to 31 October 2019;
- staff sickness and retention data for the previous three years;

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

[9] Sentinel events are unanticipated events in the healthcare setting which have resulted in serious harm to service users.

- staff vacancies at time of inspection (role and number); and
- data on staff, categorised by profession.

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.[10]

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Seclusion
- Seclusion policies and events
- Restraint
- Restraint training for staff
- Environmental restraint of voluntary service users
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Service users' and whānau views on treatment

Protective measures

- Complaints process
- Records
- Review of sentinel events

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

- Outdoor exercise and leisure activities

[10] 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.

- Programmes
- Cultural and spiritual support

Communications

- Access to visitors
- 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.[11]

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

Recommendations from previous report

The Inspectors followed up on ten recommendations, following an inspection of the Unit in 2016,[12] which were:

a. The seclusion register should be fully maintained and a quality assurance framework applied to the completion of all seclusion documentation (including electronic records).

b. The restraint register should be fully maintained and a quality assurance framework applied to the completion of all restraint documentation (including electronic records).

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

d. Notices detailing the process for entry and exit into the Unit for informal (voluntary) service users (and visitors) should be displayed in prominent areas, including the Unit entrance.

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

[12] *Office of the Ombudsman report on an unannounced visit to He Puna Wāiora Mental Health Inpatient Unit under the Crimes of Torture Act 1989*, February 2016.

e. Information on the DHB's complaints process should be easily accessible to all service users. The contact details of District Inspectors should be verified and updated on a regular basis.

f. Service users should be invited to attend their MDT meeting and routinely provided with a copy of the minutes of their review.

g. The DHB should consider adopting a zero-tolerance approach on violence (to service users, staff and visitors) by automatically referring assaults and other serious incidents to the Police. This could be incorporated into the current serious and sentinel events policy.

h. In order to protect service users' dignity staff need to be more vigilant with regard to ensuring service users are appropriately clothed.

i. Service users need to be offered at least one hour fresh air daily.

j. Service users should be offered privacy when accessing the telephone(s).

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

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.

Seclusion

Seclusion facilities

The Unit had one dedicated seclusion[13] room and small de-escalation area which adjoined the female HCA.

The seclusion room was basic, with a bed base and a mattress. The seclusion room also had an alarm. A window set up high in the wall provided the only natural light and there was no access to fresh air.

There was a separate toilet and shower facility in the de-escalation area. The seclusion room however had no such facilities.

Service users in seclusion were provided with a cardboard receptacle in which to urinate or defecate. Cups of drinking water were placed in the seclusion room in the corner opposite the receptacle.

Inspectors noted that service users urinating or defecating in a cardboard receptacle would be visible from the seclusion door window and the observation room. While observation of service users in seclusion is responsible, the observation of service users urinating or defecating can and should be avoided.

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

There was also a strong musty, stale odour in the seclusion area on the first day of the inspection. The odour was worse on the final day of the inspection. Staff informed my Inspectors that the smell was due to longstanding issues with the pipes. Inspectors noted that the odour would be extremely unpleasant for service users in seclusion.

I therefore consider that the seclusion area was not fit for purpose at the time of the inspection and that action is required to address the odour.

[13] 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.

One service user was secluded during the inspection. The seclusion event was brief and took place overnight. My Inspectors were therefore unable to observe the conditions and treatment of the service user while in seclusion.

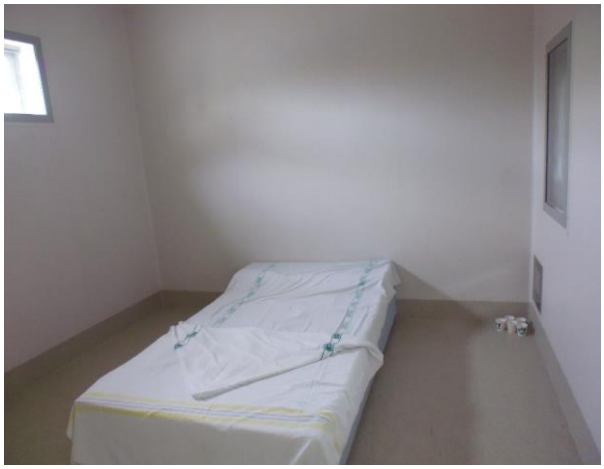

Figure 1: Seclusion room in He Puna Wāiora

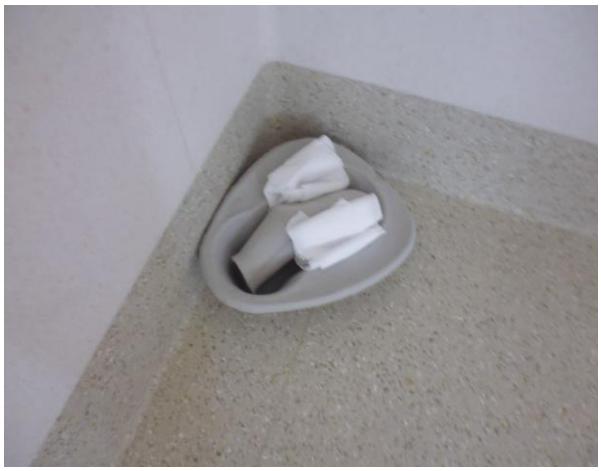

Figure 2: Receptacle for ablutions in seclusion

Seclusion policies and events

The Unit provided Inspectors with its *Seclusion Procedures and Guidelines – Speciality Mental Health & Addictions* (dated May 2018). The procedure had a review period of 36 months.

