



Ombudsman

Fairness for all

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OPCAT Report

Report on an unannounced inspection of Stanford House, Whanganui Hospital, under the Crimes of Torture Act 1989

August 2021
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National Preventive Mechanism

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata





OPCAT Report: Report of an announced inspection of Stanford House, Whanganui Hospital under the Crimes of Torture Act 1989

ISBN: 978-1-99-115262-6 (PDF)

Published August 2021

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 Contents

Executive summary	1
Background	1
Summary of findings	1
Recommendations	2
Good practice	2
Feedback	2
Facility facts	3
Stanford House	3
Region	3
District Health Board	3
Operating capacity	3
Previous inspections	4
The inspection	5
Inspection methodology	5
Inspection focus	6
Treatment	6
Protective measures	6
Material conditions	6
Activities and programmes	6
Communications	7
Health care	7
Staff	7
Evidence	7
Recommendations from previous report	7
Treatment	8
Torture or cruel, inhuman or degrading treatment or punishment	8
Seclusion	8
Seclusion policy	9
Restraint	9
Restraint training for staff	9
Electro-convulsive therapy	9
Sensory modulation	9
Client and whānau views on treatment	9
Recommendations – treatment	10
Protective measures	10
Complaints process	10
Records	11
Recommendations – protective measures	12

Material conditions	12
Accommodation and sanitary conditions	12
Food	13
Recommendations – material conditions	14
Activities and programmes	14
Outdoor access and leisure activities	14
Outdoor areas	14
Activities	15
Programmes	16
Cultural and spiritual support	16
Recommendations – activities and programmes	17
Communications	17
Access to visitors	17
External communication	18
Recommendations – communications	18
Health care	18
Recommendations – health care	19
Staff	19
Staffing levels and staff retention	19
Recommendations – staff	20
Acknowledgements	20
Appendix 1. List of people who spoke with Inspectors	21
Appendix 2. Legislative framework	22
Tables	
Table 1: List of people who spoke with Inspectors	21
Figures	
Figure 1: Main communal area	13
Figure 2: Occupational Therapy meeting room	13
Figure 3: The largest courtyard	15
Figure 4: The games room	15

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 clients¹ detained in secure units within New Zealand hospitals.

Between 14 and 17 September 2020, four Inspectors² — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an announced four-day inspection of Stanford House, located in the grounds of Whanganui Hospital.

Summary of findings

My findings are:

- There was no evidence that any patient had been subject to torture or cruel, inhuman or degrading treatment or punishment.
- There were no instances of seclusion or restraint between 1 March 2020 and 31 August 2020.
- The sensory modulation room was well signposted, and clients could easily access the room to relax and enjoy time away from the Unit.
- Inspectors saw empathetic, polite and meaningful interactions between staff and clients.
- Whānau felt welcomed and respected by Unit staff.
- The Unit had adopted a co-design approach to care, and encouraged clients and whānau to be involved in decision-making.
- Special Patient Review (SPR) and Multi-Disciplinary Team (MDT) meetings were thorough and client-centric. Clients and whānau were invited to both SPR and MDT meetings.
- The Unit was clean, spacious and homely. Unit management were proactive in maintaining the Unit and its facilities.
- A range of meaningful activities were available to clients, both on and off the Unit.
- The Unit provided strong cultural support to clients.
- Staff encouraged visits for clients.

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

² When the term 'Inspectors' is used, this refers to the inspection team comprising two Inspectors and two Specialist Advisors.

Recommendations

I have no recommendations to make.

Follow up inspections will be made to monitor the treatment of clients.

Good practice

I saw examples of good practice, including that:

- Clients played an active role in SPR and MDT Meetings, supported by staff, volunteers, and whānau.
- Unit staff had developed user-friendly *Rongoā Pānui Medication Cards* to help clients and whānau understand prescribed medication and its side effects.
- Staff were proactively working to improve their understanding of te ao Māori and tikanga Māori.

Feedback

On completion of the inspection, my Inspectors met with Unit staff to outline their initial observations.

A provisional draft of this report was provided to the Manager and Director of Area Mental Health Services for feedback prior to publication.

Facility facts

Stanford House

Stanford House – Extended Term Regional Medium Secure Forensic Service (the Unit) is a 15-bed medium secure³ forensic rehabilitation mental health unit. Its focus is recovery and rehabilitation, providing clients with the opportunity to learn new skills and move towards independence in the wider community.⁴

Admission to the Unit is by referral from Capital and Coast District Health Board's Te Korowai Whāriki – Central Regional Forensic Adult Mental Health Service. Clients are admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) or the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act).

