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OPCAT inspection final report

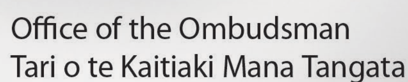
# Report on an unannounced inspection of STAR 1 (Services for Treatment, Assessment & Rehabilitation), Palmerston North Hospital, under the Crimes of Torture Act 1989

June 2021


Peter Boshier

Chief Ombudsman

National Preventive Mechanism

**OPCAT Report: Report of an announced inspection of STAR 1 under the Crimes of Torture Act 1989**

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# Executive summary

## Background

Ombudsmen are 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 patients detained in secure units within New Zealand hospitals.

Between 29 September and 1 October 2020, Inspectors[1] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of STAR 1[2], which is located in the grounds of Palmerston North Hospital in the MidCentral District Health Board region.

## Summary of findings

My findings are:

- staff engaged with the patients and their family in a warm and respectful way;
- staff used caring and supportive language when speaking about the patients.

The issues that needed addressing are:

- alternative interventions to de-escalate situations should always be tried before using personal restraint and pro re nata medication;
- the Unit was not fit-for-purpose:
    - it had an institutional rather than homely feel;
    - there was a lack of space to conduct group activities;
    - there was no dining room and no kitchen for patients to use;
    - the outdoor space was unsafe and not therapeutic;
    - access to the outdoor space was restricted when the patient lounge was in use;
    - there were no quiet spaces for patients outside of their room;
    - the patient lounge was small and poorly resourced; and
    - patient movement was restricted by staff seated in the doorway of a patient's room.

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1 When the term Inspectors is used, this refers to the inspection team comprising of the OPCAT Manager, Senior Inspectors and Inspectors.

2 Services for Treatment, Assessment and Rehabilitation.

## Recommendations

**I recommend that:**

1. Least restrictive measures are attempted by staff (and recorded) to de-escalate situations before personal restraint and pro re nata medication is considered.
2. There is a sensory modulation room with appropriate resources, light, ventilation and uncluttered space. **This is an amended repeat recommendation.**
3. Patients and their whānau are made aware of how to make a complaint, and brochures and a complaint box are readily available in the Unit.
4. The Facility has fit for purpose areas for: quiet time outside of bedrooms, interacting with other patients and visitors and engaging in cultural and religious groups and activities, physical exercise and relaxation outside, and dining and access to snacks and drinks. **This is an amended repeat recommendation.**
5. Patients are provided with the opportunity to engage in group activities.

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 MidCentral District Health Board (MDHB) and the Unit's leadership team, to summarise their initial observations.

# Facility facts

## STAR 1 (Services for Treatment, Assessment and Rehabilitation)

STAR 1 is a seven bed secure inpatient unit (the Unit). It provides specialist services for people aged 65 and over with serious behavioural and psychological symptoms of dementia, recent onset mental health disorders with or without one or more chronic medical conditions, and/or functional impairment or decline.[3] Patients can be admitted to the Unit voluntarily, under the Protection of Personal and Property Rights Act 1988 (PPPR Act), or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

### MDHB's proposed changes to their model of care

My Inspectors were provided with the document *MidCentral District Health Board Older Adult Model of Care* which sets out the MDHB's proposed changes to its model of care. In October

[3] Sourced from *MidCentral District Health Board Older Adult Model of Care*, dated 30 June 2020.

2019, the MDHB approved a review of its older adult mental health services to confirm a best practice model of care that considers inpatient and community care services. It was proposed that STAR 2[4] manage STAR 1 as part of a 31-bed facility with seven secure beds.

The Associate Charge Nurse in STAR 1 would report to the Charge Nurse of STAR 2. STAR 1 would retain nursing mental health expertise, a dedicated older adult psychiatrist and the capacity for specialist psychogeriatric inpatient services, while providing effective clinical and operational oversight across ElderHealth.[5]

In March 2020, work began on the relocation of STAR 1. On 22 June 2020, the Unit moved to its current location. Management invited staff to submit on the proposed model of care by 30 July 2020, but the Unit had relocated by then.

