



Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced inspection of Ward 10a and Helensburgh Cottage, Wakari Hospital Dunedin, under the Crimes of Torture Act 1989

February 2022

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National Preventive Mechanism

Office of the Ombudsman

Tari o te Kaitiaki Mana Tangata





OPCAT Report: Report on an unannounced inspection of Ward 10a and Helensburgh Cottage, Wakari Hospital Dunedin, under the Crimes of Torture Act 1989

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Executive summary

Background

Ombudsmen are designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions of detention and treatment of patients¹ detained in secure units within New Zealand hospitals.

Patients receive treatment and rehabilitation services provided by Southern District Health Board's (DHB's) Mental Health Addictions and Intellectual Disability Service (the Service).

The Service are contracted by the Ministry of Health's Regional Intellectual Disability Secure Services (RIDSS).²

Between 3 and 7 May 2021, two Inspectors³ — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Ward 10a (the Ward) and the Helensburgh Cottage (the Cottage), which are located in the grounds of Wakari Hospital, Dunedin.

A note about terminology

I acknowledge the importance of language around disability, and that people have differing views on the meaning, accuracy, and effects of particular terms. I have chosen to use the term 'intellectual disability' in this report where patients are detained under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act).

There is no single definition of 'intellectual disability'. People with intellectual disabilities are a diverse group who may experience challenges understanding new or complex information, learning new skills, and living independently. The IDCCR Act provides a legal definition⁴ and, relevant to this report, a framework for the compulsory care, rehabilitation, and special rights of people with intellectual disabilities.

Other terms used to refer to people with intellectual disabilities include 'tangata whaikaha hinengaro', 'intellectually impaired people', or 'people with a learning disability'.

¹ The Ward referred to people under the IDCCR Act, the Mental Health (Compulsory Assessment Treatment) Act 1992 and people under Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act) as 'patients'.

² RIDSS provide hospital level secure residential services and assessment beds. Both Auckland and Wellington RIDSS services provide some beds for clients transferring from other regions. RIDSS are contracted through the DHBs.

³ When the term Inspectors is used, this refers to the inspection team comprising of two Inspectors.

⁴ Section 7.

Summary of findings

My findings are:

- Most patients spoken with felt safe and confirmed that they were treated with dignity and respect. Whānau spoken with were also positive regarding the treatment of their family members.
- The Ward and Cottage did not use Night Safety Orders.
- Patients could wear their own clothing when in seclusion; the Ward did not use anti-ligature gowns in seclusion.
- Staff were up-to-date with mandatory training. It was pleasing to see that this matter had been rectified since my predecessor's previous inspection in 2014.⁵
- Files contained the necessary paperwork to detain and treat the patients on the Ward and Cottage.
- The 'Ward Rounds' was a positive initiative.
- Care and Rehabilitation Plans / Treatment Plans were individualised and detailed.
- Patients were able to keep most of their toiletries and could lock their bedroom doors and bathrooms.
- Patients had access to snacks and Inspectors were pleased to see patients could leave the dining area once they finished their meals.
- All patients had access to the courtyard, fresh air and outdoor exercise.
- The Service had adopted the Safewards approach,⁶ which was well embedded on the Ward. The Mutual Help Meeting⁷, in particular, was a positive initiative.
- Patients' access to leave was well utilised and supported by Ward and Cottage staff.
- There were no issues with visits and there was active whānau involvement.
- There were no prescriptive times to access phones.
- Patients had good access to primary health care services.
- Interactions between staff and patients were respectful and staff appeared to know their patients well. Leadership on the Ward and Cottage was visible.

⁵ Office of the Ombudsman report on an unannounced inspection to Ward 10a Wakari Hospital under the Crimes of Torture Act 1989, September 2014.

⁶ Safewards is a model of care, developed in the United Kingdom, designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units. For a more comprehensive description of the Safewards model, go to the Safewards website at: <http://www.safewards.net/>

⁷ Patient-led community meetings were held three times a week in the Ward and Cottage.

- Inspectors observed a dedicated team in both the Ward and Cottage.
- Staff reported feeling supported by the leadership team.
- Clinical supervision was actively promoted and staff were supported to attend.