The Unit consists of three wings. Two of the wings have six bedrooms and two bathrooms each, and one wing has three bedrooms and one bathroom. Attached to the Unit is a 'step-down' self-contained one-bedroom flat, with a lounge, kitchenette, and a bathroom.

The Unit is located in the grounds of Whanganui Hospital, Whanganui.

Region

Whanganui

District Health Board

Whanganui District Health Board

Operating capacity

15 (plus a self-contained flat)

³ 'Medium Secure' is a term derived from the *Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients, (the Mason Report)*, August 1988. The Mason Report, at page 115, states that:

'The Medium Secure Unit will offer specialized assessment, treatment and rehabilitation to carefully selected patients who:

- 1. require treatment in varied and adjustable levels of security as identified by each patient's individual needs;*
- 2. will benefit from an intensive and carefully planned programme of care...;*
- 3. are not considered to be an immediate danger to themselves or to the general public should they absent themselves without permission.'*

⁴ See the Healthpoint website at <https://www.healthpoint.co.nz/mental-health-addictions/mental-health-addictions/stanford-house-extended-secure-rehabilitation/> for more information about the Unit.

Previous inspections

Unannounced inspection – July 2017

Unannounced visit – August 2013

Unannounced visit – May 2011

The inspection

Four Inspectors conducted the inspection of the Unit between 14 and 17 September 2020. On the first day of the inspection, there were 16 male clients in the Unit.

At the time of inspection, Whanganui was at COVID-19 Alert Level 2.⁵

Inspection methodology

At the beginning of the inspection, Inspectors met with the Manager and Clinical Nurse Manager. Inspectors were then shown around the Unit.

Inspectors were provided with the following information during the inspection:⁶

- a list of clients and the legal authority for their detention at the time of the inspection;
- seclusion and restraint incident data, and the DHB's seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events;
- client absent without leave (AWOL) events;
- details of all sentinel events;⁷
- complaints received, responses and associated timeframes, and a copy of the complaints policy;
- copies of minutes of client group meetings;
- activities programme;
- information provided to clients and their whānau on admission;
- incident reports relating to medication errors;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number); and
- records of staff mandatory training, including *Safe Practice Effective Communication* (SPEC)⁸ training;

⁵ See <https://covid19.govt.nz/alert-system/covid-19-alert-system/> for more about New Zealand's COVID-19 alert system.

⁶ Unless otherwise noted, data was requested for the period 1 March 2020 to 31 August 2020.

⁷ Sentinel events are unanticipated events in the healthcare setting which have resulted in serious harm to clients.

⁸ SPEC training was designed to support staff working within inpatient mental health units to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication

- 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 clients.⁹

Treatment

- Torture or cruel, inhuman or degrading treatment or punishment
- Seclusion and de-escalation
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Clients' and whānau views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

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

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 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.apr.ch.

Communications

- Access to visitors and external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

Inspectors spoke with a number of managers, staff, clients, and whānau.¹⁰ Inspectors also observed the facilities and conditions, and reviewed client records and other documents.

Recommendations from previous report

The Inspectors followed up on five recommendations made following an inspection to the Unit in 2017.¹¹ These were:

- a. The DHB's complaint process is made available in the Unit.
- b. Review care plan paper work should be completed, and a copy given to the client, in a timely manner.
- c. Windows in the nursing station should be configured to ensure client information is protected and staff have greater observation of the Unit.
- d. Cultural programmes need to be made available to clients in the Unit.
- e. A local 'step down' facility would be beneficial for transitioning clients to the community.

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

¹⁰ For a complete list of people Inspectors spoke with, see Appendix 1.

¹¹ *Report on an announced visit to Stanford House under the Crimes of Torture Act 1989*, August 2017.

Treatment

Torture or cruel, inhuman or degrading treatment or punishment

There was no evidence any client had been subject to torture or cruel, inhuman or degrading treatment or punishment.

Seclusion

The Unit's seclusion facilities consisted of a separate area with three seclusion rooms,¹² one bathroom, and a small courtyard.

No clients had been subject to an episode of seclusion since my 2017 inspection. I note that, at that time, my Inspectors found no clients had been subject to seclusion for six years.