Unit staff told Inspectors they were unable to provide access to the seclusion register during the inspection, because the responsible staff member was on leave. However, Inspectors were able to review documentation of individual seclusion events for service users on the Unit. The Unit provided Inspectors with data from the seclusion register following the inspection.

Seclusion paperwork viewed by Inspectors appeared to have accurate seclusion time registered, but had inconsistent levels of detail and was often incomplete. Seclusion review panel minutes viewed by Inspectors also highlighted problems with incomplete seclusion documentation.

I highlighted concerns about the completion of all seclusion documentation (including electronic records) following my previous inspection in 2016. I consider that further work to ensure the accuracy and completeness of seclusion paperwork is required.

Data provided by the Unit indicated that between 1 May and 31 October 2019 there were 16 seclusion events involving 12 service users. This is broken down as follows:

Table 1: Seclusion events 1 May – 31 October 2019[14]

Month	Events	Service user numbers	Time	Average time
May	1	1	4 minutes	4 minutes
June	5	5	4,020 minutes (67 hours)	804 minutes (13 hours and 24 minutes)
July	1	1	1,400 minutes (23 hours and 20 minutes)	1,400 minutes (23 hours and 20 minutes)
August	5	3	2,230 minutes (37 hours and 10 minutes)	446 minutes (7 hours and 26 minutes)
September	2	2	1,230 minutes (20 hours and 30 minutes)	615 minutes (10 hours and 15 minutes)
October	2	2	505 minutes (8 hours and 25 minutes)	252 minutes (4 hours and 12 minutes)
Total:	**16**	**12**	9,389 minutes (156 hours and 29 minutes)	587 minutes (9 hours and 47 minutes)

In 2016, Inspectors were unable to accurately determine the total seclusion events and time because information provided to them was incomplete and inaccurate. I am, therefore, unable to determine whether the use of seclusion on the Unit has reduced since 2016.

Restraint

The Unit provided Inspectors with its *Restraint Minimisation – Adult and Auckland Regional Forensic Mental Health Services* document (dated May 2018). The procedure had a review period of 36 months.

Data supplied by the Unit showed that between 1 May and 31 October 2019 there were 45 episodes of restraint. This is broken down as follows:

[14] Data as provided by the Unit.

Table 2: Restraint data (exclusive of seclusion data) 1 May – 31 October 2019[15]

	May	June	July	August	September	October
Total restraint episodes	3	5	8	6	10	13
Total service users restrained	3	5	7	5	8	9
Personal restraint[16]	3	5	8	6	10	13
Number of males restrained	1	5	2	4	6	5
Number of females restrained	2	0	5	1	2	4
Number of Māori restrained	0	1	1	0	1	0
Number of non-Māori restrained	3	4	7	6	9	13
Youngest person restrained (years)	27	18	27	18	28	27
Oldest person restrained (years)	62	40	69	35	56	74

As with seclusion, Inspectors in 2016 were unable to accurately determine the levels of restraint because information provided to them was incomplete and inaccurate. I am, therefore, unable to determine whether the use of restraint has reduced since 2016.

[15] Data as provided by the Unit.

[16] 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.

Environmental restraint of voluntary service users

Inspectors were provided with a copy of the DHB's *Door Locking: Egress of Adult Inpatient Unit Doors Policy* (the Door Locking Policy) (dated August 2015). The procedure had a review period of 24 months and was out-of-date at the time of the inspection.

The Door Locking Policy stated that, as part of voluntary service users' treatment, an agreed leave process may be utilised. Inspectors reviewed clinical notes and found that, despite the policy, leave restrictions were in place for all voluntary service users.

The Door Locking Policy also included several caveats on voluntary service users' right to leave the Unit. For example, voluntary service users had a right to leave the unit *'unless specified as part of their treatment* plan'.

There was no information detailing the process for entry and exit into the Unit for voluntary service users or visitors. The information provided to service users on induction also did not explicitly state that voluntary service users had the right to leave when they wish to. [17] The induction information did cover the process for leaving the unit for those allowed to do so.