The issues that needed addressing are:

- The mixing of differing patient status on the Ward and Cottage (forensic and non-forensic).
- Non-forensic patients were subject to restrictive practices due to the Ward being a forensic medium secure environment.
- There was a lack of gender separation on the Ward.
- The District Health Boards' (DHB) *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District)* definition of seclusion did not align with the Ministry of Health's (MOH) definition of seclusion.
- Seclusion events were being incorrectly recorded as environmental restraint.
- Staff had used a surgical mask on a patient during a restraint event.
- Use of non-approved restraint – use of surgical mask.
- The Sensory Modulation room was not operational at the time of inspection.
- Information on the complaints process was not displayed on the Ward or Cottage.
- Contact details for the District Inspector were not visible or clearly displayed on the Ward or Cottage.
- Copies of the *Health and Disability Commissioner's Consumer Rights* were not well displayed throughout the Ward and Cottage, nor was it available in Easy Read or accessible format.
- There was no independent Consumer Advocate available to patients accommodated in either the Ward or Cottage.
- The Ward was not fit-for-purpose and was in critical need of upgrade and redevelopment, an issue my predecessor raised in their 2014 report. I consider the current state of the Ward to be unacceptable and compromised patient and staff safety as well as patient's dignity.
- The Ward required significant maintenance. Carpets, beds and soft furnishings needed urgent replacement.
- Patients could not access hot and cold drinks independent of staff on the Ward.
- The activities programme was not available in the evenings or at weekends.
- Cultural support was limited.

- Access to the telephone was not available independent of staff and did not afford privacy, an issue my predecessor raised in their 2014 report.

Recommendations

I recommend that:

1. Forensic patients are accommodated separately from non-forensic patients.
2. 'Medium secure restrictive practices' are not placed on non-forensic patients.
3. Gender separation is provided on the Ward wherever possible.
4. The DHBs *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District)* use the MOH's definition of seclusion.
5. All events which meet the definition of seclusion as set out by the Ministry of Health, are recorded as seclusion events.
6. Facial coverings or masks are never applied to a patient when they are being restrained.
7. Staff only use DHB approved restraint techniques.
8. The Sensory Modulation Room is made operational.
9. Independent Consumer Advocate support is available to patients.
10. The Ward is rebuilt or at the very least upgraded, including remedying ligature points, upgrading soft furnishings, carpets and bedding. **This is an amended repeat recommendation.**
11. Cleanliness and facilities maintenance issues are attended to as a matter of priority.
12. Patients can access drinking water and hot drinks independently of staff, unless this is considered unsafe based on an individual risk assessment. If a patient is not able to access drinking water or hot drinks independently, the reasons are recorded and regularly reviewed.
13. The activities programme is extended to evenings and weekends.
14. Regular and ongoing access to Kaioranga Hauora Māori⁸ support is provided.
15. Patients in the Ward and Cottage can make a telephone call in private and independent of staff. **This is an amended repeat recommendation.**

I intend to monitor the implementation of my recommendations, including conducting follow-up inspections at future dates.

⁸ Māori cultural worker.

Feedback meeting

On completion of the inspection, my Inspectors met with the Charge Nurse Manager and the General Manager, to outline their initial observations. A written copy of the initial observations was provided to the facility on 7 May 2021.

Consultation

My provisional report was forwarded to the Service for comment. A copy of my provisional report was also sent to the Ministry of Health for comment.

The District Health Board (DHB) responded to my provisional report. Their comments are set out within the report. In response to my provisional report, the Ministry of Health stated they supported my recommendations 8, 10, 11, 15 and 16. The Ministry of Health also advised they would follow up with the DHB and the District Inspectors regarding recommendations 7, 9, 12, 13, 14 and 17. The Ministry of Health stated that they were *'engaging in a capacity planning process that has identified the need for both remedial work and additional bed planning nationwide. It is likely this will progress to an investment proposal process to support government consideration of future needs'*.

Facility facts

Ward 10a

Ward 10a (the Ward) is a 12-bed medium secure facility. At the time of inspection, the Ward admitted patients of all genders.

The Ward provided treatment and rehabilitation services for people over the age of 18 with an intellectual disability (ID), who have been convicted of criminal offences, and who demonstrate behaviour that has been assessed as posing a serious risk to themselves or others (i.e. forensic patients). Patients may also have a comorbid mental illness.