However, I found that the seclusion rooms were used by tāngata whai ora¹³ from Te Awhina – Inpatient Acute Mental Health Service (Te Awhina), also based on the Whanganui Hospital campus, three times in the six months prior to the inspection.¹⁴ Unit staff would assist with nursing care when tāngata whai ora were secluded in the Unit.

The Unit's seclusion facilities were clean and well maintained. However, they were bleak, dark and institutional. The windows were small and placed high on the wall. The windows did not provide adequate natural light, and had no blinds or coverings. The view from the window was of a small storage area, which, at the time of inspection, held bikes and other items in various states of disrepair. There was a clock and calendar for clients to orient themselves, but they was not visible from all three seclusion rooms.

Both Unit staff and clients told Inspectors the use of the Unit's seclusion rooms by Te Awhina was disruptive to the Unit. Inspectors were told programmes and activities were cancelled while Unit staff were occupied in the seclusion area, and that clients could become unsettled while tāngata whai ora from Te Awhina were secluded there.

Overall, I consider that the Unit's seclusion facilities were not fit for purpose and should not have been used to seclude tāngata whai ora. I have made a recommendation to the Te Awhina Unit and the Whanganui DHB¹⁵ that the seclusion area in Stanford House is never used to seclude tāngata whai ora.

¹² Seclusion is defined as: 'Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit'. Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health, Wellington, 2010.

¹³ Te Awhina refer to people in their care as 'tāngata whai ora'.

¹⁴ Discussed in more detail in *Report on an unannounced inspection of Te Awhina Unit, Whanganui Hospital, under the Crimes of Torture Act 1989*, July 2021.

¹⁵ *Report on an unannounced inspection of Te Awhina Unit, Whanganui Hospital, under the Crimes of Torture Act 1989*, July 2021, Recommendation 2.

Seclusion policy

The DHB provided Inspectors with its *Seclusion Policy* (dated 4 September 2020). The Seclusion Policy had a review date of 4 September 2023.

Restraint

There had been no restraint events during the review period.

Inspectors were provided with the DHB's *Restraint Policy* (dated 17 January 2018). The procedure had a review date of 17 January 2021.

Restraint training for staff

Inspectors requested data on the number of staff who were up-to-date with Safe Practice Effective Communication (SPEC) training. All staff were up-to-date with SPEC training.

Electro-convulsive therapy

There were no clients undergoing Electro-convulsive therapy (ECT)¹⁶ in the Unit at the time of the inspection.

Sensory modulation

The Unit had a well-equipped Sensory Modulation¹⁷ room, located off the main communal area. Clients told Inspectors they could easily access the room with staff assistance.

Staff records showed that most staff had completed training in sensory modulation.

Client and whānau views on treatment

Inspectors spoke with most of the clients on the Unit.¹⁸ With clients' consent, Inspectors also spoke with whānau.

¹⁶ 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>

¹⁷ '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.

¹⁸ Two clients were offered the opportunity to speak with Inspectors, and declined.

Clients told Inspectors staff treated them respectfully. They said they felt comfortable and safe in the Unit. Inspectors saw empathetic, polite and meaningful interactions between staff and clients.

Staff were clear with Inspectors on arrival that the Unit was the clients' home, and that it should be treated as such. My Inspectors saw staff practices and interactions with clients which reinforced this principle.

The Unit had adopted a co-design approach to care. This meant clients and whānau would have equal partnership with Unit staff and management in decision-making to improve the overall experience of both clients and staff in the Unit.

Clients had an opportunity to voice any concerns and ask questions about Unit operations in 'Morning Meetings' three times a week. Inspectors attended a meeting, reviewed meeting minutes, and saw clients actively involved in the meetings. Inspectors saw staff acknowledging client feedback and responding to this directly.

Clients and whānau spoke of the Unit's awareness of individual needs and vulnerabilities. Inspectors were told by clients and whānau that staff made an effort to ensure each client felt safe on the Unit, along with appropriately catering for any personal preferences of clients. The Unit proactively communicated any treatment-related decisions to whānau.

Whānau spoke positively of the progress seen in their loved ones, and told Inspectors it reflected the treatment, care, and support provided to clients. Whānau said they felt welcomed and respected by staff.

I am pleased to see such considered treatment of clients and whānau. The Unit was making a noticeable effort to meet its desired model of care by providing clients with a physically and emotionally safe environment, with practices tailored for individual needs.

Recommendations – treatment

I have no recommendations to make.

