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OPCAT Report

Report on an unannounced inspection of Te Awhina, 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 Te Awhina Unit, Whanganui Hospital 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 tāngata whai ora¹ 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 Te Awhina (the Unit), which is 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.
- The Unit had eliminated the use of Night Safety Orders (NSOs) shortly prior to the inspection.
- Tāngata whai ora and whānau had positive things to say about the Unit.
- Tāngata whai ora were invited to their multi-disciplinary team (MDT) meetings.
- The Unit was generally clean, tidy and well maintained. However, refurbishment of the Unit was completed in late 2012 and the Unit was showing signs of wear and tear.
- All rooms had adequate natural light, with the exception of the de-stimulation or quiet room in Kiwi.
- Courtyards were generally unlocked during the day, with the exception of the courtyard located off the day services area.
- Haumoana Navigators were actively providing cultural support to tāngata whai ora on the Unit during the inspection.
- There were no concerns with tāngata whai ora access to visitors and external communications.
- Staff were generally optimistic about the direction of the Unit and they felt supported by the new management team.

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

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

The issues that need addressing are:

- The de-stimulation room in the Kiwi wing was used as a bedroom during the inspection, despite having no natural light.
- The Unit used the seclusion³ area in Stanford House⁴, which was not fit for purpose and should not have been used to seclude tāngata whai ora from the Unit.
- Seclusion in the six months prior to my inspection had increased significantly compared to the same period before my previous inspection in 2017.
- Two-thirds of tāngata whai ora secluded by the Unit were Māori, totalling almost 90 percent of the Unit's total seclusion hours in the six-month period. Māori made up approximately 46 percent of tāngata whai ora at the Unit over the same period.
- Not all seclusion events were being recorded by the Unit.
- There was evidence that a security guard had been present during a seclusion event and had directly interacted with the tangata whai ora, including verbally directing the tangata whai ora.
- The furnishings in the Sensory Modulation room were tired and uncomfortable. The light was not fully operational and the light fittings had a large a number of dead bugs in them.
- There was no information about the DHB complaints process or complaints forms on the Unit. Tāngata whai ora did not have a clear understanding of the complaints process.
- Duly Authorised Officers (DAO)⁵ did not routinely record their name on the detaining paperwork given to tāngata whai ora.
- Tāngata whai ora could not open and close their blinds without staff assistance, meaning they could not independently control the level of natural light in their own bedrooms.
- A greater degree of privacy was needed for tāngata whai ora residing in the Kererū wing.
- Activities on the Unit were limited and staff told my Inspectors that they were not adequately resourced to implement the activities programme.

³ 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.

⁴ Stanford House is an extended secure rehabilitation regional forensic service located on the grounds of Whanganui hospital. See *Report on an unannounced inspection of Stanford House, Whanganui Hospital, under the Crimes of Torture Act 1989*, July 2021, Wellington.

⁵ A Duly Authorised Officer (DAO) is authorised by the Director of Area Mental Health Services to perform the functions and exercise the powers conferred on the DAO under the Mental Health Act. See: <http://www.legislation.govt.nz/act/public/1992/0046/34.0/DLM262181.html>

- Tāngata whai ora were not receiving timely physical examinations on admission to the Unit.
- The number of medication errors in the six months prior to the inspection was high and remedial action had not addressed the issue.

Recommendations

I recommend that:

1. The de-stimulation room in Kiwi is not used as a bedroom.
2. The Unit never seclude tāngata whai ora in Stanford House.
3. The high and increasing use of seclusion is addressed with a particular focus on equitable treatment of Māori.
4. The Unit ensures that all events which meet the definition of seclusion are recorded as seclusion events.
5. Security guards are never involved in the care of tāngata whai ora.
6. The furnishings and light fittings in the Sensory Modulation Room are replaced or upgraded.
7. The complaints process, including complaint forms, are well advertised and accessible to tāngata whai ora on the Unit and their whānau (**This is an amended repeat recommendation**).
8. Duly Authorised Officers complete detaining paperwork with their name.
9. Tāngata whai ora are able to control the level of natural light in their bedrooms independently of staff.
10. Rooms without external window coverings are not used as bedrooms.
11. The privacy of tāngata whai ora residing in Kererū is improved.
12. Additional resources and supervision are available for programmes and activities on the Unit.
13. Tāngata whai ora receive timely physical examination on admission. If the examination is unable to occur, the reasons why, and a plan for the examination to occur, are documented in the clinical file.
14. The DHB develop and implement a plan to significantly reduce the number of medication errors.

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.