In my previous report, I considered that the lack of information detailing the process for entry and exit into the Unit had the potential to arbitrarily detain voluntary service users.[18] The Unit accepted my recommendation to display notices with this information in prominent areas.

I am concerned that the risk of arbitrarily detaining voluntary service users', as identified in 2016, had not been addressed at the time of the inspection. The right not to be arbitrarily detained is to protect human dignity, autonomy and liberty.[19] I expect these values to be upheld.

Restraint training for staff

Information provided by the Unit showed that all Unit staff (other than five recent recruits) had received Safe Practice Effective Communication (SPEC) training, which provides strategies to reduce the use of restraint.[20] All recent starters had been booked onto SPEC training which was due to take place soon after the inspection.

Unit staff were expected to attend a one-day refresher SPEC training every 12 months. Several training sessions had been cancelled meaning that 12 staff members' annual refresher training had been postponed. All staff affected had been rebooked for refresher training in 2020. I

[17] Waitematā District Health Board, *Welcome Book – He Puna Waiora – What you need to know*.

[18] Office of the Ombudsman, *Report on an unannounced visit to He Puna Waiora Acute Adult Inpatient Mental Health Unit under the Crimes of Torture Act 1989*, February 2016

[19] *R v Briggs* [2009] NZCA 244 at [85] per Arnold J.

[20] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques.

encourage the Unit leadership team to prioritise the SPEC refresher training to support the reduction of restraint incidents.

Electro-convulsive therapy

There were no service users undergoing electro-convulsive therapy (ECT)[21] on the Unit at the time of the inspection.

Sensory modulation

The Unit had a robust process for recording who had been offered use of sensory modulation, and what service users' sensory preferences were. Inspectors were also pleased to note that service users were given a sensory pack on admission to the Unit.

The Unit had a total of four Sensory Modulation Rooms. The Sensory Modulation Rooms were locked and service users had to locate staff to facilitate and supervise their access to the rooms. Furnishings in the Sensory Modulation Rooms were showing signs of wear and tear, particularly the massage chairs.

My Inspectors observed service users using the Sensory Modulation Rooms during the inspection. There was no register for recording actual use of the Sensory Modulation Rooms.

Service users' and whānau views on treatment

Service users' views on their treatment on the Unit were generally positive. Several service users praised staff for their work and conduct, saying that they felt well cared for. Inspectors observed respectful and positive interactions between service users and staff.

Inspectors also reviewed feedback from the weekly 'Mutual Help Meetings'.[22] Service users appeared to be actively involved and meeting minutes indicate a broad range of topics discussed, including spirituality, creation of a suggestions box, and the establishment of new therapeutic groups and activities. The Unit also facilitated monthly forums with the Health and Disability Advocate to discuss service user rights.

However, service users also told Inspectors they were frustrated with aspects of their treatment. Service users' concerns generally focussed on their medication, the restrictive environment, lack of information about the complaint process, and staff availability. Mutual Help Meeting minutes also indicated other concerns included service users' bedrooms being cold at night, and service users wanted more books and magazines available. Staff were aware of these issues during the inspection and the Mutual Help Meeting minutes indicated that the concerns were being followed up by the Unit.

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[21] 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

[22] Service user group meetings.

Inspectors were able to speak to a limited number of whānau about service users' treatment on the Unit. Those whānau were generally positive about the Unit, but raised some issues around the level of communication from the Unit to whānau.

Recommendations – treatment

I recommend that:

1. Measures are taken to ensure that service users in seclusion cannot be viewed when urinating or defecating.
2. The toilet in the de-escalation area be accessible by service users in seclusion, unless this would pose a serious risk of harm to the service user or staff. If an individual service user is not allowed to access the toilet, the reasons are recorded and regularly reviewed.
3. Measures are taken to eliminate the unpleasant musty odour in the seclusion area.
4. All seclusion paperwork is fully and accurately completed.
5. The *Door Locking: Egress of Adult Inpatient Unit Doors Policy* be reviewed, and updated to accurately reflect the status of voluntary service users.
6. The Unit address the risk of arbitrarily detaining voluntary service users by prominently displaying the process for entry and exit into the Unit, including in the Unit entrance. **This is an amended repeat recommendation.**

He Puna Wāiora comments

The DHB accepted recommendations 3, 4, 5 and 6.

The DHB rejected recommendations 1 and 2.

Recommendation 1 response:

> *Seclusion is used as a last resort when there is evidence of imminent risk of danger for the service user. All service users are required to be on constant observations to assist in monitoring the service user's risk and identifying the earliest time at which seclusion can be terminated. This means it is not possible to screen off any area within the seclusion room.*
>
> *He Puna Waiora has low levels of seclusion use and attempts are made to minimise the length of time spent in seclusion and service users are brought out of the room and into the high care area as soon as it is safe to do so.*

Ombudsman response:

I acknowledge that the Unit did not appear to have high levels of seclusion at the time of the inspection. I also agree that service users should be brought out of seclusion as soon as possible. However, I do not consider that these factors justify the observation of service users in seclusion while urinating or defecating, or that the need for constant observation for risk management extends to a routine need to observe service users whilst urinating and defecating.