Protective measures

Complaints process

A copy of the DHB's *Consumer/Patients Complaints Management Policy* (the Complaints Policy), dated 10 June 2018 was provided to Inspectors. The Complaints Policy had a review period of three years.

Posters for the Health and Disability Commissioner's *Code of Health and Disability Services Consumers' Rights* were displayed throughout the Unit. Information on the role and functions of the District Inspector (DI) was also available on the Unit and in clients' induction packs.

Clients told Inspectors they knew who the DI was and how to contact them.

The Unit gave clients information on the DHB's complaints process in induction packs. Complaints forms were also available in the reception area.

Both staff and clients told Inspectors that complaints and issues were quickly resolved on the Unit. Clients told my Inspectors they could raise issues with staff or, if the complaint was serious, to the Clinical Nurse Manager by letter. The Unit also had an 'Ideas Box', in which clients could lodge a complaint or a suggestion for the Unit.

Records

Of the 16 clients on the Unit on the first day of the inspection, three were detained under the MHA. The remaining 13 clients were detained under the CPMIP Act. Inspectors reviewed a sample of client files.

Client files contained up-to-date copies of their detaining paperwork. The Unit completed section 76 reviews (Certificate of Clinical Review of Conditions of Patient Subject to Compulsory Treatment Order) in a timely manner. All files reviewed by Inspectors contained the necessary treatment consent form for each client.¹⁹ Historical Clinical Risk Scale (HCR-20) assessments were also completed in a timely manner.²⁰

Inspectors reviewed clients' recovery plans, leave paperwork, clinical notes, and clinical review meeting minutes. Files were thorough and organised. Clients' whānau contacts were comprehensive and clearly documented on file. As recommended in my 2017 Report, copies of paperwork were given to clients.

The Unit ran formal Multi-Disciplinary Team (MDT) meetings for each client every three months. Clients and whānau were invited to attend their MDT meetings. A range of participants were included in the MDT meetings – for example, the Chaplain and the Peer Support Advocate would attend. I regard this as good practice, and I consider the inclusion of clients in their MDT meetings to be essential to client-centred care.

Inspectors reviewed MDT documentation and found the meetings were well documented. An effective, client-centric, multi-disciplinary approach was apparent.

¹⁹ Despite a compulsory treatment order, section 59 of MHA requires clinicians to make efforts to obtain clients' consent to treatment wherever possible. See *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health. 2020.

²⁰ HCR-20 is an instrument that focuses on historical variables, personality characteristics, and clinical status to predict future risk or future violent behaviour. The HCR-20 is used in correctional and forensic settings. For more information on the HCR-20 see: Ministry of Health *Guidelines for the Role and Function of Specialist Assessors under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003*. Ministry of Health. 2004.

The Unit's process for Special Patient Review (SPR) meetings was balanced and thorough. Prior to each SPR meeting, the Unit invited and assisted clients to prepare a report for the SPR panel to consider. Moreover, whānau and support staff were invited to SPRs. Such staff included the Chaplain, Peer Support Advocate, Assistant Occupational Therapist and Cultural Advisor.

The Unit had a robust feedback system for clients and whānau who declined the invitation to their SPR meeting, with each client's care worker required to provide an account of the meeting. Future responsibilities and delegations were clear to all attendees, and clients and whānau were routinely updated of progress made before, during, and after each SPR meeting.

I am pleased that the Unit has involved clients and whānau with the development of clients' care plans.

In my 2017 Report, I recommended that the Unit configure its nursing station windows so that client information is protected. Management told Inspectors that new blinds had been ordered to protect client privacy. Accordingly, I consider the Unit has made acceptable progress on my recommendation.

Recommendations – protective measures

I have no recommendations to make.

Material conditions

Accommodation and sanitary conditions

The Unit was light, modern and spacious. Inspectors were told that the Unit design was developed in consultation with a number of stakeholder groups, including clients and whānau. Clients' artwork and various projects decorated the Unit's walls. The Unit was clean, tidy and well maintained throughout.

There was a large open communal area with a lounge and dining area. Off the communal area was a kitchen, the sensory modulation room, and the Occupational Therapy area. In the Occupational Therapy area was a kitchen, a workshop, a large meeting room, and a computer area. Clients could use each of these facilities with staff supervision. Additionally, there was a sunroom where clients could relax away from the rest of the Unit. The Unit's furnishings were modern and comfortable.