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

Te Awhina

Te Awhina (the Unit) is a 12-bed inpatient acute mental health unit. The Unit treats people *'in the acute phase of their mental illness when they would typically find it hard to deal with at home.'*⁶

Tāngata whai ora are admitted either voluntarily or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

The Unit is a locked facility consisting of four wings:

- Kea - main accommodation
- Kiwi – seclusion area
- Tūi - Intensive Psychiatric Care (IPC)
- Kererū – a self-contained wing generally used for mothers with babies, elderly patients and emergency youth admissions

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

Region

Whanganui

District Health Board

Whanganui District Health Board

Operating capacity

12 (plus one seclusion room)

Previous inspections

Unannounced inspection – July 2017

Unannounced inspection – August 2013

Unannounced inspection – May 2011

⁶ <https://www.wdwb.org.nz/patients-and-visitors/our-departments-and-wards/mental-health-and-addiction/>

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 15 tāngata whai ora on the Unit. Of those, 11 tāngata whai ora were present on the Unit, two were in respite and two were on leave. The average length of stay for the preceding six months was approximately 17 days.

At the time of inspection, Whanganui was at COVID-19 Alert Level 2.⁷

Inspection methodology

At the beginning of the inspection, Inspectors met with the Clinical Nurse Manager (CNM), before being shown around the Unit.

Inspectors were provided with the following information during the inspection:⁸

- a list of tāngata whai ora and the legal authority for their detention at the time of the inspection;
- seclusion and restraint incident data, and the seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events;
- tāngata whai ora absent without leave (AWOL) events;
- details of all sentinel events;⁹
- information provided to tāngata whai ora and their whānau on admission;
- complaints received, a sample of responses and associated timeframes, and a copy of the complaints policy;
- activities programme;
- 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);

⁷ See <https://covid19.govt.nz/alert-system/covid-19-alert-system/> for more about New Zealand's COVID-19 alert system.

⁸ Unless otherwise noted, data was requested for the period 1 March 2020 to 31 August 2020.

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

- records of staff mandatory training, including Safe Practice Effective Communication (SPEC)¹⁰ training; 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 tāngata whai ora.¹¹

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
- Tāngata whai ora 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

¹⁰ SPEC training was designed to support staff working within inpatient mental health units to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. <https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149>

¹¹ 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.ap.t.ch.

- Programmes
- Cultural and spiritual support

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, tāngata whai ora and whānau.¹² Inspectors also observed the facilities and conditions, and reviewed tāngata whai ora records and other documents.

Recommendations from previous report

My Inspectors followed up on four recommendations made following an inspection to the Unit in 2017.¹³ These were:

- a. Client bedrooms should have natural light.
- b. Where clients are locked in their room, this is recorded as a use of force event on the restraint register in accordance with the December 2016 draft Ministry of Health night safety procedure guidelines.
- c. The DHB's internal complaints process is readily available in all areas of the Unit.
- d. The client telephone is replaced as a matter of urgency.

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

¹² For a list of people spoken with by the Inspectors, see Appendix 1.

¹³ *Report on an unannounced visit to Te Awhina Unit (Whanganui District Health Board) Under the Crimes of Torture Act 1989, August 2017.*

Treatment

Torture or cruel, inhuman or degrading treatment or punishment

There was no evidence that any tāngata whai ora had been subject to torture or cruel, inhuman or degrading treatment or punishment.

Seclusion

Seclusion facilities

The seclusion and de-escalation area comprised of a bedroom, bathroom, lounge, 'quiet room' and courtyard.

The seclusion room was basic, with a mattress on the floor and a small window set high up on the wall. There was a call bell in the seclusion room and bathroom. There was adequate natural light in the seclusion room and de-escalation lounge, however none of the windows had window coverings. Tāngata whai ora could access fresh air in the courtyard which was accessible from the de-escalation lounge. The de-escalation area also had comfortable furnishings. There was a clock visible from the seclusion room, to allow tāngata whai ora to orient themselves to date and time. The seclusion facilities in the Unit were clean and well maintained.

The seclusion room had an en-suite toilet and shower, which tāngata whai ora could use in private. The en-suite could be locked to prevent its use, if required based on individual risk assessment.

The seclusion area had a de-stimulation room, also called the 'quiet room', which was a small internal room with no windows. In my 2017 inspection I recommended that this room was not used as a bedroom. My Inspectors were told by staff that this room was no longer used as a bedroom. However, I found that the de-stimulation room was used as a bedroom for a night during the inspection. I remain of the view that the de-stimulation room is inappropriate to be used as a bedroom.

Stanford House seclusion facilities

The Unit also used the seclusion facilities at Stanford House – Extended Secure Rehabilitation Regional Forensic Service (Stanford House), also based on the Whanganui Hospital campus. The Stanford House seclusion facilities consisted of a separate area with three seclusion rooms,¹⁴ one bathroom, and a small courtyard.

¹⁴ 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.

I found that the seclusion rooms in Stanford House were used by the Unit three times in the six months prior to the inspection. Stanford House staff would assist with nursing care when tāngata whai ora were secluded in their seclusion facilities.

The Stanford House 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 mechanism to allow tāngata whai ora to orient themselves to time and date, but it was not visible from all three seclusion rooms.