Due to multiple contracts with the Ministry of Health, the Ward also admitted non-forensic patients⁹ with an ID or dual diagnosis.¹⁰ This will be discussed further on page 19 of this report.

Patients admitted to the Ward had to be assessed as having an ID as defined under the IDCCR Act. Patients may be admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act), or the IDCCR Act.

Patients were admitted to the Ward via the DHB's Emergency Psychiatric Services or through prison or court referrals.

The Ward accepts admissions from the Otago and Southland region and is located in the grounds of the Wakari Hospital Campus, Dunedin.

Helensburgh Cottage

Helensburgh Cottage (the Cottage) is a 4-bed medium secure cottage and admitted patients of all genders.

The Cottage is a transitional step-down accommodation, designed specifically to provide care for patients transitioning from the Ward to the community. At the time of inspection, there were two long-term patients residing in the Cottage who were in the process of transitioning to the community. This will be discussed further on page 22 of this report.

The Cottage is located in close proximity to the Ward and situated in the grounds of the Wakari Hospital Campus, Dunedin.

⁹ People who had not been convicted of a criminal offence.

¹⁰ Dual diagnosis, or co-existing disorders or co-morbidity, is the term used to describe the interaction of addiction and mental health problems. For more information, see: https://www.health.govt.nz/system/files/documents/pages/ct_service_specification.pdf

Region

Otago and Southland

District Health Board

Southern

Operating capacity

The Ward – 12 beds

The Cottage – four beds

Last inspection

Unannounced visit – February 2019

Unannounced inspection – September 2014

Unannounced inspection – March 2013 (Helensburgh Cottage only)

Unannounced inspection – November 2008 (Ward 10a only)

Scoping visit – May 2008

The inspection

Two Inspectors conducted the inspection of the Ward and Cottage between 3 and 7 May 2021. On the first day of the inspection, there were seven patients in the Ward, including three females and four males. There were three patients in the Cottage, comprising one female and two males. The ages of these patients ranged from 20 to 64. The length of time patients spent on the Ward varied.¹¹ The Service had no waitlist at the time of inspection.

At the time of inspection, New Zealand was at COVID-19 Alert Level 1.¹²

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (CNM), before being shown around the Ward and Cottage.

Inspectors were provided with the following information during and after the inspection:

- a list of patients and the legal authority for their detention (at the time of the inspection);
- breakdown of patients in the Ward and Cottage from 1 November 2020 to 30 April 2021;
- monthly admissions/discharges and bed occupancy rates from 1 November 2020 to 30 April 2021;
- length of stay for each patient in the Ward and Cottage;
- waitlist from 1 November 2020 to 30 April 2021, including location and length of time on waitlist (community/prison);
- the seclusion and restraint data from 1 November 2020 to 30 April 2021, and the seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events from 1 November 2020 to 30 April 2021;
- number of assaults on staff and other patients from 1 November 2020 to 30 April 2021;
- search policy and procedures;
- night safety policy and procedures;
- observations policy and procedures;

¹¹ Dates are calculated from admission to 30 April 2021: Patient A 4129 days, Patient B 217 days, Patient C 329 day, Patient D 6 days, Patient E 1634 days, Patient F 380 days, Patient G 77 days, Patient H 3110 days, Patient I 5316 days and Patient J 1 day.

¹² See <https://covid19.govt.nz/alert-system/covid-19-alert-system/> for more about New Zealand's COVID-19 alert system.

- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);¹³
- complaints received from 1 November 2020 to 30 April 2021, a sample of responses and associated timeframes, and a copy of the complaints policy;
- copy of minutes of patient group meetings from 1 November 2020 to 30 April 2021;
- activities programme;
- information provided to patients and their whānau on admission;
- visits policy and procedures;
- incident reports relating to medication errors from 1 November 2020 to 30 April 2021;
- breakdown of current staff in the Ward;
- daily staffing levels & shift times;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number);
- overtime for Registered Nurses (RNs), Enrolled Nurses (ENs) and Mental Health Assistants (MHAs) 1 November 2020 to 30 April 2021;
- data on use of bureau/pool staff from 1 November 2020 to 30 April 2021;
- specific training schedule for staff (specific to ID) such as PBS training; and
- data on staff, categorised by profession.

¹³ 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. See <https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149> for more detail.