The Unit is part of the STAR Centre that encompasses STAR 1 (Mental Health service) and STAR 2 (ElderHealth). The Centre is located on the Palmerston North Hospital campus in the MidCentral District Health Board region – Te Pae Hauora o Ruahine o Tararua (MDHB).

## Region

MidCentral North Island – Palmerston North and environs

MidCentral District Health Board – Te Pae Hauora o Ruahine o Tararua

## Previous inspections

Unannounced inspection – May 2012

Unannounced inspection – December 2015

Unannounced follow-up visit – May 2017

Unannounced drop-in visit – August 2020

[4] STAR 2 is an inpatient ward for people over 16 years of age who require assessment, treatment and rehabilitation (https://www.midcentraldhb.govt.nz/HealthServices/ElderHealth/Documents/STAR%202-1940.pdf).

[5] ElderHealth is a specialist service for people over the age of 65 years (55 years for Māori) with a focus on assessment, treatment and rehabilitation.

# The inspection

Inspectors conducted the inspection of the Unit between 29 September 2020 and 1 October 2020. At the time of the inspection, there were six patients in the Unit, comprising one female and five males. The average length of stay for the period 3 February 2020 to 25 September 2020 was 41 days.

## Inspection methodology

The physical inspection spanned three days – Tuesday 29 September to Thursday 1 October 2020 and included formal interviews with the Charge Nurse Manager (CNM) and Associate Charge Nurse Manager (ACNM). Interviews were undertaken with staff involved with patient care, patients themselves and their whānau. The physical inspection included reviewing a sample of patient clinical records, and observing interactions between staff and patients.

The inspection also included remote inspection activity including reviewing operating policies, plans and incident data. A full list of documents requested and reviewed is attached as Appendix 1.[6]

The Unit received a copy of my provisional report and was invited to comment. I appreciate the efforts made by the Unit to address the issues identified during the inspection and documented in my provisional report. I have had regard to their feedback when preparing my final report.

## Inspection focus

Six key 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 patients.[7] These areas were:

- Healthcare and treatment, such as the use of de-escalation and restraint, and patients' and whānau views on treatment;
- Protective measures, such as the patients' ability to make complaints;
- Material conditions;
- Activities and programmes including access to outdoor areas;
- Access to visitors and external communications; and
- Staffing levels.

[6] For a list of people spoken with by the Inspectors, see Appendix 2.

[7] 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.

## Recommendations from previous inspections

The Inspectors followed up on three recommendations previously made by me, following an inspection of STAR 1 in May 2017[8]:

- All staff should be up to date with their restraint training refresher course.

  Following the May 2017 inspection the MDHB advised that 75 percent of staff had completed the training, and future dates had been set for the remaining staff.

- The HNU (High Needs Unit) is redesigned to better meet the needs of older persons. This was a repeat recommendation.

  Following the May 2017 inspection the MDHB advised that a project was underway to review and change the current environment. The goal for completion was late 2017.

- A wider selection of sensory modulation resources is made available for use.

  Following the May 2017 inspection the MDHB advised that a Charge Nurse and Occupational Therapist had commenced with a plan to purchase more resources.

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

[8] *Office of the Ombudsman report on an unannounced visit to STAR 1 under the Crimes of Torture Act 1989,* May 2017.

# Healthcare and treatment

Inspectors observed that staff engaged with the patients and their family in a warm and respectful way. Staff used caring and supportive language when speaking about the patients.

There was no evidence that any patient had been subjected to torture or cruel, inhuman or degrading treatment or punishment. There was also no evidence that seclusion was used in the Unit, and there were no patients undergoing Electro-convulsive therapy (ECT) in the Unit at the time of the inspection.