Staff would facilitate access to the shared bathroom depending on individual risk assessment. Cardboard receptacles for toileting purposes were also provided in each seclusion room. Inspectors noted that tāngata whai ora using these receptacles would be visible through windows in each seclusion room door. I note that a lack of privacy while toileting has the potential to amount to degrading treatment and a breach of Article 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Overall, I consider that the seclusion area at Stanford House was not fit for purpose and should not have been used to seclude tāngata whai ora.



Figure 1: Seclusion room in Te Awhina



Figure 2: Seclusion room in Stanford House

Seclusion policies and events

A copy of the DHB's *Seclusion Policy* (dated 4 September 2020) was provided to Inspectors. The policy had a review date of 4 September 2023.

Data provided by the Unit indicated that between 1 March and 31 August 2020 there were 10 seclusion events involving six tāngata whai ora. The total seclusion time for the six-month period was 315 hours and 45 minutes. This is broken down as follows:

Table 1: Seclusion events 1 March – 31 August 2020¹⁵

Month	Events	Tāngata whai ora numbers	Hours	Average hours
March	1	1	21 hours and 10 minutes	21 hours and 10 minutes
April	1	1	30 hours and 50 minutes	30 hours and 50 minutes
May	0	0	N/A	N/A
June	4	3	101 hours and 35 minutes	25 hours and 20 minutes
July	0	0	N/A	N/A
August	4	2	162 hours and 10 minutes	40 hours and 35 minutes
Total:	10	6¹⁶	315 hours and 45 minutes	31 hours and 34 minutes

In 2017, the number of seclusion events and hours in a six-month period was significantly lower.¹⁷ While I acknowledge that rates of seclusion can be affected by a variety of factors, I am concerned that the use of seclusion had increased since my last inspection.

I am also concerned that the data indicated disproportionate seclusion of Māori by the Unit. Two-thirds of tāngata whai ora secluded were Māori, with their time in seclusion constituting almost 90 percent of the Unit's total seclusion hours in the six-month period reviewed.¹⁸ By contrast, the proportion of Māori tāngata whai ora in the Unit varied from between approximately 36 percent in March 2020 to approximately 60 percent at the time of the inspection.¹⁹

¹⁵ Data as provided by the Unit. The total events, tāngata whai ora numbers, hours and average hours calculated by Inspectors.

¹⁶ The total does not tally as one tangata whai ora was secluded in two different months (June and August).

¹⁷ From 1 January to 30 June 2017 there had been five seclusion events totalling just over 190 hours.

¹⁸ The total seclusion hours for Māori tāngata whai ora was 275 hours and 25 minutes.

¹⁹ Based on information provided by the Unit, the approximate proportion of tāngata whai ora who identified as Māori in the Unit was 36 percent in March 2020, 38 percent in April 2020, 32.5 percent in May 2020, 40.5 percent in June, 42 percent in July 2020 and 53 percent in August 2020.

I acknowledge that a sample size of 10 seclusion events means that the acuity and risk of one or two tāngata whai ora can have a sizeable impact on the data. Nevertheless, to ensure humane and equitable treatment of Māori, and to act consistently with the principles of te Tiriti o Waitangi,²⁰ it is necessary to recognise and remedy the disproportionality as a matter of urgency.

I consider that additional action is required to reduce and eliminate the use of seclusion in the Unit, with a particular focus on equitable treatment of Māori.

Seclusion recording and paperwork

Not all seclusion events were being recorded by the Unit. My Inspectors witnessed an event during the inspection that met the definition of seclusion but was not recorded as such. My Inspectors saw a tāngata whai ora, who had been admitted the previous day, was left alone by staff in the seclusion area. The tāngata whai ora was unable to freely exit the seclusion area.

Staff told my Inspectors that the event was not being recorded as seclusion. Staff also indicated that there had been other occasions where tāngata whai ora were locked in part of the Unit on their own and this had not been recorded as seclusion.

Staff told my Inspectors that the tangata whai ora had two nurses assigned to their treatment, and that staff had been present with them for much of their admission process. However, staff said that the tangata whai ora did not want staff with them in the seclusion area and they were concerned about the risk posed by the tangata whai ora if they remained.

I acknowledge that there were safety concerns for the staff at the time of this event. However, the event clearly met the definition of seclusion and should have been recorded as such.

Night safety orders (NSOs) had also been used prior to the inspection which had the effect of secluding tāngata whai ora overnight, but these events had not been recorded as seclusion events. The Unit is taking steps to address this, as discussed below.

The Unit provided seclusion documentation for the 10 seclusion events in the six months prior to the inspection.

Seclusion paperwork was routinely completed in a timely fashion. However, there was little evidence of de-escalation attempts in the paperwork, including the use or consideration of alternatives to seclusion. The regular seclusion reviews were often light on detail and did not evidence the need for tāngata whai ora to remain in seclusion. It did not appear that tāngata whai ora secluded overnight were robustly assessed to determine whether they could exit seclusion. In some cases, seclusion paperwork indicated that tāngata whai ora were calm and settled for hours prior to their release from seclusion.