I have consistently been of the view that the observation of people in detention urinating or defecating constitutes 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 note that the average period of seclusion from 1 May to 31 October 2019 was approximately 10 hours. It is reasonable to assume that, in a 10 hour period (or less), a service user will either need to urinate or defecate, or will force themselves to wait until they are released from seclusion. Either way, I would consider it to constitute degrading treatment. That service users are required to use a cardboard receptacle for urinating or defecating exacerbates the degrading nature of the treatment.

There should be practical ways of undertaking observations without unreasonably compromising the privacy and dignity of service users. My Inspectors have observed several facilities where service users have access to an en-suite, or where other measures are taken to ensure service users' privacy and dignity when secluded. I do not accept that the Unit cannot do the same.

Recommendation 2 response:

> *There is no access to the toilet directly from the seclusion room.*
>
> *If a service user is deemed safe and not posing imminent risk to self or staff they would be transferred to open seclusion which would give them access to the toilet.*
>
> *The seclusion policy requires a service use to be reviewed hourly and a room entry conducted to assess the level of care required.*
>
> *We use a seclusion template to record the hourly reviews and the outcomes. This is within the HCC notes.*
>
> *There is a seclusion panel held weekly to review all seclusions episodes. The panel consists of the senior nurse lead, Clinical Nurse Specialist, Service Clinical Director, Lead Occupational Therapist, Clinical educator, Pharmacist and Consumer Advisor.*

Ombudsman response:

For the reasons above in relation to recommendation 1, I disagree with the DHB's response. I acknowledge that there was not direct access to the bathroom from the seclusion area. However, the bathroom is directly adjacent to the seclusion room and is therefore accessible. I remain of the view that access to the bathroom should be facilitated for service users in seclusion, unless this would pose a serious risk of harm to the service user or staff.

I also note that seclusion paperwork and seclusion review panel minutes provided to my Inspectors did not demonstrate that service users' privacy and dignity while urinating or defecating was an area of focus.

Protective measures

Complaints process

A copy of the DHB's *Complaints Management Policy* (dated November 2019) was provided to Inspectors. The policy had a review period of 36 months.

Up-to-date contact details for District Inspectors (DIs) were visible in each of the wards on the Unit. Inspectors observed an active presence of the DIs on the Unit.

However, there was no information about the complaints process on display on the Unit. Complaint forms were also not available on the Unit. Some service users told Inspectors that they did not know how to make a complaint.

My Inspectors also observed that service users often lacked an understanding of the roles of DIs and Health and Disability Advocates. There was also no information displayed about the role of the DIs. Posters for the Health and Disability Commissioner's '*Code of Rights*' were displayed on the Unit.

I highlighted the lack of information about the complaints process following the previous inspection in 2016. I am concerned that, at the time of this inspection, this had not been resolved.

Information provided by the Unit showed that 10 complaints had been made between 1 March and 31 August 2019. Four of the complaints had not been resolved within 14 calendar days, which was the expected standard in the *Complaints Management Policy*.

The Unit provided an informal feedback process for service users, a 'suggestion box' located in the art room. This process was facilitated by the Consumer Advisor and allowed service users to provide suggestions for improvement, highlight issues of concern and make general comments.

Records

Of the 35 service users on the Unit on the first day of the inspection, 33 were detained under the MHA. The other two service users had voluntary status. All 33 files had the necessary paperwork for service users to be detained and treated on the Unit.

Consent to treatment forms were completed for most, but not all, service users subject to a compulsory treatment order.[23]

Inspectors also reviewed a selection of service users' clinical notes and inpatient care plans. Clinical notes were thorough and up-to-date. However the majority of inpatient care plans reviewed by Inspectors were incomplete and lacking in detail.

Service users were not invited to their MDT meetings, contrary to my recommendation following the inspection in 2016. Inspectors also did not see any evidence that service users were routinely or proactively provided with feedback about the outcome of the MDT.

I acknowledge the Unit's view, expressed in 2016 and again during this inspection, that inviting all service users to each MDT meeting is impracticable. However, I do not consider it will be impracticable in all cases. It is my view that service users should be invited to their MDT wherever possible and kept informed of the outcome of their meetings.

MHA court sittings are regularly scheduled and take place on the Unit. Inspectors attended a hearing and had no concerns with service users' access to legal representation.

Review of sentinel events

There were three sentinel events in the Unit between 1 May and 31 October 2019, including two service users' deaths by suicide. These two deaths occurred within five days of each other. Inspectors were advised that the third event was the death of another service user due to physical ill health.