Figure 1: Main communal area



Figure 2: Occupational Therapy meeting room

Clients had personalised their bedrooms, including the outside of the door to their room. Bedrooms had natural light and ventilation. Rooms were locked while the door was closed, but clients had swipe-card access to their room at all times and could enter and exit their rooms at will. Clients told Inspectors that their bedrooms were a comfortable temperature in both the cooler and warmer months. While only one bedroom had an en-suite, there were sufficient bathrooms available to clients throughout the wings and the Unit. The communal bathrooms were clean and in acceptable condition.

The Unit also had a fully equipped ‘step-down’ flat, which, like the rest of the Unit, was at a high standard.

Linen was available on the Unit and clients could access laundry facilities to wash their own clothes.

I was pleased to see that Unit management were proactive in maintaining the Unit and its facilities. Inspectors saw evidence repairs were carried out in a timely manner. This provided a safe, clean and therapeutic environment for both clients and staff.

Food

The main hospital kitchen delivered clients’ meals to the Unit in heated trolleys. Both the Unit and the hospital catered for clients’ dietary requirements. Clients had breakfast at around 7:30am, lunch around 12:30pm, and dinner was around 5:30pm. The Unit supplied clients a range of snacks, fruit, and yoghurt throughout the day. Inspectors noted that meals were of a sufficient proportion, and were well balanced. Some clients told Inspectors their hospital food was bland.

Once a month the Unit would arrange a ‘special meal’ for clients, such as takeaways or hāngī. The Unit also allowed clients to cook food for themselves or for other clients, such as pikelets, baking, or various fritters. Clients were also able to grow vegetables in a communal vegetable garden, and the vegetables were used as part of clients’ individualised cooking programmes to

supplement meals. Clients with leave off the Unit were taken to the community for meals. Staff and clients also celebrated special events with food, such as birthdays, Puanga²¹ and other holidays.

Information on the importance of a healthy diet was displayed throughout the Unit. Inspectors were told this was part of a wider effort to encourage good health in clients.

Clients spoke positively of the Unit's initiatives. They told Inspectors they appreciated the Unit's efforts to ensure food was enjoyable. This effort, clients said, added to the feeling that the Unit was their home and helped to provide a sense of normalcy.

Clients could make hot and cold drinks throughout the day in the Occupational Therapy Area, independent of staff.

Recommendations – material conditions

I have no recommendations to make.

Activities and programmes

Outdoor access and leisure activities

Outdoor areas

The Unit had three outdoor areas, each one well-maintained and spacious, with a good balance between sun and shade.

The largest courtyard was kept unlocked throughout the day. It was used mainly for exercise and relaxing in the sun. The courtyard had trees, tables, basketball hoops and could also be used for tennis.

The second outdoor had a vegetable garden, a washing line, and a grass patch. There was also a rabbit hutch. Some clients were able to be in the garden by themselves, based on MDT approval.

The third outdoor area had trees, tables and chairs, and plenty of grass. Inspectors were told this area was built by clients, assisted by staff. While the second and the third outdoor areas were kept locked, Inspectors saw that staff would readily unlock the areas for clients' use.

²¹ Puanga is observed by Whanganui iwi in June – July to mark the New Year and celebrate an abundant harvest. See: <https://www.tepapa.govt.nz/discover-collections/read-watch-play/maori/matariki-maori-new-year/what-matariki/difference-between-matariki-puanga>, Museum of New Zealand Te Papa Tongarewa, accessed online 18 August 2020.

Activities

Inspectors saw a wide range of activities available to clients, both on and off the Unit.

The Unit had a games room available to clients. It had a pool table, a table tennis table, a darts board, a well-resourced library, and a television. My Inspectors observed clients playing pool with staff and relaxing in the games room. There was evidence this was a common occurrence.



Figure 3: The largest courtyard



Figure 4: The games room

Clients had a personalised timetable of activities designed to promote social inclusion and personal development. Each client's programme was posted on the inside of their bedroom door and included both group and 1:1 activities. Group activities were displayed throughout the Unit.

The Assistant Occupational Therapist and staff were proactive in facilitating activities. Staff were encouraged by management to apply their creative skills to provide meaningful activities for clients. For example, a staff member spent time working with clients in the small workshop. They would collect broken bicycles from the community, repair them, and then donate the bicycles to community groups. Clients told Inspectors this gave them a sense of purpose and fulfilment. A small welding kit was also brought into the workshop, and some clients were learning to weld. The workshop kept thorough documentation, and each client's access to tools were approved by the MDT.