²⁰ Specifically the principles of active protection and equity. These principles include that the Crown be fully informed of how Māori are treated and make available services that reasonably and adequately attempt to address inequitable health outcomes. See, for example, Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wellington, Legislation Direct, 2019) pp 27 – 35 and 138.

Security guard involvement in seclusion events

I was concerned to hear about the involvement of a security guard in one seclusion event. Staff told my Inspectors that the Unit had occasionally used security guards to help staff feel safe when staffing levels were low and when there were highly acute tāngata whai ora in the Unit. Staff assured my Inspectors that security guards did not have an active role in seclusion or restraint. However, the seclusion paperwork clearly indicated that a security guard had been present during a seclusion event and had directly interacted with the tāngata whai ora, including verbally directing the tāngata whai ora.

I understand that the Unit had decided to stop using security guards on the Unit entirely. However, I am seriously concerned that a security guard had been involved in a seclusion event. I am also concerned that staff did not appear to be aware that security guards had been more directly involved in seclusion than intended. Tāngata whai ora in seclusion are highly vulnerable. Where seclusion is necessary, only appropriately trained staff should interact with tāngata whai ora.

Night Safety Orders

In my previous report, I raised concerns about the use of Night Safety Orders (NSOs) on the Unit. Specifically, I recommended that where tāngata whai ora were locked in their room, this is recorded as a use of force event on the restraint register.

The Unit had not recorded NSOs as either restraint or seclusion. My previous recommendation had therefore not been implemented.

Data provided by the Unit indicated that between 1 March and 31 August 2020 there were 68 NSO episodes involving 10 tāngata whai ora.

Table 2: Night Safety Order episodes 1 March – 31 August 2020²¹

Month	Episodes (nights)	Tāngata whai ora numbers	Hours	Average hours
March	28	5	201 hours and 40 minutes	7.5 hours
April	14	4	104 hours and 5 minutes	8 hours
May	12	3	98 hours	8 hours
June	14	3	125 hours	9 hours
July	0	0	N/A	N/A

²¹ Data as provided by the Unit. The total events, tāngata whai ora numbers, hours and average hours calculated by Inspectors.

August	0	0	N/A	N/A
Total:	68	10²²	528 hours and 45 minutes	7.8 hours

My Inspectors reviewed a sample of NSO paperwork. The quality of NSO paperwork was inconsistent. In particular, the rationale for imposing NSOs was brief or, in some cases, non-existent. There were also examples of NSOs being imposed “to promote sleep”. In my view, promoting sleep is an insufficient justification to seclude tāngata whai ora by way of an NSO.

I was pleased that the Unit had eliminated the use of NSOs shortly prior to the inspection. Staff told my Inspectors that they would instead follow seclusion procedures, where such an action was justified, and record seclusion accordingly.

Staff acknowledged that there had been difficulties transitioning from the use of NSOs. Staff told my Inspectors that a tangata whai ora had been locked in their bedroom overnight, without observation and not under seclusion protocols, in the week prior to the inspection. My Inspectors were told that this event had also not been recorded as seclusion, despite meeting the definition.

Overall seclusion use for the Unit

Overall recorded seclusion hours²³ for the period 1 March to 31 August 2020 was 844 hours and 30 minutes. This represents an approximately 60 percent increase from the six-month period preceding my inspection in 2017.²⁴

I do not have full confidence that the data accurately reflected the seclusion levels in the Unit. As I have noted above, there were at least two events which met the definition of seclusion but had not been recorded as such. However, the data available is sufficient to identify the issues I have noted above.

Restraint

The Unit provided a copy of the DHB’s *Restraint Policy* (dated 17 January 2018) and *Restraint Procedure* (dated 18 October 2019).

Data provided by the Unit indicated that between 1 March and 31 August 2020 there were 17 episodes of restraint. This is broken down as follows:

²² The total does not tally some tangata whai ora were secluded in more than one month.

²³ Recorded seclusion events and NSO episodes.

²⁴ Overall seclusion hours for the period 1 January to 30 June 2017 was just over 513 hours.

Table 3: Restraint data (exclusive of seclusion data) 1 March – 31 August 2020²⁵

	March	April	May	June	July	August
Total restraint episodes	4	3	2	1	3	4
Total tāngata whai ora restrained	2	3	2	1	3	3
Personal restraint ²⁶	2	2	0	0	0	0
Medication administration	2	0	2	0	1	0
Police restraint	0	1	0	1	1	0
Number of males restrained (Māori)	2	1	0	1	1	1
Number of males restrained (non-Māori)	0	0	0	0	1	1
Number of females restrained (Māori)	0	1	0	0	0	1
Number of females restraint (non-Māori)	0	1	2	0	1	0
Youngest person restrained (years)	37	23	36	22	21	21
Oldest person restrained (years)	57	37	65	22	58	68

On the face of the data, I do not have any concerns with the level of restraint on the Unit. However, as with seclusion paperwork, it was not possible for my Inspectors to review restraint paperwork for all restraint events because it was kept on individual files rather than centrally. Following the inspection, my Inspectors requested and were provided with restraint paperwork completed under section 122B of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA). This paperwork did not clearly align with the data. For example, the Unit provided paperwork for 12 restraint events, not for the total of 17 events in the six-month period. There appeared to be some confusion as to when reporting under section 122B was required and what other reporting on restraint events was available or might be required.