The DHB announced an independent external review of the Unit on 17 May 2019 following the deaths of the two service users by suicide. The review was still in progress at the time of the inspection.

Recommendations – protective measures

I recommend that:

7. Information on the complaints process should be easily visible and accessible to all service users, including information on the role of the District Inspectors. **This is an amended repeat recommendation.**
8. Service users be invited to attend their Multi-Disciplinary Team meeting, wherever possible, and routinely informed of the outcome of their review. **This is an amended repeat recommendation.**

[23] Despite a compulsory treatment order, section 59 of the MHA requires clinicians to make efforts to obtain service users' consent to treatment wherever possible. See *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health. 2008.

He Puna Wāiora response

The DHB accepted recommendation 7.

The DHB rejected recommendation 8.

Recommendation 8 response:

> *The MDT review form is updated weekly and nursing staff give feedback to the service user as soon as practicable.*
>
> *Following the inspections, there has been a discharge planning project underway which involves the clinical team, the family, the social worker, the community mental health team, the service user and relevant support services to achieve a collaborative approach and seamless care and treatment throughout their admission period.*
>
> *Service users are invited to their discharge planning meetings (note: these are not discharge meetings) held with relevant parties including their responsible clinician, primary nurse, shift coordinator, social worker, occupational therapist, community team and/or cultural advisor. This is a process that leads to the development of an ongoing, individualised care and support for the service user.*

Ombudsman response:

I am pleased that staff endeavour to give feedback to service users as soon as practicable after their MDT. I acknowledge that the Unit has taken steps to increase service users' involvement in discharge planning since the inspection. However, my Inspectors' observations was that feedback was not routinely being provided to service users. I also do not consider that the Unit has provided a clear explanation for not including servicer users in their MDT. My Inspectors' observations are that, where service users are invited to their MDT, this also supports the development of an ongoing, individualised care and support for the service user.

Material conditions

Accommodation and sanitary conditions

The Unit, which opened in 2015, was generally clean, tidy and well maintained.

The admissions area, where new service users were welcomed before settling in to the 'open care' Rongoa or Rerewai wards, was a pleasant space with comfortable seating and access to hot and cold drinks.

Service users each had their own bedroom with an en-suite toilet, shower and basin. Each service user had a unique electronic bracelet that unlocked their bedroom. The bedroom door observation windows had blinds for privacy, and there was storage for personal possessions.

However, the courtyards in the HCAs required cleaning due to birds roosting in the area. Some en-suite toilets also showed signs of water staining.

All en-suite doors had been removed as a preventive measure due to ligature risk following the deaths of two service users in May 2019. The removal of the en-suite doors had a significant impact on service users' privacy and dignity.

In particular, an en-suite in the HCA was in direct line of sight from the corridor. The bedroom door blinds were operated from the outside, meaning there was the possibility that anybody could view a service user undertaking their ablutions in the en-suite.

Inspectors were told that there was a plan to replace the doors with 'stable doors' to remove the risk of ligature points. I consider addressing this issue to be a matter of priority to preserve service users' privacy and dignity.

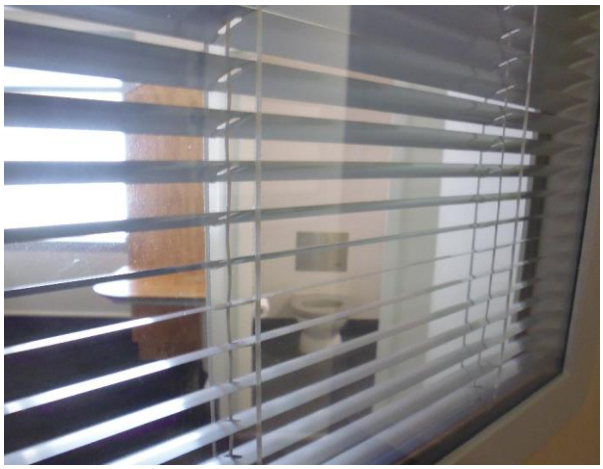

Figure 3: View into a HCA bedroom from corridor

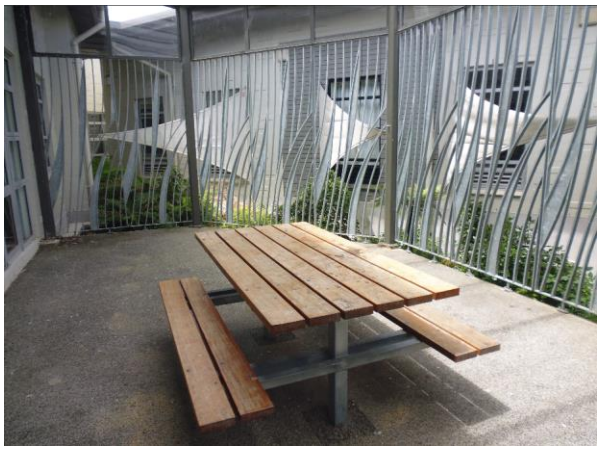

Figure 4: Courtyard in Rerewai HCA

There were laundry facilities on the Unit. All linen was locked away and had to be requested from staff.