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 care recipients.¹⁴

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Mixing of forensic and non-forensic patients
- Restrictive practices
- Gender separation
- Long-term patients
- Seclusion facilities
- Seclusion policies and events
- Night safety procedures (NSP)
- Restraint
- Environmental restraint
- Use of surgical masks
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Patients' and whānau views on treatment

Protective measures

- Complaints process
- Records
- Consumer Advocate

Material conditions

- Accommodation and sanitary conditions
- Food

¹⁴ 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.

Activities and programmes

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

Communications

- Access to visitors
- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention
- Security staff
- Workforce training

Evidence

In addition to the documentary evidence provided, Inspectors spoke with a number of managers, staff, patients, and whānau.¹⁵

Inspectors also reviewed patients' records and additional documents provided by staff, and observed the facilities and conditions.

Recommendations from previous report

The Inspectors followed up on three recommendations following an inspection to the Ward in September 2014¹⁶, which were:

- a. All staff should be up to date with their restraint training. **This is a repeat recommendation.**
- b. The Unit needs to be upgraded/redeveloped to fully accommodate the needs of the patients in its care. Long term, the Southern District Health Board (SDHB) should consider replacing the existing building with a purpose built facility.

¹⁵ For a list of people spoken with by the Inspectors, see Appendix 1.

¹⁶ *Office of the Ombudsman report on an unannounced inspection to Ward 10a Wakari Hospital under the Crimes of Torture Act 1989*, September 2014.

- c. Patients should be able to access the telephone in private.

There were no recommendations from the inspection of the Cottage in March 2013.¹⁷

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

¹⁷ *Office of the Ombudsman report on an unannounced inspection to Helensburgh Cottage Wakari Hospital under the Crimes of Torture Act 1989, March 2013.*

Treatment

Mixing of forensic and non-forensic patients

At the time of inspection, the Service held three separate contracts with the Ministry of Health, which catered for a diverse patient mix, and comprised the following:

- Intellectual Disability Compulsory Care and Rehabilitation (IDCCR) secure stream with four beds, one assessment bed, and two fee-for-service¹⁸ beds. All beds were forensic and funded via direct Ministry of Health contracts;
- Intellectual Disability Assessment, Treatment and Rehabilitation (ID ATR) stream with three beds funded via direct Ministry of Health contracts; and
- Dual Diagnosis (DD) stream with four beds, funded by the DHB's Adult Mental Health Services.

As a result, the purpose or function of the Ward was unclear as different contracts meant the Ward operated with different models of care, training, understanding of legislative frameworks and reporting processes.

Due to the physical environment of the Ward, there was no capacity to separate forensic and non-forensic patients.¹⁹

Senior management stated in an *Options Paper* to the DHB that '*patients charged and convicted of serious criminal offences share an environment with non-offenders. Additionally, the Ward operated as a mixed gender Ward which further complicated clinical management of patients as female patients required additional oversight (such as one to one observation) due to their vulnerability on the Ward*'.²⁰

The *Options Paper* also stated '*the secure environment requirements of forensic inpatients necessitates (DD and ATR) all other patients to be under the Mental Health Act as they are not able to provide informed consent for voluntary admission to a locked Ward. This creates significant concerns regarding patients' rights and treatment in the least restrictive environment*'.²¹

Staff raised concerns that the complex patient mix, as well as the physical environment, contributed towards ongoing elevated acuity on the Ward, which was resulting in high numbers of assaults²² to both patients and staff as well as impacting on staff retention.

¹⁸ Fee-for-service is the funding arrangement where the Ministry of Health purchases additional beds and associated services from a provider once their capacity funded beds are all in use.

¹⁹ My concerns around the physical environment of the Ward will be discussed further on page 34 of this report.

²⁰ *Options Paper Southern DHB Intellectual Disability Services Ward 10a*.

²¹ *Options Paper Southern DHB Intellectual Disability Services Ward 10a*.

²² There had been 23 incidents of assault/harm on staff and one near miss incident between patients for the reporting period.

Senior management told my Inspectors that the Ward had always operated with multiple contracts, due to funding requirements and geographical disparities. Senior management also told my Inspectors that different options had been presented to the DHB, including ceasing the ID ATR contract and reducing bed numbers, ceasing the DD contract and reducing bed numbers, or both.

I have serious concerns about non-forensic patients being placed in a forensic setting, subject to restrictive environments and practices.