There were other well-attended group activities on the Unit. Such groups included current affairs discussions, gardening and horticulture, group exercise, cooking, car cleaning, and a music appreciation group.

The Unit additionally facilitated activities off the Unit and in the community. Clients participated in bicycle rides, photography sessions, and fishing trips to the local beach.

Clients told Inspectors the activities allowed them to participate in hobbies, learn new skills, and be part of the community. Because of a recent retirement, the Unit did not have a full-

time equivalent (FTE) Occupational Therapist. Management told Inspectors the Unit was actively recruiting to fill this vacancy.

Inspectors' review of Care Plans indicated clients had appropriate access to leave. Clients told Inspectors they enjoyed the ability to take leave, which included staying with and visiting whānau, van rides, and visiting the local shops. During the course of inspection, a number of clients were on leave – either visiting their family, on day trips, or going for walks outside the Unit.

Inspectors also attended a 'Group Venture' meeting, facilitated by the Peer Support Worker. These meetings featured an educational presentation on topics relevant to clients, followed by group discussion. Topics included medication surveys, mental wellbeing, or developments to the Unit.

Programmes

Therapeutic programmes included both individual and group sessions designed to meet the clinical needs of each client. Sessions focussed on areas such as social skills, relationships, cultural groups, managing stress and regulating emotions. Staff told Inspectors that programmes were facilitated off-site as often as possible to engage clients in the community.

Along with external providers, the Unit's part-time Intern Psychologist (IP) facilitated most of the therapeutic programmes. A key role of the IP was to build positive, healthy relationships with clients who have history of trauma. The IP told Inspectors they based their practice in tikanga Māori and that they were working with staff to improve their understanding of te ao Māori. Both clients and staff spoke of the IP's positive influence on the Unit.

A Peer Support Worker, employed by Balance Aotearoa,²² spent three days a week at the Unit. This role was highly valued by staff and by clients, and Inspectors were told that the connection with Balance opened doors to several off-site programmes for clients with appropriate leave.

Staff told Inspectors that they had struggled to secure some clients external Anger Management counselling and Alcohol and Other Drugs counselling programmes.

Cultural and spiritual support

Cultural support and programmes were readily available on the Unit during my inspection.

The Unit recruited an FTE Cultural Advisor in 2017. The Cultural Advisor hosted Waiata Group, Tai Chi, and Te Reo lessons. The Cultural Advisor worked closely with the IP to help clients connect with whānau. Staff and clients spoke positively of the Cultural Advisor's input in the Unit.

²² Balance Aotearoa provide peer support and advocacy services for people who experience mental illness and/or addiction issues. See <https://balancewhanganui.org.nz/index.php> for more information.

Staff were proactively working to improve their understanding of te ao Māori and tikanga Māori. During the Inspection, for example, some staff were attending cultural training.

The Unit had also employed a Pasifika advisor, who visited the Unit one day a week, as I recommended in my 2017 Report.

Staff and clients spoke of the Unit's emphasis on facilitating clients' cultural involvement. Clients told Inspectors they felt supported and safe to explore their cultural identity in the Unit. Staff and clients celebrated cultural events, such as Puanga, together.

A Chaplain visited several times a week to provide non-denominational services and company for clients in both group and individual sessions. Additionally, the Chaplain would visit individual clients upon request. The Unit provided new clients with information about the chaplain service. Inspectors saw staff valued the input of the Chaplain and shared a productive working relationship.

Both cultural and chaplaincy staff were heavily involved in clients' ongoing care, for example, attending MDT and SPR meetings.

Like whānau and clients, I was pleased with the Unit's effort to provide cultural and spiritual support. It was clear that the Unit was making an active effort to embrace a *'Te Whare Tapa Wha'*²³ model of care. I encourage the Unit to maintain this practice.

Recommendations – activities and programmes

I have no recommendations to make.

Communications

Access to visitors

Staff actively encouraged and facilitated relationships between whānau and clients.

Whānau told Inspectors they felt welcome to visit the Unit as and when they needed, and that staff were accommodating and responsive to visiting requests. Clients said they enjoyed seeing whānau and appreciated the efforts staff made to organise the best possible experience with their loved ones.

Clients and whānau could engage in meaningful activities during visits. The Unit had several dedicated locations where visits could take place.

