Ombudsman

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OPCAT Report

Report on an unannounced inspection of the Kensington Centre Mental Health Inpatient Unit, Timaru, under the Crimes of Torture Act 1989

August 2020

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an unannounced inspection of the Kensington Centre Mental Health Inpatient Unit, Timaru, under the Crimes of Torture Act 1989

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Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions and treatment of people[1] detained in secure units within New Zealand hospitals.

Between 7 and 9 October 2019, Inspectors[2]— whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of the Kensington Inpatient Mental Health Unit (the Unit), Timaru.

Summary of findings

My findings are:

- There was no evidence that any clients had been subject to torture or other cruel, inhuman or degrading treatment or punishment.
- Clients felt safe on the Unit.
- Files contained all the necessary legal paperwork to detain and treat clients on the Unit.
- Seclusion area upgrades had resulted in an improved environment for clients.
- Unit leave for clients was encouraged and well utilised.
- Whānau felt included in clients' care.
- The complaints process was visible on the Unit.
- Accommodation was clean and tidy. Clients had their own bedrooms, which they could lock from the inside.
- The Unit's kitchen and comfort room[3] were open for clients' use through the day.
- Food and drinks were available to clients at any time.
- Support for whānau was comprehensive.
- Activities for clients were available on the Unit. Staff adapted activities to suit the client group.

[1] The term client is used to describe people receiving treatment in Kensington Inpatient Mental Health Unit, as this is the term the Unit uses to describe individuals in their care.

[2] When the term Inspectors is used, this refers to the inspection team comprising of the Manager, OPCAT and a Senior Inspector.

[3] A dedicated room for relaxation and quiet time.

- Leadership on the Unit was visible and staff felt supported.

The issues that needed addressing are:

- External window shutters in the seclusion rooms were not operational.
- The low stimulus area (LSA) courtyard lacked privacy and could be viewed by members of the public.
- The high care room had no natural light.
- Seclusion and restraint policies were out of date.
- Review and recording processes for restraint incidents were not robust.
- Safe Practice Effective Communication (SPEC) training attendance was not tracked or recorded.
- The District Inspector's contact details were not displayed on the Unit.
- Clients were not invited to multi-disciplinary team (MDT) meetings.
- Clients were not provided with a copy of their discharge summary letter sent to the client's GP.
- There was not a sufficient gender balance among staff.
- There was little evidence in Māori clients' care plans of Māori models of care being delivered.

Recommendations

I recommend that:

1. All seclusion room window shutters are operational.
2. Privacy screening is installed in the LSA yard.
3. All client bedrooms have natural light.
4. The seclusion and restraint policies are updated.
5. A robust system for accurately reviewing and recording restraint incidents is implemented.
6. SPEC training attendance for staff is comprehensively monitored and recorded.
7. The District Inspector's contact details are displayed on the Unit.
8. Clients are invited to attend their MDT meetings.
9. Clients are provided with a copy of their GP discharge summary letter.
10. The DHB takes a planned approach to recruitment and developing a culturally competent health workforce.

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 a representative of the Unit's leadership team, to outline their initial observations.

Further comment

A provisional report was forwarded to the South Canterbury District Health Board (the DHB) for comment as to fact, finding or omission prior to finalisation and distribution. I have carefully considered the comments made by the DHB before finalising my report.

Facility Facts

Kensington Inpatient Mental Health Unit

Kensington Inpatient Mental Health Unit (the Unit) is a 12 bed acute adult inpatient unit, providing assessment, treatment and stabilisation of clients experiencing acute mental health issues, who are unable to be cared for safely in a community environment.

The Unit is an 'open facility' which does not have exit doors locked at all times.[4] It is located at the eastern end of the Kensington Centre in Timaru, which also accommodates community mental health services.

Region

Timaru

District Health Board

South Canterbury

Operating capacity

12 bedrooms plus two seclusion rooms

Last inspection

Unannounced inspection – May 2015

Unannounced inspection - April 2011

Announced visit – November 2009

[4] In contrast, a designated 'locked unit' is where 'the locked exit is a permanent aspect of service delivery'. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

The Inspection

Two Inspectors conducted the inspection of the Unit between 7 and 9 October 2019.