²⁵ Data as reported by the Unit.

²⁶ Personal restraint is when a service provider(s) uses their own body to limit a service user's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

I consider that it is essential to have clear and accessible reporting on all restraint events. Regardless of the precise reporting mechanism, it should be simple to source relevant paperwork and reporting on all restraint events recorded in the register. I expect the Unit to improve its systems in this respect.

Restraint training for staff

At the time of the inspection, all staff were up-to-date with their *'Safe Practice and Effective Communication'* (SPEC) training.²⁷

Electro-convulsive therapy

There were no tāngata whai ora undergoing Electro-convulsive therapy (ECT) in the Unit at the time of the inspection.

Sensory modulation

In my previous report, I noted that the Unit had two dedicated Sensory Modulation Rooms.²⁸ One of the Sensory Modulation Rooms had been decommissioned since 2017.

The remaining Sensory Modulation Room was reasonably well-equipped with items such as a massage chair, rocking chair, weighted blankets and other sensory items. However, the room was small, the furnishings were tired and some tāngata whai ora said that the furnishings were uncomfortable. My Inspectors also noted that the light was not fully operational²⁹ and that the light fittings had a large a number of dead bugs in them.

The sensory modulation room was locked, and staff supervised tāngata whai ora when using it.

Tāngata whai ora and whānau views on treatment

Tāngata whai ora had varying experiences in the Unit. Tāngata whai ora told my Inspectors that there were several good things about the Unit, including that:

- they had positive relationships with staff;
- rooms were clean, tidy, and kept at a comfortable temperature; and
- the Unit was generally calm with low levels of violence.

²⁷ SPEC training was designed to support staff working within inpatient mental health units to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. <https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149>

²⁸ *'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 clients to regain a sense of calm'*. Te Pou o te Whakaaro Nui. *Sensory modulation in inpatient mental health: A summary of the evidence*. (2011), Te Pou o Te Whakaaro Nui, Auckland, at page 3.

²⁹ The light could be turned off and on, but could not be dimmed, brightened or colour-adjusted.

However, tāngata whai ora also had concerns about the Unit. For example, tāngata whai ora said that they felt restricted, that there were not enough activities on the Unit and that they did not know how to make complaints.

Whānau told my Inspectors that they were generally impressed with the Unit. Whānau were positive about the staff and the treatment that tāngata whai ora received. However, whānau raised some concerns about seclusion practices and a Pākehā-centric model of care in the Unit.

Recommendations – treatment

I recommend that:

1. The de-stimulation room in Kiwi is not used as a bedroom.
2. The Unit never secludes tāngata whai ora in Stanford House.
3. The high and increasing use of seclusion is addressed with a particular focus on equitable treatment of Māori.
4. The Unit ensures that all events which meet the definition of seclusion are recorded as seclusion events.
5. Security guards are never involved in the care of tāngata whai ora.
6. The furnishings and light fittings in the Sensory Modulation Room are replaced or upgraded.

Te Awhina comments

The Unit accepted recommendations 3 to 6.

The Unit partially accepted recommendations 1 and 2.

Recommendation 1 response:

Accept with reservations. During my tenure (7/9/20 to the present) I have experience of four tangata whai ora asking specifically to use the room, commenting variously that 'it feels like my own little cave' 'I like the dark, the other rooms are too bright' 'I like being close to the staffroom' 'it's very private and very quiet'. In principle the lack of natural light is the rationale. I am proposing a dimmable Solatube be installed to achieve both affordable and achievable alterations and the option of natural light or dimming at the Tangata whai ora's choice.

Ombudsman response:

I welcome the Unit's efforts to engage with tāngata whai ora and cater to their preferences. I also encourage the Unit in its goal to make alterations to the de-stimulation room to allow for

natural light and for tāngata whai ora to be able to tailor this to their preferences. I will assess the impact of these alterations on future inspections.

Recommendation 2 response:

Accept with reservations. Historically Stanford House have provided a capacity of over-flow seclusion bed or beds – Te Awhina has not secluded any tangata whai ora for many months (nil this quarter) and our IPC and restraint use is tracking steadily lower however I cannot guarantee that this will always be the circumstance.

Ombudsman response:

I am pleased that the Unit reports progress in reducing the use of seclusion since my inspection. I acknowledge also that over-occupancy had been a contributing factor to the use of Stanford House as a seclusion area. However, I emphasise my view that the Stanford House seclusion facilities are not fit for purpose and should not be used to seclude tāngata whai ora. I encourage the Unit, as part of its ongoing efforts to reduce seclusion, to think of other, more therapeutic, alternative arrangements in the event of future over-flow.