When possible, staff accompanied clients to visit whānau in their homes.

²³ <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha>

Clients and whānau made it clear to Inspectors that visits were accessible and encouraged by staff.

External communication

Clients had independent access to the telephone, located in a private phone room off the main communal area that was kept unlocked throughout the day. Inspectors observed clients using the phone throughout the inspection. The contact details for the DI and legal services were advertised inside the room. Some clients had access to cell phones, facilitated by staff, which they could use in the phone room. The facility also said clients could use the reception area, as approved by the MDT.

Clients had access to mail. The facility also advised us that, if approved by the MDT, clients could access text messages.

I have no concerns surrounding the Unit's approach to external communication.

Recommendations – communications

I have no recommendations to make.

Health care

A Resident Medical Officer was tasked with screening clients on a three monthly basis due to a lack of a General Practitioner (GP). Inspectors were told that a lack of a GP made it difficult to ensure continuity of care for clients. I note that the DHB was in the process of appointing a GP.

A treatment room was available on the Unit for physical examinations. This room also stored medications, including controlled drugs. The room was tidy and well organised.

A Psychiatrist spent two days a week at the Unit. The Unit was recruiting a Consultant Psychiatrist at the time of inspection.

There was evidence of clients regularly accessing the dentist, optometrists and physiotherapists when needed in a timely manner.

The Unit had developed the *Rongoā Pānui Medication Card* (Medication Card), a tool the Unit was trialling to help clients and whānau understand prescribed medication and side effects. The cards used pictures and accessible language to encourage medical directions.

Each Medication Card was individualised to each client's level and style of understanding and were designed by clients, whānau, and staff. Clients completed a consent form before sharing their medication information with whānau. Medication Cards were placed in clients' files.

The Unit reported positive feedback on its use of Medication Cards from staff, clinicians, whānau and clients. I am pleased to see an innovative and humanising approach to client-centred care. I encourage the Unit to continue this good practice.

There were no medication errors recorded for the period requested. The Unit carried out a monthly medication self-audit and used the reports as a quality assurance tool. Inspectors reviewed a sample of audits and observed them to be thorough and without evidence of medication errors.

The main hospital had a Medication Incident Review Committee, which was tasked with reviewing errors across the DHB. Members of the Committee told Inspectors they audited the Unit on a six-monthly basis and that the Committee had found no problems with the Unit in recent times. Inspectors were told the Unit was proactive in seeking pharmaceutical advice.

However, a Pharmacist was unavailable to the Unit at the time of inspection due to DHB staff pressures. The DHB was, however, in the process of recruiting a Pharmacist with knowledge of mental health medications at the time of inspection.

Recommendations – health care

I have no recommendations to make.

Staff

Staffing levels and staff retention

Data provided by the Unit showed a staff complement of 13 RNs; one Clinical Nurse Manager; 15 Health Care Assistants (HCAs); and one Assistant OT. The Unit also employed one Administration Support Officer and one Enrolled Nurse. The Unit had one vacancy for a FTE OT.

Staff worked a three-shift roster, with a designated staffing level on each shift. The morning shift ran from 7am to 3:30pm with seven staff; the evening shift ran from 3.30pm to 11pm with six staff; and the night shift ran from 11.30pm to 7.15am with three staff. Each shift had a mix of RNs and HCAs.

Data also showed there was little nursing staff turnover for the year 2019/2020, at 0.13 percent.

The majority of staff had worked on the Unit for over five years, with only one RN who had joined the Unit within the last year.²⁴ Inspectors were told that the Unit was seeking to recruit

²⁴ Eleven RNs and 12 HCAs had worked on the Unit for over five years, whereas two RNs and three HCAs had less than five years' experience. There were no RNs or HCAs with less than one year's experience.

more graduate RNs, and that the Unit was mindful that some staff members would soon be reaching retirement age.

Recommendations – staff

I have no recommendations to make.

Acknowledgements

I appreciate the full co-operation extended by the Clinical 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 1: List of people who spoke with Inspectors

Managers	Ward staff	Others
Service Manager	Charge Nurse Manager Associate Charge Nurse Manager Clinical Nurse Specialist Registered Nurses Consultant Psychiatrist Clinical Psychologist Occupational Therapist Social Worker Family/whānau Advisor Mental Health Assistants House Officer Cleaner	Clients District Inspector Family/whānau Cultural Advisor Family Advisor Chaplains 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.