On the first day of the inspection, there were 10[5] clients on the Unit, comprising two females and eight males. Two of these clients were on overnight leave.

The average length of stay for the preceding six months was eight days.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (CNM), before being shown around the Unit. Inspectors requested the following information during and after the inspection:

- a list of clients and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data for 1 April to 30 September 2019, and the seclusion and restraint policies;
- reports relating to restraint, seclusion minimisation, and adverse events;
- records of staff mandatory training, including Safe Practice Effective Communication (SPEC);[6]
- client absent without leave (AWOL) events 1 April to 30 September 2019;
- details of all sentinel events[7] from 1 April to 30 September 2019;
- complaints received 1 April to 30 September 2019, a sample of responses and associated timeframes, and a copy of the complaints policy;
- minutes of client community group meetings for the previous month
- a copy of the activities programme;
- information provided to clients and their whānau on admission;
- staff sickness and retention data for the previous three years; and

[5] The Unit is funded for eight beds. Staff reported it was common for the Unit to regularly accommodate nine or 10 clients. The Unit had 12 bedrooms.

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

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

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

Inspection focus

The following areas were examined to determine whether there had been torture or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on clients.[8]

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Seclusion
- Seclusion policies and events
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- 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
- Cultural and spiritual support

Communications

- Access to visitors

[8] My inspection methodology is informed by the Association for the Prevention of Torture's *Practical Guide to Monitoring Places of Detention* (2004) Geneva, available at www.apt.ch.

- Access to external communications

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of managers, staff and clients. Whānau were also spoken with.[9]

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

Recommendations from previous report

There were no recommendations made by my predecessor following an inspection of the Unit in 2015.[10]

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

[10] Report on an unannounced visit to Kensington Centre – Inpatient Acute Unit under the Crimes of Torture Act 1989 (2015). The DHB has a copy of this report.

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

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

Seclusion

Seclusion facilities

The seclusion[11] area had undergone significant modernisation since my predecessor's inspection in 2015.

It now comprised a low stimulus area (LSA) and two seclusion rooms (Seclusion Room 1 and 2). A door from the LSA led directly to a fenced courtyard.

The seclusion area was located at the end of a corridor, close to the nurses' station. The area could be accessed either internally through the Unit, or externally from the courtyard.

Both seclusion rooms were large, clean and well maintained. Bedding was clean and anti-rip bedding had been made to look more comforting. Each seclusion room had an en-suite bathroom containing a toilet, hand basin and shower. There was adequate lighting and ventilation in both rooms. Large windows in each room allowed natural light. External shutter blinds had been installed, but not all were operational. Staff demonstrated to Inspectors that to open and close the shutters for Seclusion Room 1, they went to the courtyard and used a broom.

Staff reported that, on occasion, clients had placed mattresses up against the seclusion room door, affecting staff's ability to conduct observations. The Unit's managers were working to find solutions to this issue, including purchasing heavier mattresses.

An intercom system allowed for two-way conversation between staff and clients. There was a calendar outside Seclusion Room 1 for clients in seclusion to orientate themselves to the day and date. The calendar for Seclusion Room 2 had fallen off the wall. There was no clock in the LSA that could be seen by clients.

Clients in the LSA area did not regularly access the adjoining courtyard. Staff recognised the benefits in facilitating access to fresh air for these clients, but stated that as the courtyard could be seen from a public road, clients could have their privacy and dignity compromised. Staff identified that a possible solution would be to place mural boards along the wire fencing to create a private outdoor space for clients in the LSA.

[11] Seclusion is defined as: '*Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit*'. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

A high care bedroom located on the main Unit was used to monitor clients who had spent a period in seclusion, or who were recent admission and had high levels of acuity. The high care bedroom had no natural light. There was an internal window that faced onto the corridor. Inspectors observed clients keeping the door to the bedroom open to increase the provision of light. The bedroom was located opposite the comfort room and adjacent to the seclusion area. Inspectors were concerned that the privacy of clients accommodated in the high care bedroom could be compromised, by those passing the open bedroom door.