Food

Service users were able to choose their own meals from the hospital menu. The menu catered to a range of dietary requirements and preferences. Breakfast was served at approximately 7.45am to 8am, lunch at 12pm, dinner at 6pm, and supper at 8pm.[24]

There were open dining areas in each wing of the Unit where service users could have their meals. While kitchens on the Unit were locked, there were facilities for service users to access hot drinks during the day independently of staff. Staff informed Inspectors that access to hot drinks was only restricted on a case-by-case basis, depending on service users' level of risk.

[24] Waitematā District Health Board, *Welcome Book – He Puna Waiora – What you need to know*.

The Unit had also recently restarted its fortnightly barbeques for service users, and had a regular Baking Group and shared afternoon tea.

Recommendations – material conditions

I recommend that:

9. The High Care Area courtyards are cleaned regularly.
10. The replacement of en-suite doors with 'stable doors', or a suitable safe alternative, takes place as a matter of priority to ensure service users' privacy.

He Puna Wāiora comments

The DHB accepted recommendations 9 and 10.

Activities and programmes

Outdoor exercise and leisure activities

Each Unit wing and HCA had its own courtyard, located off the communal area. Courtyard size varied, with Rongoa the largest, followed by Rerewai and then the HCA courtyards were significantly smaller.

I was pleased to see that, following my recommendation in 2016, service users had ready access to fresh air, supported by staff. The Occupational Therapists (OTs) also facilitated a walking group for service users.

The corridor between Rongoa and Rerewai had several rooms for activities and programmes, including a gym, an art room, and the OT room. The schedule of activities and programmes was on display in the corridor.

Access to the gym was limited. Service users were required to undergo a risk assessment to be allowed to use the gym and some equipment had been removed having been deemed a safety risk.

The garage area at the rear of the facility also had some exercise equipment, including for boxing, which could be used by service users in the HCAs. Service users in Rongoa and Rerewai did not have access to the garage area.

The art room was well supplied and used regularly by service users.

The door from Rerewai to the corridor was locked at times during the inspection, preventing service users in Rerewai from freely accessing the activities rooms. Service users needed to locate staff to facilitate their access to the corridor. Service users in Rerewai expressed frustration with this situation, and noted that service users in Rongoa were not similarly

restricted. However, the service users also expressed gratitude to the OTs for making an additional activities schedule viewable even when the corridor was locked.

Figure 5: Rongoa courtyard

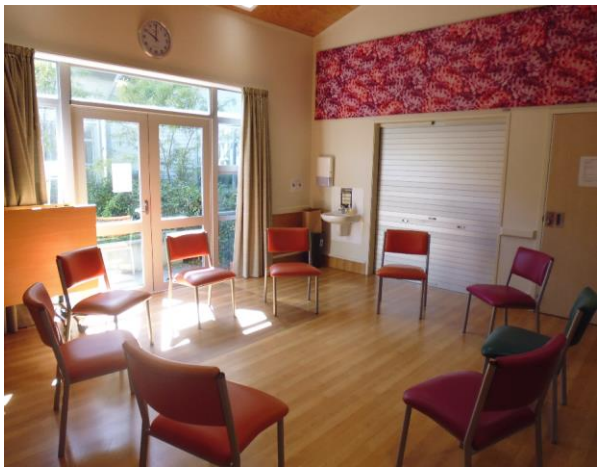

Figure 6: Occupational Therapy room

Programmes

The Unit employed a Clinical Psychologist who conducted one-on-one work with service users.

The four OTs and two Assistant OTs provided a structured programme of daily activities. Activities in the programme looked at areas such as healthy lifestyles, skills for living, addressing alcohol and drug use and managing mood. There was a mixture of one-on-one and group sessions available, depending on service users' preferences.

Inspectors were pleased to note that the Unit had recently begun offering activities after hours and at the weekend. During the inspection, several service users expressed their gratitude for the work done by the Unit to increase the number of activities available.

Cultural and spiritual support

The Unit had relationships with a broad range of cultural services, including Whitiki Maurea Services, Asian Mental Health Services and Isa Lei Pacific Island Mental Health Services.

The Unit employed a Cultural Advisor who had regular contact with several tāngata whai ora to help guide them from a state of mauri moe[25] to mauri ora.[26] The Cultural Advisor was also involved in many working groups and governance groups to provide a te ao Māori perspective on behalf of the Unit.

[25] An unconscious state. Definition available on Māori Dictionary, maoridictionary.co.nz

[26] A state of wellbeing. Definition available on Māori Dictionary, maoridictionary.co.nz

The Cultural Advisor was well regarded and integral to the functioning of the Unit. However, Inspectors observed there to be more demand for cultural competency, support and guidance than could feasibly be provided by one person.