Protective measures

Complaints process

A copy of the DHB's *Consumer/Patient Complaints & Compliments Management Policy* (the *Complaints Policy*) (dated May 2018) was provided to Inspectors. The policy had a review period of 36 months.

There was no information about the DHB complaints process on display on the Unit. Complaint forms were also not available on the Unit. Tāngata whai ora did not have a clear understanding of the complaints process.

Information provided by the Unit showed that one complaint had been made between 1 March and 31 August 2020. The DHB also provided Inspectors with a copy of a complaint from February 2020. Staff met with tāngata whai ora to discuss the issue and both complaints were closed within the timeframes required by the *Complaints Policy*. However, the tāngata whai ora did not receive a written response to their complaint, which was required under the *Complaints Policy*.

Up-to-date contact details for District Inspectors (DIs) were visible in the Unit. Posters for the Health and Disability Commissioner's '*Code of Rights*' and information on advocacy services were also displayed on the Unit.

Records

Of the 15 tāngata whai ora on the Unit on the first day of the inspection, eight were detained under the MHA. All files had the necessary paperwork for tāngata whai ora to be detained and treated on the Unit.

Voluntary tāngata whai ora

Five tāngata whai ora had voluntary status. Two tāngata whai ora were recorded as voluntary admissions under section 29(3) of the MHA. However, section 29(3) is a compulsory direction.

Section 29 concerns tāngata whai ora subject to a community treatment order. Specifically, section 29(3) provides that:

(3) If, at any time during the currency of the community treatment order, the responsible clinician considers that the patient cannot continue to be treated adequately as an outpatient, the responsible clinician may direct that the patient—

(a) be treated as an inpatient for a period of up to 14 days; or

(b) be re-assessed in accordance with sections 13 and 14.

A direction under section 29(3)(a) may not be made for the same tangata whai ora more than twice in six months.³⁰ Once a direction under section 29(3) is made, the responsible clinician must also notify a range of people including any welfare guardian, principal caregiver and primary health provider for the tangata whai ora.³¹

No such direction appeared to have been made. Instead, the Unit had sought and recorded the informed consent of the two tāngata whai ora subject to community treatment orders to be admitted to the Unit voluntarily. In one instance, the community treatment order and the voluntary admission to the Unit were recorded as occurring on the same day.

In my view, this situation created uncertainty about the legal status of the tāngata whai ora. They were simultaneously subject to a compulsory order, albeit to be treated in the community, while also being voluntarily admitted to a secure Unit. I note that this practise also had the potential to bypass the limitations and safeguards in the MHA that are triggered by making a direction under section 29(3). Indeed, staff told my Inspectors that this practice was in part to avoid exceeding two section 29(3)(a) admissions within the six-month period.

While I do not make any findings in respect of this practise at this stage, I intend to follow up on this issue.

Duly Authorised Officers

I was concerned by the practice of the Duly Authorised Officers (DAO) not routinely recording their name on the detaining paperwork given to tāngata whai ora. My Inspectors saw examples of paperwork being completed with a DAO number and a signature, but no name was clearly recorded. In my view, this practise does not promote transparency and accountability.

Multi-disciplinary team meetings

Tāngata whai ora were invited to their multi-disciplinary team (MDT) meetings. My Inspectors observed an MDT where whānau also attended. The MDT began and closed with karakia and included thorough consideration of the tāngata whai ora cultural needs. Staff explained that not all MDTs ran that way but that the Unit wanted to ensure that a more tāngata whai ora-centric MDT became standard practise.

³⁰ Section 29(5).

³¹ Section 29(6).

Recommendations – protective measures

I recommend that:

7. The complaints process, including complaint forms, is well advertised and accessible to tāngata whai ora on the Unit and their whānau **(This is an amended repeat recommendation)**.
8. Duly Authorised Officers complete detaining paperwork with their name.

Te Awhina comments

The Unit accepted recommendations 7 and 8.

Material conditions

Accommodation and sanitary conditions

The Unit was generally clean, tidy and well maintained. However, refurbishment of the Unit was completed in late 2012 and the Unit was showing signs of wear and tear.

The main wing of the Unit had a flexible configuration. Kea contained eight bedrooms and a small self-contained area. Kererū could be open or closed to Kea and could contain one or two bedrooms. Tūi, the IPC, contained two bedrooms. There was one seclusion room in Kiwi.

All bedrooms were single occupancy and of an adequate size. Kea had two shared bathrooms with toilets and showers, one of which also had a bath. Three bedrooms in Kea had en-suite facilities, as did the two bedrooms in Tūi. There was a bathroom in Kererū. I consider there was sufficient access to bathrooms. My Inspectors noted, however, that ventilation was limited and that the shared bathrooms in Kea caused an unpleasant smell throughout the wing after use.

One room in Kea was accessible for tāngata whai ora with mobility issues and contained an accessible bathroom and hospital bed.

There were no separate areas on the Unit for male and female tāngata whai ora. Staff told my Inspectors that Kererū and Tūi could be used for vulnerable tāngata whai ora.