## Assessment and care planning

Records showed patient assessment on admission laid the foundation for their care planning. Care plans were in place for each patient and were updated every three to four days. Multidisciplinary team (MDT) meetings were held regularly and recorded, which included discussion of discharge planning for the patient. While these MDT meetings did not include patient or whānau representation, patient files showed evidence of meetings with members of the clinical team and whānau on patient progress.

## Restraint as least restrictive practice

In observing restraint practices while at STAR 1 my Inspectors reviewed a sample of patient clinical records, incidents of restraint, the use of 'specials', staff training records, and the *Restraint Minimisation and Safe Practice Policy*.[9] Inspectors also sought staff views on restraint practices in STAR 1.

### Clinical record review

My Inspectors reviewed three patient clinical records and two patient medication charts.[10] There was no documented evidence of staff having tried alternative interventions (for example pain management, offering food or drink, toileting, or therapeutic touch and voice) to de-escalate situations before PRN (pro re nata) medication was administered.[11] According to the patient clinical records, when a patient showed mild or early signs of anxiety it appeared that medication was administered as the first line of intervention.[12]

In responding to my provisional report the Unit provided clinical documentation dated January and February 2021 showing that attempts to implement de-escalation strategies had been made and recorded prior to the use of PRN medication or personal restraint. The Unit also said

[9] *Restraint Minimisation and Safe Practice Policy* 18 September 2020.

[10] The patients whose medication records were reviewed were the only patients in STAR 1 on prescribed PRN psychotropic medication at the time of the inspection.

[11] PRN stands for 'pro re nata', and means 'when necessary' or 'as needed'.

[12] The Health and Disability Services Standards 8132:2008 provide that all medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

that impulsive and unpredictable physical aggression from some patients meant there was little opportunity to apply diversional or distraction techniques. However, the Unit informed me, *'The recent introduction of restraint evaluation stickers includes a section on the least restrictive alternatives or de-escalation strategies to avoid future restraints; this provides transparent and clear recorded documentation of every event.'* It is pleasing to learn this, as I would expect de-escalation strategies to be attempted (and recorded) on every occasion before personal restraint and pro re nata medication is considered.

## Use of personal restraint and 'Specials'

MidCentral DHB provided my Inspectors with restraint incident data for the period between 1 July 2020 and 29 September 2020[13]. There were 85 recorded incidents of personal restraint[14] during that time. The majority of those incidents, (70 incidents or 82 percent), were attributed to two patients. My Inspectors found it difficult to determine whether the number of reported incidents were impacted by the environmental factors identified in this report.[15] There was no evidence of the use of physical restraint (restraint involving equipment, devices, or furniture) in patient clinical records or observed during the inspection.

Records show that two patients had 'Level 3' monitoring in place at the time of the inspection, where a healthcare assistant (a 'Special') was provided to constantly watch a patient. Inspectors observed the Specials seated in the doorway of two patients' rooms. I consider this practice restricts a patient's ability to move freely in and out of their room and within the Unit, impinging on their dignity. It is acknowledged that both patients were in rooms that had an ensuite toilet. I suggest the Unit review its practice of having a Special seated in the doorway of a patient's room and ensure the patient can move about freely, while maintaining the safety of other patients, staff, and visitors.

## Staff views about use of restraint in the Unit

Staff told Inspectors that personal restraint was common in the Unit. For several patients in the Unit during the inspection, staff reported it was necessary to use restraint every time the patient required personal care. Some staff said they were aware restraint should be a last resort, but that this was rarely the case. Other staff showed a lack of understanding about the need to attempt de-escalation first. They said that restraining patients was necessary for staff safety.

## Restraint training for staff

I considered whether the following recommendation from May 2017 had been met:

[13] STAR 1 moved to its current location on 22 June 2020.

[14] Use of the body to limit the movement of a patient.

[15] The Restraint Coordinator informed Inspectors at the closing meeting that the number of restraint incidents had increased since STAR 1 relocated to its current location.