My Inspectors also heard that spaces which had previously been designated as the wharenui and wharekai had been repurposed for general use. While there were several spaces for tāngata whai ora to enter the Unit,[27] the changes had limited the capacity for the Unit to hold a pōwhiri or whakatau for new service users and staff.

Inspectors also heard that tāngata whai ora would often be brought into the Unit through the garage area at the rear of the facility, and then through into the HCA.

While understandable for service users who, due to high levels of distress, could not safely enter the Unit via the main entrance, Inspectors heard from staff and service users that entering through the garage impacted negatively on the mana and dignity of service users. This practice was of particular concern for Māori, as entrance through the garage was not a culturally safe way to bring tāngata whai ora into the Unit.

My Inspectors also found evidence that tāngata whai ora were transferred to other facilities at short notice and without the involvement of cultural support providers. Again, I consider that transfer of tāngata whai ora without seeking cultural advice is not culturally safe.

Inspectors did not have an opportunity to speak to the Chaplain during the inspection. Mutual Help Meeting minutes indicated that staff had facilitated access to Bibles, held Bible study groups and contacted the Chaplain at the request of service users.

Recommendations – activities and programmes

I recommend that:

11. The level of cultural support on the Unit be increased and appropriate spaces are designated to welcome tāngata whai ora and staff to the Unit with a pōwhiri or mihi whakatau.
12. The garage is not used as an entrance to the Unit unless other options are deemed unsafe based on individual risk assessment.
13. Cultural advice informs decisions on transferring or discharging tāngata whai ora.

He Puna Wāiora comments

The DHB accepted recommendations 11, 12 and 13.

Recommendation 11 response:

[27] Including, for example, the admissions area for the Rongoa or Rerewai wards.

> *The cultural advisor is a full time position 0800 until 1630 with an identified area to welcome with a pōwhiri or mihi whakatau.*
>
> *The challenge is that most admissions occur out of her working hours so it is not possible to welcome all new admissions. Following the receipt of this recommendation, there is a process in place to adjust hours to increase availability.*

Ombudsman response:

I am pleased to hear the Unit had adopted process to adjust the hours for the cultural advisor to increase their availability. I also acknowledge that the cultural advisor is a full time role. I emphasise, however, that my Inspectors observed that the demand for cultural support was more than could feasibly be provided by one person and that an increase in the level of cultural support was required.

Recommendation 12 response:

> *The transition suite is designed to accept all new admissions unless high care is required then an admission is accepted via the garage.*
>
> *The cultural advisor is present at MDT reviews, family/whānau meetings and clinical reviews to actively advocate for tāngata whai ora.*

Ombudsman response:

I am pleased that the DHB has accepted my recommendation. However, I do not consider that placement in the High Care Area is sufficient reason alone to justify using the garage as an entrance. Service users and tāngata whai ora who require assessment and treatment in the High Care Area may nonetheless be able to be welcomed safely onto the Unit via a more therapeutic and culturally appropriate entrance than the garage. In my view, this requires individual risk assessment and justification in each case, including where service users and tāngata whai ora are being admitted to the High Care Area.

Communications

Access to visitors

The Unit provided Inspectors with the DHB's *Visiting Guidelines for Acute Adult Inpatient Units* (dated March 2016). The guidelines had a review period of 36 months and were out-of-date at the time of the inspection.

Visits could take place on the Unit from 10am to 8pm in Rongoa and Rerewai, and from 10am to 11am and then 1pm to 8pm in the HCAs.

The Unit provided Inspectors with a copy of the DHB's pamphlet *'The whānau/family information pack*' (the whānau pack). The whānau pack contained useful information for whānau about key recovery concepts, questions to ask of staff, and what support was available to both service users and whānau.

Inspectors observed whānau visiting service users regularly and noted that staff treated whānau with respect. There were a number of spaces on the Unit for whānau to sit with service users in private. Whānau spoken with by Inspectors did not report any concerns about service users' access to visitors.

Access to external communication

Inspectors were informed that the telephones in the booths on the Unit had been removed due to being a ligature risk. However, the majority of service users had access to their mobile phones, and the Unit had portable phones in the staff office, and spaces available to use these phones, including bedrooms and interview rooms.

Staff informed Inspectors that cell phones would only be removed from service users on a case-by-case basis, for example if a service user was filming other people on the Unit.

If service users did not have a cell phone, they were dependent on staff to provide access to a portable phone. Inspectors saw a service user, who wanted to call their child, being told to wait for a prolonged time outside the staff office to make a phone call, even though several staff were present and the phone was available.

Recommendations – communications

I recommend that:

14. Service users have access to a telephone, independent of staff, unless deemed unsafe based on individual risk assessment.