Figure 1: A seclusion room with modified bedding.

Figure 2: High care bedroom with external blinds controlled from the corridor

Seclusion policies and events

A copy of the DHB's *Seclusion Procedure/ Protocol* (dated February 2017) was provided to Inspectors. The procedure had a review date of February 2019 and was out of date.

The Unit staff were working to reduce seclusion events by holding regular 'zero seclusion' meetings. The zero seclusion meetings were attended by the Charge Nurse Manager, Psychiatrist, Consumer Advisor, Family Advisor, Consumer Representative, Māori Leads and representatives from the Crisis Team and the Unit. The meetings were comprehensively minuted, with clear action points. Staff with whom my Inspectors spoke were committed to reducing seclusion on the Unit.

A strong focus of the zero seclusion meetings was to co-design and work alongside clients and their whānau to identify approaches to reducing seclusion, as well as mitigating negative impacts of seclusion when used.

There were no clients in seclusion at the time of the inspection.

Data provided by the DHB following the Inspection indicated that, for the six-months between 1 April and 30 September 2019 there were six seclusion events involving six clients. The total seclusion time was 302.3 hours, and the average number of seclusion hours was 50.2 hours. I was concerned to see that one client was recorded as having been secluded for seven days (168 Hours) in total.

Table 1: Seclusion data from 1 April – 30 September 2019[12]

Number of seclusion events	6
Number of clients secluded	6
Number of males secluded (Māori)	0
Number of males secluded (non-Māori)	3
Number of females secluded (Māori)	2
Number of females secluded (non-Māori)	1
Youngest person secluded	25
Oldest person secluded	55
Shortest seclusion episode	580 minutes (5 hours and 45 minutes)
Longest seclusion episode	10,080 minutes (168 hours)
Average seclusion episode	3021 minutes (50 hours and 21 minutes)
Total seclusion time	18,128 minutes (302 hours and 8 minutes)

Restraint

A copy of the DHB's *Restraint Minimisation and Safe Practice Policy* (dated October 2014) was provided to Inspectors. The procedure had a review date of October 2016 and was out of date. A copy of the DHB's *Protocol for Restraint Minimisation and Safe Practice* (dated October 2014) was also provided. This was also due for review in October 2016 and was out of date.

Data provided by the DHB showed that there had been four instances of personal restraint involving four clients for the period 1 April to 30 September 2019.

My Inspectors noted a restraint event, initiated by staff in the Mental Health Crisis Team, had resulted in the client being personally restrained and taken to an 'open seclusion room'[13] in the LSA. The documentation relating to the restraint event was poorly completed and lacked sufficient detail; particularly the length of time the client was in restraint. Furthermore, the documentation did not indicate whether or not the client had been subject to environmental restraint[14] while in the LSA.

[12] Data as reported by the DHB.

[13] The Unit's Mental Health and Addition Manager defined open seclusion as '*caring for a service user in one of the rooms available for seclusion in the low stimulus area but the door is not closed'*.

[14] Where a service provider intentionally restricts a client's normal access to their environment, for example locking the door between the Unit and the low stimulus area.

Table 2: Restraint data (exclusive of seclusion data) from 1 April 2019 – 30 September 2019[15]

Total restraint episodes	4
Total clients restrained	4
Personal restraint[16]	4
Mechanical/ physical[17]	0
Environmental (door locking)[18]	0
Police restraint	0
Number of males restrained (Māori)	0
Number of males restrained (Non-Māori)	1
Number of females restrained (Māori)	1
Number of females restrained (Non-Māori)	2 [19]
Youngest person restrained	38
Oldest person restrained	71
Shortest restraint episode	1 minute
Longest restraint episode	4 minutes
Average restraint episode	2.5 minutes
How many episodes of restraint resulted in consumers being secluded	1

15 Data as reported by the DHB.

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

17 Physical restraint is when a service provider(s) uses equipment, devices or furniture that limits the client's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

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

19 There were inaccuracies in the data provided to Inspectors. The Service reported four restraint episodes, but the number of females and males restrained totals three restraint episodes.