*All staff should be up to date with their restraint training refresher course.*

The MDHB informed my Inspectors they use the four-day Safe Practice Effective Communication initial training (SPEC) in Mental Health areas.[16]

Records provided confirmed all Unit staff completed the initial 4-day training programme between 2016 and 2019. It appears regular refresher training is available, with 20 of the 24 listed staff having completed a refresher programme between 2019 and 2020, and no staff being marked as overdue for their refresher programme. Therefore, I consider the recommendation has been met.

Regarding contract (and/or bureau[17]) staff, the MDHB said it '*can confirm that staff assigned from the bureau or security to STAR 1 are SPEC trained whenever possible'.* The MDHB also reported only SPEC trained staff from STAR 2 would be asked to work in STAR 1. This is consistent with the information provided on page 12 of the STAR 1 and STAR 2 *Operational Framework* which says that, '*Full Safe Practice Effective Communication (SPEC) training is considered essential for staff working in STAR 1, with a modified version of SPEC for staff working across both areas'.* Contrary to the *Operational Framework*, staff told Inspectors that *'not all staff practising personal restraint had received SPEC training, particularly bureau staff'*. They said bureau staff were most likely to be assigned as 'Specials' to high needs patients and, therefore, were more likely to be required to practice restraint. It is acknowledged my Inspectors did not validate the number of instances patients were restrained by staff who were not SPEC trained. However, I would expect the MDHB to ensure that only staff trained in restraint use, and its minimisation, are involved in restraint practice.

## Sensory modulation

I considered whether the Unit had met the following recommendation from May 2017:

*A wider selection of sensory modulation resources is made available for use.*

The recommendation had not been met. Staff told Inspectors that patients lacked access to sensory modulation.[18] My Inspectors' observation was that the sensory modulation room was small and cluttered, lacked ventilation and was not set up with appropriate resources. My Team did not see patients involved in either sensory modulation or creative therapies.

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[16] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a focus on therapeutic interventions that reduce the incidence of restraint and seclusion. See https://www.tepou.co.nz/news/safe-practice-effective-communication-launch/911#:~:text=SPEC%20is%20a%20training%20programme,and%20implementation%20of%20the%20programme.&text=There%20are%20a%20number%20of%20outcomes%20sought%20from%20SPEC%20National%20Training.

[17] Staff not employed by the Unit.

[18] Sensory modulation is an approach that uses sensory based equipment, strategies and environments to assist people in optimising emotional levels and engagement in everyday life. See the following study from the National Centre of Mental Health Research, Information and Workforce Development: *Sensory modulation in acute mental health wards: a qualitative study of staff and service user perspective.*

Staff reported that the lack of a suitable sensory modulation space with appropriate resources, and an inadequate outdoor courtyard, created agitation among patients. I consider that providing a room for sensory modulation that is free of clutter and has appropriate light and ventilation would help to improve the wellbeing of patients.

In its response to my provisional report the Unit advised that appropriate light and ventilation in the sensory modulation room is limited by the available space. The Unit said this is because the Occupational Therapy Assistant uses the room as a temporary office space. The Unit also advised that this situation would be rectified in the next two months when a separate room becomes available. This is a positive development, as I consider a sensory modulation room with appropriate resources, light, and ventilation will help to improve the wellbeing of patients.

### Recommendations – healthcare and treatment

**I recommend that:**

1. Least restrictive measures are attempted by staff (and recorded) to de-escalate situations before personal restraint and pro re nata medication is considered.
2. There is a sensory modulation room with appropriate resources, light, ventilation and uncluttered space.

### STAR 1 comments

The MDHB accepted recommendation 1.

The MDHB partially accepted recommendation 2.