All rooms had adequate natural light, with the exception of the de-stimulation room in Kiwi (as described in my previous section on seclusion). Bedroom windows also had blinds for privacy.

I was concerned that tāngata whai ora could not open and close their blinds without staff assistance, meaning they could not independently control the level of natural light in their own bedroom. There was also a lounge in Tūi which was not designated as a bedroom but which staff told my inspectors was regularly used as a bedroom when the Unit was over-occupancy. As with the seclusion room, the lounge did not have any external window coverings. In my view, the lack of external window coverings meant the lounge in Tūi was unsuitable for use as a bedroom.

The windows separating Kererū and the Kea wing were tinted and afforded some level of privacy to tāngata whai ora residing there. However, my Inspectors noted that tāngata whai ora were still clearly visible from the Kea wing. During the inspection, Inspectors observed a tāngata whai ora in a state of undress in the Kererū lounge from the Kea corridor. I consider that a greater degree of privacy was needed, particularly given that vulnerable tāngata whai ora, including mothers and babies and the elderly, were usually accommodated there.

Tāngata whai ora had access to several communal areas, including the main lounge and the day services area. The lounge and day services area were light, relaxed and welcoming. However, furnishings and carpets in communal areas were worn and stained.

Laundry facilities were available and tāngata whai ora were supported to wash their own clothing. Staff facilitated access to the laundry facilities.



Figure 3: Kea communal lounge



Figure 4: Kererū lounge

Food

Tāngata whai ora were able to choose their own meals from the hospital menu. The menu catered to a range of dietary requirements and preferences. Meals were served at appropriate hours. Tāngata whai ora did not tell my Inspectors that they had concerns with the quality or quantity of the food.

There were open dining areas in the Unit where tāngata whai ora could have their meals. The kitchens in Kea and Kererū were not locked and tāngata whai ora could freely access drinking water, hot drinks and snacks during the day independently of staff. Tāngata whai ora in Kiwi and Tūi relied on staff to facilitate access to hot drinks and snacks, unless these areas were unlocked.

Recommendations – material conditions

I recommend that:

9. Tāngata whai ora are able to control the level of natural light in their bedrooms independently of staff.
10. Rooms without external window coverings are not used as bedrooms.
11. The privacy of tāngata whai ora residing in Kererū is improved.

Te Awhina comments

The Unit accepted recommendations 10 and 11.

The Unit partially accepted recommendation 9.

Recommendation 9 response:

Accept with reservation. The double-glazed nature of the design requires a specific tool is used to vary the angle of the captive venetian blind. The risk inherent in [this] and the engineering involved in replacement confounds simple achievement. A routine is being established each waking shift to offer this support to each tangata whai ora.

Ombudsman response:

I acknowledge that the design of bedroom windows may limit what options are available in the short term to achieve my recommendation. I also welcome the short term measure to try and implement my recommendation. However, I remain of the view that tāngata whai ora should be able to control the level of natural light in their bedrooms independently of staff. While the proposed measure may assist tāngata whai ora for now, it does not appear to achieve the intent of my recommendation. I encourage the Unit to consider further practical ways of mitigating the risks identified by the Unit while also ensuring tāngata whai ora have independent control of natural light.

Activities and programmes

Outdoor exercise and leisure activities

The Unit had several courtyards located off the individual wings where tāngata whai ora could access fresh air. The courtyards were generally unlocked during the day, with the exception of the courtyard located off the day services area.

Access to the day services courtyard was facilitated by staff to mitigate the risk of tāngata whai ora absconding over the relatively low fence. My Inspectors noted that the day services courtyard was the most welcoming outside space for tāngata whai ora. The other courtyards, which were smaller, darker and lacked furnishings, were unwelcoming. My Inspectors did not see tāngata whai ora using the smaller courtyards during the inspection, despite them being unlocked.

There was also a gym, an Occupational Therapist (OT) kitchen and a quiet room located off the day services room. Tāngata whai ora were supervised when using the gym.

Programmes

The Unit had one full-time OT who was responsible for a programme of daily activities. Activities for tāngata whai ora included a morning walk and sessions on sleeping well, healthy eating, and mindfulness.

However, my Inspectors noted that the provision of activities was limited. Staff told my Inspectors that the OT was not adequately resourced with enough staff to implement the programme. Staff also said that the OT was effectively left to supervise tāngata whai ora in the day services room, rather than having time to plan and deliver structured programmes. Tāngata whai ora and staff told my Inspectors that there were not enough activities and programmes on the Unit.

The Unit did not employ a Clinical Psychologist to conduct one-on-one work with service users.

Cultural and spiritual support

Whanganui Hospital has Haumoana Navigators who support tāngata whai ora, whānau and staff. The Haumoana Navigators were not based on the Unit but were available when needed. My Inspectors saw that Haumoana Navigators had an active presence on the Unit throughout the week. During the inspection, a Haumoana Navigator arrived to support a new admission within 10 minutes of being requested by staff.