Restraint training for staff

The Charge Nurse Manager (CNM) was unable to provide Inspectors with an official register detailing when Unit staff had completed their SPEC training. The CNM also reported that three staff who had recently joined the Unit were yet to receive SPEC training. Inspectors were not provided with dates of future scheduled training.

Inspectors were informed that Unit staff undertook SPEC refresher training in a large meeting room each week. The room in which these sessions were held had examples of SPEC holds on the walls as teaching aids. There was no formal register of attendance, so Inspectors were unable to ascertain how regularly staff were attending refresher training sessions.

Electro-convulsive therapy

There were no clients undergoing electro-convulsive therapy (ECT)[20] on the Unit at the time of inspection.

Clients' and whānau views on treatment

Clients and whānau told Inspectors they felt safe on the Unit. Clients reported feeling well cared for and supported. Whānau with whom Inspectors spoke were highly complementary of the care provided and had confidence in the skills and expertise of the treating team.

Clients informed Inspectors that they understood why they were on the Unit. These clients knew their legal status, if applicable, and what medication they were prescribed. They also knew who their Responsible Clinician and primary nurse were.

One client was receiving palliative[21] care on the Unit, while waiting for a hospice placement. The client was transferred to the hospice on the second day of inspection. Whānau recognised the specialist support that had been provided and were extremely complimentary of the care and support received. Even though staff on the Unit were attentive in their care, it should be recognised that palliative care is not their area of expertise.

A 'green card' admission service was available on the Unit. Its purpose is 'to provide a structured and safe limited admission to the Unit in order to reduce unhelpful and risky behaviours.'[22] Clients who had been issued with a green card were eligible for an admission for

[20] 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

[21] Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (World Health Organisation)

[22] Green Card - Guidelines And Process For Case Management In Adult Mental Health Services. South Canterbury Mental Health Board.

up to 48 hours,[23] to obtain support and respite. Clients, whānau and staff all spoke highly of the initiative and its benefits in preventing clients reaching crisis point.

Recommendations – treatment

I recommend that:

1. Seclusion room window shutters are operational.
2. Privacy screening is installed in the LSA yard.
3. All client bedrooms have natural light.
4. The seclusion and restraint policies are updated.
5. A robust system for accurately reviewing and recording restraint incidents is implemented.
6. SPEC training attendance for staff is monitored and comprehensively recorded.

Kensington Centre comments

The DHB accepted recommendations 1, 4 and 5.

The DHB partially accepted recommendation 2.

The DHB rejected recommendation 3, and an earlier iteration of recommendation 6.[24]

Recommendation 2 response:

The opportunities and costs will be explored before making a decision on any action.

Ombudsman response:

I acknowledge your response to explore the opportunities and costs to install privacy screening in the LSA yard. I look forward to hearing the outcome of the decision.

Recommendation 3 response:

It is not possible to change the structure of the room in question.

Ombudsman response:

I acknowledge your response regarding clients' bedrooms having natural light. I remain of the view that all client bedrooms should have natural light.

Recommendation 6 response:

[23] If beds are available.

[24] SPEC training attendance for staff is monitored and recorded.

This already occurs and a copy of the records kept are attached.

Ombudsman response:

I have reviewed the SPEC training attendance sheet provided with the DHB's feedback comments. The sheet does not capture the year staff attended their training, if it was a full or refresher training course, when the next refresher course is due and if the staff member passed the course. I remain of the view that SPEC training attendance for staff should be robustly monitored and comprehensively recorded. I have adjusted my recommendation accordingly.

Protective measures

Complaints process

A copy of the DHB's *Complaint Management Policy and Process* (dated October 2017) was provided to Inspectors. The procedure had a review date of October 2019 and was up-to-date at the time of inspection.