## Protective measures

### Complaints process

The Unit provided Inspectors with a copy of its feedback brochure entitled *'Tell us what you think'*. It invited a patient, whānau, or visitor to provide a compliment, concern, query or suggestion. The brochure listed five ways feedback could be provided (by word of mouth, email, phone, online feedback form, or pre-paid post). Inspectors did not see any feedback brochures or a suggestions box in the Unit. They did see a *'Tell us what you think'* poster in the Unit advertising the feedback process. I would expect the Unit to make sure patients and their whānau are aware of how to make a complaint, and brochures and a complaint box are readily available In the Unit.

The Unit has responded to my provisional report saying, *'Patients and their whanau are now routinely made aware of how to make a complaint, and brochures and a complaint (suggestion) box are readily available in the Unit.'* I am pleased to learn this.

### Recommendations – protective measures

**I recommend that:**

3. Patients and their whānau are made aware of how to make a complaint, and brochures and a complaint box are readily available in the Unit.

### STAR 1 comments

The MDHB accepted recommendation 3.

## Material conditions

### Accommodation and sanitary conditions

#### The environment in the Unit

I considered whether the following recommendation from May 2017 had been met:

> *The HNU (High Needs Unit) is redesigned to better meet the needs of older persons. This is a repeat recommendation.*

I found that this recommendation had again not been achieved. Despite the Unit having recently moved to a new location within the hospital building, the new environment did not better meet the needs of older persons. I consider the environment in the Unit diminished the ability of staff to provide spaces for patients outside of their rooms.

Managers and staff told Inspectors that managing behaviour in a respectful, least restrictive, and safe way was more difficult in the new location. Managers also told Inspectors that in hindsight relocating the Unit to the smaller space in June 2020 without refitting the new location to accommodate patients' needs was *'not ideal'*.

In a guided tour by the Clinical Nurse Manager, Inspectors noted that the new Unit is smaller than the previous Unit.

#### The patient lounge was small and poorly resourced

Inspectors observed the patient lounge to be small and poorly resourced. Inspectors did not see patients using the lounge during the inspection. Patients were seen spending most of their time in their rooms or gathered around the nurses' station. Activities that Inspectors observed

patients undertaking were individualised activities such as knitting, listening to music in their room, watching tv in their room, and walking in the courtyard.

## Patient rooms were not personalised

Inspectors observed that patient rooms were not personalised. People whose rooms are personalised with elements such as wall decorations, ornaments and pictures have been found to present less problematic behaviour.[19] This is particularly significant because Inspectors observed patients spending a lot of time in their rooms. I would like to see each patient encouraged to personalise their room to help distinguish their personal space.

In response to my provisional report the Unit provided photos showing that bedrooms have since been *'individualised'.* I was also advised that the décor in the Unit has also been upgraded since my inspection with murals, plants, pictures and a tropical fish tank providing *'a light, bright and less clinical space'*. I am pleased to learn of this, as I consider it will create a more homely environment in the Unit.

## Lack of a dining room or kitchen

The Unit did not have a dining area. My Inspectors saw patients receive their meals wherever they were sitting at mealtimes. They saw patients eating by the nurses' station, which was visible to visitors to the Unit. My Inspectors also observed that the Unit did not provide a kitchen for patients to use, and drinks or snacks were not available for patients to access. I consider that providing a dining room and kitchen for patients to use would help maintain each person's dignity and independence, and support an increase in communication and socialisation.

In response to my provisional report the Unit advised, *'Patients assessed as cognitively able can utilise the shared dining and social space available in the adjoining rehabilitation unit.'* This is positive, but I would expect the shared dining and social space to be available to all patients daily, with assistance provided where necessary. The Unit also advised that staff provide drinks and snacks to patients and family on request and there is a water cooler. However, because the Unit's patients include people who are *'significantly cognitively and behaviourally compromised'* it is considered not safe to have hot drinks readily accessible due to the risk of accidental harm or injury. I appreciate that making hot drinks available may cause safety issues for some patients. However, I would like the Unit to consider how it can make hot drinks and snacks available for all patients to access.