Recommendations – activities and programmes

I recommend that:

12. Additional resources and supervision are available for programmes and activities on the Unit.

Te Awhina comments

The Unit accepted recommendation 12.

Communications

Access to visitors and external communication

The Unit visiting hours were 3.30pm to 6pm from Monday to Friday and 9am to 6pm in the weekend and on public holidays.

Inspectors observed whānau visiting tāngata whai ora during the course of the inspection. There were a number of rooms which could be used for visits depending on the needs of the tāngata whai ora and visitors.

There was one corded telephone available in a small telephone booth. I was pleased to note that the corded telephone was now in the booth, following my 2017 recommendation. A portable phone was available on request for tāngata whai ora to use and a number of tāngata whai ora had their cell phones.

I have no concerns with tāngata whai ora access to visitors and external communications.

Recommendations – communications

I have no recommendations to make.

Health care

Primary health care services

Tāngata whai ora generally received a physical assessment following their admission. However, I found that physical assessments did not appear to be consistently happening in a timely manner. My Inspectors saw evidence in some files of tāngata whai ora declining the assessment, but records were inconsistent. In some cases, there was no evidence of physical assessment being considered for several days after admission, or following an initial refusal by tāngata whai ora.

There was a treatment room and a separate medication room on the Unit. These rooms were well-equipped, tidy and well organised.

I was seriously concerned to see that there were 23 reported medication errors between 1 March and 31 August 2020. My Inspectors reviewed the incident report for each medication error with staff. There was a clear pattern of documentation errors, which often led to missed medication or, in some cases, medication overdoses. Incident reports from as early as May indicated that the Unit had identified there was a systemic problem with medication errors. However, details on the preventive actions taken were limited and the same errors were repeated in the following months.

Records showed that one preventative action following review of a medication error was to keep all medication charts in the medication room. My Inspectors observed during the

inspection that medication charts were left lying around in the nursing station. One medication chart also went missing during the inspection.

I acknowledge that staff were aware of the issue and appeared to be taking their obligation to report medication errors seriously. I also recognise that, where adverse health consequences had occurred, the Unit had taken robust action.

However, the volume of medication errors was high. The Unit had failed to adequately address the issue at the time of the inspection. I consider that urgent action is required to reduce the occurrence of medication errors in the Unit. As the Health and Disability Commissioner notes: *'when medication errors do occur they have the potential to cause significant harm'*.³²

Recommendations – health care

I recommend that:

13. Tāngata whai ora receive timely physical examination on admission. If the examination is unable to occur the reasons why, and a plan for the examination to occur, are documented in the clinical file.
14. The DHB develop and implement a plan to significantly reduce the number of medication errors.

Te Awhina comments

The Unit accepted recommendations 13 and 14.

³² The Health and Disability Commissioner. 2018. *Complaints Closed by the Health and Disability Commissioner and Medication Errors: Analysis and Report 2009-2016*.

Staff

Staffing levels and staff retention

The Unit had a vacancy for 1 FTE Registered Nurse (RN) at the time of the inspection due to maternity cover.

Nursing staff and Health Care Assistants (HCAs) worked a three-shift roster, with a designated staffing level on each shift. The morning shift was from 7am to 3.30 pm with five RNs and one HCA³³, afternoon shift was from 2.30pm to 11.00pm with five RNs and one HCA, and night shift was from 10.45pm to 7.15am with two RNs and one HCA.

Data provided by the Unit showed an average turnover for RNs of 5.7 percent for the previous three financial years. Average turnover of HCAs in the same period was 4.6 percent.

There was a good mix of age, experience and ethnicity among staff.

My Inspectors saw that some nursing staff and HCAs wore uniforms and all Unit staff had identification badges, making them identifiable to tāngata whai ora and visitors.

Staff told my Inspectors that morale on the Unit had been poor since my last inspection. A new Clinical Nurse Manager had been appointed and was in their second week at the Unit at the time of inspection. Staff were positive about the new leadership of the Unit. My Inspectors observed that staff were generally optimistic about the direction of the Unit and that they felt supported by the new management team.

Recommendations – staff

I have no recommendations to make.

³³ For Monday, Tuesday, Saturday and Sunday. On Wednesday, Thursday and Friday there were six RNs rostered to the morning shift.

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 4: List of people who spoke with Inspectors

Managers	Ward staff	Others
Associate Director of Nursing	Charge Nurse Manager Registered Nurses Enrolled Nurses Consultant Psychiatrist Occupational Therapist Family/whānau Advisor Mental Health Assistants House Officer	Tāngata whai ora District Inspector Family/whānau Chaplains

Appendix 2. Legislative framework

In 2007 the New Zealand Government ratified the *United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – health and disability facilities

Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

(d) a hospital

(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM’s functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - for improving the conditions of detention applying to detainees;
 - for improving the treatment of detainees; and
 - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and
- choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on his behalf.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read his reports online: ombudsman.parliament.nz/opcat.