The DHB's complaints process and the Health and Disability Commissioner Code of Rights were well displayed on the Unit. Complaint forms were available on the Unit and were given to clients on request.

The District Inspector's (DI) contact details were not visible on the Unit. Inspectors spoke with the District Inspector who regularly visited the Unit and met with the clients.

The Unit had received two complaints between 1 April and 30 September 2019. Inspectors reviewed both complaints, which were responded to within the DHB's policy timeframes. One complaint raised numerous separate issues. The responses were courteous in tone, individualised and addressed most of the issues that were raised.

Records

Of the 10 clients on the Unit at the start of the Inspection, two were detained under the Mental Health Act (MHA) and the remainder of the clients had voluntary status. All MHA client files contained the necessary legal paperwork to detain the clients.

All clients had consent to treatment forms on their files. If consents were not signed, the reason was clearly documented on file. Consent forms were lengthy and complex. Staff were considering if the form should be reviewed and simplified. Streamlining the form would be beneficial.

Inspectors found clients' files were well organised and easy to navigate. There was no evidence in clients' files that clients were invited to attend their weekly multi-disciplinary team (MDT) meetings. Staff confirmed that clients were not invited to attend MDT meetings as it may affect how information relating to a client's risk and recovery was shared. Some staff suggested inviting clients to attend a segment of their MDT, following risk discussions, might

resolve this concern. Each client also had a Wellness Recovery Action Plan that identified goals for recovery.

The Kensington Centre information booklet states *'Your general practitioner will receive a letter from the Kensington Centre, giving an outline of your treatment. You will receive a copy of this letter, and you will be advised of any follow-up care that is necessary.'* Staff informed Inspectors that clients no longer received a copy of their GP letter, because of a previous complaint. All clients have rights in relation to their health information and health sector organisations have important responsibilities regarding that information.[25] I believe clients should be kept informed of their diagnosis and associated relevant information and the previous practice of providing the discharge summary letter should be reinstated.

Recommendations – protective measures

I recommend that:

7. District Inspector's contact details are displayed on the Unit.
8. Clients are invited to attend their MDT meetings.
9. Clients are provided with copies of their discharge summary letter.

Kensington Centre comments

The DHB accepted recommendation 7.

The DHB partially accepted recommendations 8 and 9.

Recommendation 8 response:

There will need to be client and team discussion to determine how this would best be done. In its current format the MDT meeting is likely to be overwhelming for many clients. To be able to implement MDT meetings that are small enough and personal enough for clients to be able to fully participate in them staff resourcing needs to be considered. To better inform change SCDHB will investigate what happens in different regions and services.

Ombudsman response:

It is encouraging to note that the DHB will be investigating this issue.

[25] *Mental Health Commission and Office of the Privacy Commissioner.* 'Guidance material for health practitioners on mental health information'. *18 November 2009. Retrieved on 22 November 2019 from www.privacy.org.nz/news-and-publications/guidance-resources/guidance material-for-health-practitioners-on-mental-health-information/*

Recommendation 9 response:

The normal practice of providing the clients a copy of the discharge letter will resume. If there are significant issues or concerns regarding an individual client these will be discussed within the MDT forum.

Ombudsman response:

It is pleasing to hear that the general practice of providing the client with a copy of their discharge letter will resume.

Material conditions

Accommodation and sanitary conditions

The Unit was clean, tidy and well maintained.

The Unit comprised one main corridor with 12 spacious bedrooms and communal areas located off it. Showers, toilets, and bathrooms were also located off the main corridor. There were sufficient numbers of toilets and showers for the number of clients. Two bedrooms had en-suite facilities. All rooms had plenty of natural light with the exception of the high care bedroom (as described in my previous section on seclusion).

Two rooms were suitable for clients with mobility issues and could accommodate wheelchairs.

There were no separate areas on the Unit for male and female clients. Staff placed vulnerable clients closer to the nursing station.