## Outside area not fit for purpose

Gardens and outdoors spaces have positive impacts on the mental and physical wellbeing of people. These include reduced agitation, reduced pacing and exit-seeking, 19 percent less

[19] See discussion of the built environment on page 14 of the Ministry of Health's *Secure Dementia Care Home Design* published in 2016.

violence by people with dementia, and evidence to suggest a reduction in the type and frequency of medication used by users of a 'wander garden' with all day unimpeded access.[20]

The Unit had a fenced, sloping concreted outside area (referred to as the 'courtyard') that was unsafe, and poorly resourced. The courtyard was devoid of greenery. There was no seating and tables for residents and visiting whanau to use when outdoors. Staff were concerned about patients' safety and dignity in the courtyard and described it as *'dangerous,' 'like a prison cell,' 'like a zoo enclosure,'* and *'horrible'*. Whānau echoed these concerns. Inspectors only saw one patient using the courtyard regularly. Courtyard access was restricted when the patient lounge was in use.

It is my view that patients should be able to independently access a courtyard that is even underfoot, from inside to outside. To provide meaningful exercise and therapeutic benefit, pathways should be appropriately surfaced, and the space should be large enough for visitors. The courtyard should also include motion sensor lighting for night use, raised garden beds, seating and tables, and sunny and shaded places. The courtyard should allow for privacy but also for engagement with the wider surroundings.

In responding to my provisional report the Unit advised that since my inspection the courtyard and garden have been made safe to use but are still under development. *'Planting and installation of shade sails and garden furniture are planned before the end of summer.'* I acknowledge that the Unit has work underway to improve its outdoor area.

The lack of a functional patient lounge and courtyard coupled with a smaller sized Unit provided fewer opportunities for patients to participate in group or individual activities, de-escalate, or spend time with their whānau. This was reinforced by staff comments. Any upgrades to the Unit environment should consider how the lounge, courtyard and implementation of activities can enhance the patient experience. I consider that my recommendations for improvement to the environment, as discussed in this report, will help to address this.

## Food

Inspectors' review of clinical notes showed that a patient's care plan included their food choices, including any dietary needs and cultural requirements. The menu provided for different diets, and meals were served at regular meal times (breakfast, lunch, dinner, and snacks were provided). Patients told Inspectors they liked the food.

[20] See page 17 of the Ministry of Health's *Secure Dementia Care Home Design* published in 2016.

### Recommendations – material conditions

**I recommend that:**

4. The Facility has fit for purpose areas for: quiet time outside of bedrooms, interacting with other patients and visitors and engaging in cultural and religious groups and activities, physical exercise and relaxation outside, and dining and access to snacks and drinks.

### STAR 1 comments

The MDHB accepted recommendation 4.

## Activities and programmes

### Lack of group activities

The Unit was generally quiet with patients observed to be in their rooms or gathered by the nurses' station for the duration of the inspection. Inspectors observed that patients were not given the opportunity to interact with each other in the Unit. My Team did not observe patients engaged in any group activities during the inspection.

As mentioned above, there was no space set up for patients to interact in a group, and Inspectors did not see a group activity plan. Activities that inspectors observed were knitting by one patient, another patient listening to music in their room, one patient watching tv, and one patient regularly using the courtyard. I would expect the Unit to provide some opportunity for patients to engage in group activities.

The Unit has responded to my provisional report saying patients are provided with the opportunity to engage in group activities. It provided photos showing charts with activities listed.

### Cultural and spiritual support

Staff told inspectors that they often referred patients who identified as Māori to Pae Ora Whanau Care Team, the Māori health service. Pae Ora's kaupapa is to provide a safe supportive environment for whānau of all ethnicities. Inspectors were informed that Pae Ora was developing an internal wellbeing tool, Nga Pou o te Oranga, to track staff attendance on Te Tiriti o Waitangi training and Cultural Responsiveness in Practice training. I look forward to following the progress of the internal wellbeing tool, Nga Pou o te Oranga.