He Puna Wāiora comments

The DHB rejected recommendation 14.

Recommendation 14 response:

> *We acknowledge that service users have the right to fair and safe access to phone calls whilst in He Puna Waiora*
>
> *Unless service users have their own mobile phones they are to ask staff to use the ward mobile phone and staff will facilitate their calls. Cordless phones were accessible but were replaced with landline phones due to concerns around privacy. The landline phones have since been removed as they were identified as a ligature risk.*

Ombudsman response:

I acknowledge that there are concerns around privacy and safety which must be considered in relation to how service users access the telephone. However, service users' ability to independently contact whānau should not depend on whether they have their own mobile

phone. I consider that independent access to a telephone should be available for all service users, unless deemed unsafe based on an individual risk assessment. My Inspectors' observations are that there is not a consistent approach to this issue across all facilities in the country. There should be practical ways of mitigating the ligature risk while also ensuring independent access to the telephone.

Health care

Primary health care services

Service users received a physical assessment on admission and the House Officers were active on the Unit. A House Officer was on call after hours and at the weekend to provide assistance to service users on the Unit presenting with physical concerns.

A treatment room was available on the Unit. Medication was stored separately. These rooms were tidy and well organised.

The Unit's pharmacist worked closely with medical staff in designing appropriate medication plans and attended the weekly clinical review meeting. The pharmacist would meet one-on-one with service users to discuss medication and also facilitated education sessions with nurses to enhance their knowledge of medicines.

There were five documented medication errors between 1 May and 31 October 2019. There was no pattern to the events indicating a wider issue. The Unit's record keeping was transparent, and indicated that no serious adverse health consequences had occurred and that appropriate actions had been taken in response to the errors.

I have no concerns with service users' access to primary health care services.

Recommendations – health care

I have no recommendations to make.

Staff

Staffing levels and staff retention

There was a mix of age, gender, and experience among staff. There was also ethnic diversity in the staffing, but Māori were underrepresented in this mix.

Information provided to Inspectors indicated that the Unit had 6.9 full-time equivalent Registered Nurse (RN) vacancies at the time of the inspection.[28]

Staff worked a three-shift roster with a designated staffing level.[29] The designated staff level during weekdays was eight RNs and four Health Care Assistants (HCAs), with an additional RN rostered during the day in the weekends. For the night shift, the designated staffing level was four RNs and five HCAs.

Inspectors observed that staff in Rongoa and Rerewai were task oriented and spent most of the time in the nursing station, rather than on the Unit. Staff in the HCAs, meanwhile, spent more of their time actively on the Unit with service users.

I have serious concerns about staff morale on the Unit. Staff, service users and others involved with the Unit all highlighted staff shortages and significant workload pressures. Nearly all staff spoken with by my Inspectors said that they did not feel listened to, supported, or valued by leadership on the Unit.

Data provided by the Unit indicated that work pressures and low morale were having an impact on staff turnover.[30] RN turnover in 2018/19 was 17 percent.

The Unit had good processes in place to manage bed occupancy to try and maintain good conditions for service users and reduce pressure on staff. This was reflected in average bed occupancy rates for the six months prior to the inspection, which did not exceed 100 percent in any month. Notwithstanding these processes, Inspectors were repeatedly told that staffing levels were too low to meet the needs of service users. Staff shortages meant that staff regularly had to work double shifts and Inspectors were told that it was difficult to get leave.

An Associate Clinical Charge Nurse role had been established to provide senior oversight on the afternoon shifts. Weekly group supervision was available to RNs and HCAs.

While Inspectors observed staff doing their best to manage in difficult circumstances, the low morale and level of burnout among staff was not conducive to providing a therapeutic environment for the service users.

[28] The data showed that there were RN vacancies for 6.9 Full Time Equivalent as of 25 November 2019.

[29] The morning shift ran from 7am to 4.05pm, afternoon shift from 3pm to 11.35pm, and the night shift from 11pm to 7.35am.

[30] The turnover rate on the Unit for RNs and HCAs combined was 11.2 percent for the 2016/17 year, 16.95 percent for the 2017/18 year and 14.75 percent for the 2018/19 year.

Recommendations – staff

I recommend that:

15. The Unit takes action to rebuild staff morale and address the high turnover rate.

He Puna Wāiora comments

The DHB accepted recommendation 15.

Acknowledgements

I appreciate the full co-operation extended by the Charge Nurse Manager 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 3: List of people who spoke with Inspectors

Managers	Unit staff	Others
Clinical Nurse Leader Charge Nurse Manager Associate Charge Nurse Manager	Clinical Charge Nurse Registered Nurses Occupational Therapists Social Workers Mental Health Assistants Administrators House Officer	Service users District Inspector Whānau Cultural Advisor Chaplain Consumer Advocate Consumer Advisor

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.