Laundry facilities were available and clients were supported to wash their own clothing. A local charity donated clothing to the Unit for clients who did not have sufficient clothing. Staff managed the clothing donation and allocation system, and ensured these clothes were laundered before being supplied to clients.

Unoccupied bedrooms were made up and ready for new admissions. An information booklet was available in each bedroom. Fresh linen and basic toiletries were provided for clients on admission. Bedrooms had adequate storage space for personal possessions. Bedroom doors could be locked by clients from the inside but could not be locked by clients when leaving their rooms.

Clients had access to several communal areas. A whānau room was available for visitors. The room was comfortable and welcoming, and provided activities for young children.

Figure 3: A client bedroom

Figure 4: A communal area

Food

Clients' meals were prepared in the main hospital kitchen and delivered to the Unit. A buffet breakfast was available in the Unit's kitchen each morning. A cooked buffet breakfast was provided on Tuesdays. Clients' special dietary requirements, such as high protein and diabetic diets, were catered for. Clients were positive about the quality and quantity of the food available.

The kitchen/dining area had adequate seating and was clean and tidy. Clients could eat their meals in their bedrooms, if they preferred. Inspectors observed a lunch served to clients and thought the quality and quantity was of a good standard.

Food was available in the kitchen area and clients could make themselves snacks at any time. I was pleased that clients enjoyed free access to the kitchen and refreshments throughout the day. Food was also provided for special events, such as movie nights.

Recommendations – material conditions

I have no recommendations to make.

Activities and programmes

Outdoor exercise and leisure activities

A number of leisure activities were available to clients. My Inspectors were pleased that the communal areas, including those rooms with gaming consoles and televisions, remained open, and that electronic items were accessible to clients. A dedicated arts and crafts room was located across from the nurses' station.

The Occupational Therapist (OT) and Unit staff provided a range of activities both on and off the Unit. While not compulsory, clients were encouraged to participate in activities in order to progress their recovery. The OT had recently been appointed, and was working to establish regular client community meetings and develop more activities suited to clients' needs. Inspectors observed the OT facilitating a walking group to the local park so clients could feed the ducks. Whānau were also invited to attend.

The Unit's Sensory Modulation Room had been repurposed as a comfort room, which meant that the room could remain open for clients and did not require staff supervision. It was well equipped with relaxation aids and comfortable furniture and was well utilised.

I am pleased to note that the comfort room remains unlocked and accessible to clients throughout the day. Keeping this space unlocked enables clients the autonomy to use the room, as desired, without requiring input from staff.

As a result of the upgrade of the seclusion area, the Unit had been reconfigured and there was no longer space for a pool table. Both staff and clients said they missed this communal activity, particularly older male clients who were not interested in art and craft and video gaming. Staff felt the pool table had provided an opportunity to relax and talk with clients in an informal setting.

The Unit had an adjoining garden with greenery, bird tables and seating. My Inspectors found this area to be pleasant and well maintained. The doors to this area, as well as the front entrance, were open and clients on the Unit had free access to fresh air.

Programmes

The Unit did not employ a Clinical Psychologist. However, Inspectors observed that if a client was under Community Mental Health Services their dedicated psychologist would visit them on the Unit.

No therapeutic programmes were being offered at the time of the inspection, but the newly appointed OT was exploring options for their development. The OT undertook developing individual plans and functional assessments.

One of the Unit's support workers[26] was assisting with benefits and housing options as well as focusing on the strengths-based model of care for enabling clients to integrate back into the community. The staff member had good community networks to engage ongoing support for clients.

Cultural support

The Unit did not have a dedicated specialist Māori mental health service to provide a culturally safe and responsive mental health service for Māori. If it was considered clinically appropriate, Māori clients who requested cultural support were referred to the Hauora Māori team based

[26] The support worker was not a registered social worker.

in the community mental health team. While my Inspectors found that Unit staff had some knowledge of the principles of te Tiriti o Waitangi, there was little evidence in Māori clients' care plans of Māori models of care being delivered. Furthermore, Tikanga Best Practice did not underpin all DHB systems and policies.[27]

The Chaplain was a regular presence on the Unit. Staff informed newly admitted clients that spiritual support was available and, if requested, made referrals to the Chaplain. The Chaplain had a good working relationship with staff and was responsive to client's requests.