## Recommendations – activities and programmes

**I recommend that:**

5. Patients are provided with the opportunity to engage in group activities.

## STAR 1 comments

The MDHB accepted recommendation 5.

# Communications

## Access to visitors

Unit staff provided my Inspectors with the MDHB's *Visitors to Palmerston North Hospital/Horowhenua Health Centre Policy* (version 9, issued 31 August 2020). The Unit's visiting hours were 2pm to 8pm. Staff informed Inspectors that whānau could visit outside of those hours, and whānau were seen visiting before 2pm. Inspectors were also provided with the MDHB's *Visitor Policy COVID-19*. This document provided basic information for visitors to the Unit about wearing personal protective equipment.

### Interpretation services

Staff said that they were either not aware of, or unclear about, the process for accessing interpreters for patients. They said whānau members were mainly used to communicate with patients who did not speak English. They also said that staff who were not trained in interpretation were used to interpret for patients.

The *MDHB Interpreter Policy*[21] allows for untrained interpreters, such as bilingual staff, family and significant others, to interpret in certain circumstances, such as emergency situations or routine daily encounters. However, the Policy notes that this *'does not provide a guaranteed quality service',* and therefore it is not appropriate when consumer needs, rights and obligations are restricted. I suggest that staff are made aware of, and apply, the *MDHB Interpreter Policy*.

## Recommendations – communications

I have no recommendations to make.

[21] The *MDHB Interpreter Policy* is dated 10 September 2020.

# Staff

## Low staff morale

In interviews with staff, Inspectors heard that staff morale was low, with a number of staff having resigned or planning to leave. This was supported by the interview with management, who said they were aware of the negative impact the relocation had on staff and patients.

Staff told inspectors they had concerns with the new space but felt they had not been listened to and had therefore been wary of advocating for conditions that would improve patient well-being. I consider that staff morale has an impact on patient wellbeing and that staff feedback should be acknowledged and considered.

## Recommendations – staff

I have no recommendations to make.

# 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 documents provided to Inspectors

Inspectors were provided with the following information during the inspection:

- a list of patients and the legislative reference under which they were being detained (at the time of the inspection);
- monthly discharges, admission and occupancy for the previous three months;
- activities programme;
- Māori mental health clinicians, advocates and legal representative contact details;
- monthly meal plan;
- rights, consent and privacy information sheets;
- needs assessment template;
- patient information and clinical notes;
- COVID-19 inpatient pathway plan;
- records of staff training and education, including Safe Practice Effective Communication training (SPEC);
- feedback and incidents register, and adverse events (incidents) policy;
- restraint and seclusion register for previous six months, records of restraint use, restraint policy and procedure;
- register of Official Information Act, Privacy Act, and Health Information Privacy Code requests;
- operational and process framework;
- Older Adult Mental Health Model of Care proposal;
- risk and hazard policy and register, and risk assessment and management policies;
- medication administration policy;
- admission and discharge policy;
- visitor policy;
- informed consent policy;
- confidentiality and privacy policy;
- interpreter policy and procedure;
- medical isolation policy;
- observation for patients with behavioural disturbance policy;

- open/closed door policy;
- patient identification policy;
- Treaty of Waitangi policy; and
- Pae Ora Maori Healthcare Services Framework.

# Appendix 2. List of people who spoke with Inspectors

**Table 1: List of people who spoke with Inspectors**

| Managers | Ward staff | Others |
|---|---|---|
| Operations Executive Manager | Clinical Nurse Managers | Patients |
| Director Mental Health Services | Clinical Nurse Specialist | Whānau |
| Clinical Nurse Executive | Psychiatrist | |
| | Registered Nurses | |
| | Healthcare Assistants | |
| | Occupational Therapists | |
| | Cleaning staff | |
| | Enrolled Nurses | |
| | Social Worker | |

# Appendix 3. 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.