Figure 5: Outdoor area

Figure 6: Art and craft room

Recommendations – activities and programmes

I have no recommendations to make.

Communications

Access to visitors

The Unit operated a flexible and responsive visits system. Clients did not raise any concerns with Inspectors relating to access to visitors and spoke consistently of the ease with which visits occurred. Inspectors observed visits occurring throughout each day of the inspection.

Visits could take place in the dedicated whānau area, clients' bedrooms and also in communal areas. Staff were proactive in making whānau welcome on the Unit.

Mental Health and Addictions Service employed a part time Whānau Advisor. One of the Whānau Advisor's tasks was to telephone whānau soon after a client was discharged to

[27] *SCDHB – Māori Cultural Competency Action Plan 2015-16* is the basis for organisation work plans and encourages collective efforts that make a difference for whānau Māori.

determine what, if any, improvements could be made to the services provided. The Unit also worked closely with Family and Mental Health Support (FAMHS) Aoroki; a specialist service that provided ongoing support, advocacy and education to the whānau of clients. Staff and clients my inspectors spoke with were complimentary about this service.

I have no concerns with clients' access to whānau.

Access to external communication

The telephone was located in a booth in the main communal area of the Unit, which provided privacy for clients. Clients had independent access to the telephone throughout the day.

Clients were able to keep their cell phones in their possession. Unit staff told Inspectors that clients' cell phones were removed only if there was a clinically indicated need to do so. Inspectors observed clients in possession of their personal phones during the inspection.

Clients did not raise any concerns with Inspectors about the ability to send and receive mail. Inspectors were advised that mail could be sent and received daily.

Recommendations – communications

I have no recommendations to make.

Staff

Staffing levels and staff retention

There was a good mix of age and experience among staff. However, there was not a sufficient gender balance among staff. According to information provided by the DHB there were no male staff and only one Māori staff member.

Information provided to Inspectors indicated that the Ward had one Registered Nurse (RN) vacancy. The high turnover rate for RNs in 2016/17 (23.1 percent) appeared to have been addressed, with significantly lower turnover in 2017/18 (7.7 percent) and 2018/19 (0 percent). Data provided by the DHB indicated that staff sickness was approximately 5 percent over the 2018/19 reporting period. However, Inspectors were told that the CNM would regularly have to carry a client case load due to the RN vacancy.

While the DHB advises the Unit has access to the Mental Health and Addiction Service administration team, the Unit did not have dedicated administrative support. Administrative tasks were routinely carried out by the CNM when time permitted.

Recommendations – staff

I recommend that:

10. The DHB takes a planned approach to recruitment and developing a culturally competent health workforce.

Kensington Centre comments

The DHB partially accepted recommendation 10.

Recommendation 10 response:

There is already a workforce plan to the recruitment of Mental Health and Addiction workers. SCDHB are working closely with the newly established local Bachelor of Nursing cohort and are looking to increase the number of NESP positions offered in January 2021

Effort will be made to ensure all staff are culturally competent. The Hauora Maori Team will be asked to lead this. Although the Hauora team are located in the community team they are employed for the complete mental health and addiction service. Together we will explore the opportunities and identify the barriers of working across all the teams.

Ombudsman response:

It is pleasing to hear that work is underway to work closely with the newly established Bachelor of Nursing cohort and to ensure all staff are culturally competent.

Acknowledgements

I appreciate the full co-operation extended by the Charge Nurse Manager and staff to the Inspectors during their inspection of the Unit. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Managers	Unit staff	Others
Director of Area Mental Health Services	Charge Nurse Manager Registered Nurses Consultant Psychiatrist Occupational Therapist Mental Health Assistants	Clients District Inspector Family/whānau Māori Support Worker Whānau Advisor Chaplain Consumer Advisor Quality and Risk 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.