The importance of separating categories of persons in places of detention is well recognised. For example, Rule 11 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the ‘Nelson Mandela Rules’) states that²³:

The different categories of prisoners shall be kept in separate institutions or parts of institutions, taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment; thus:

(a) Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women, the whole of the premises allocated to women shall be entirely separate;

(b) Untried prisoners shall be kept separate from convicted prisoners;

(c) Persons imprisoned for debt and other civil prisoners shall be kept separate from persons imprisoned by reason of a criminal offence;

I urge the DHB to take measures to ensure that forensic patients and non-forensic patients are accommodated separately. I have recently raised my concerns about some of these matters with the Ministry of Health²⁴. I have also raised specific concerns about this facility directly with the Ministry of Health as a result of this inspection.

In response to my provisional report, the DHB stated they understood the ‘*need to address the co-habitation of forensic patients with non-forensic patients in Ward 10a, the restrictive practices placed upon non-forensic patients living in this environment and the gender separation of service users*’. I look forward to seeing improvements in these areas.

The Ministry of Health, in response to my concerns regarding the placement of non-forensic patients in a forensic Ward, stated:

In regions where the Ministry purchases a small number of beds from a DHB to provide RIDSS services, there is limited opportunity to provide a standalone unit. This means that in some cases beds will be provided within the wider forensic mental health service. It is expected that the DHB will manage the environment to

²³ While the Nelson Mandela Rules speak specifically to the treatment of prisoners, the basis for this Rule applies equally to other places of detention, such as inpatient mental health facilities. In particular, that such separation is important for safety, security, meeting the needs of individual patients and ensuring that the minimum restrictions apply to each person (see OSCE, ODIHR and PRI, [Guidance Document on the Nelson Mandela Rules](#)).

²⁴ See my report: *Oversight* an investigation into the Ministry’s stewardship of hospital-level secure services for people with an intellectual disability July 2021.

best meet the needs of all service users, understanding at times that placement within the wider forensic services can be very challenging.

I continue to have serious concerns about this, and have made recommendations on this matter I consider need to be met in order to improve the conditions and treatment of patients on the Ward.

Restrictive practices as a result of mixing patient cohorts

At the time of inspection, six patients on the Ward had been admitted via DHB mental health services and had a non-forensic background. However, due to the layout of the Ward, they were managed within a restrictive secure regime.

Staff told my Inspectors that due to the complexity of patient mix and the Ward designation and physical layout, the Ward applied restrictive practices to all patients, irrespective of legal status or risk.

Staff raised concerns with my Inspectors that they were forced to operate in a restrictive manner as a standard approach, as historically, varied practices had '*muddied the waters for clinical direction*' and inconsistency in rules and practices had caused concern and distress for patients.

Restrictive practices included limited access to mobile phones, internet, access to leave, and privacy for phone calls. My concerns around privacy for phone calls will be discussed further on page 42 of this report.

Patients told my Inspectors that they wanted to keep their mobile phones and did not want staff listening to their phone calls.

I consider it unacceptable that non-forensic patients are subjected to restrictive practices simply due to being accommodated with forensic patients. The limitations of the physical environment and complexities surrounding the multiple contracts and legal status of patients on the Ward were not conducive to non-forensic patients receiving care in the least restrictive manner.

I raised this concern directly with the Ministry of Health, who have responded:

The Ministry expects that the impact of any restrictive practices, which are necessary to manage forensic patients, will not affect individuals who are placed voluntarily. The Ministry works with individual DHBs to address individual placement issues and will follow up the use of restrictive practices with the DHB.

While I welcome the commitment to follow this matter up with the DHB, I maintain that it is not acceptable for blanket restrictions to be in place and applicable to all patients irrespective of their legal status or individual risk assessment.

Gender separation

At the time of inspection the Ward admitted patients of all genders. On the first day of inspection, there were three female patients in the Ward and one female patient in the Cottage.

Due to the physical layout of the Ward, there was no gender separation and a lack of separate communal areas. Of particular concern, female patients were residing with male patients with forensic backgrounds, some of whom were known to present a high risk to women.²⁵ One patient my Inspectors spoke with said they felt unsafe on the Ward.

Staff raised concerns with my Inspectors regarding the safety of vulnerable female patients. In order to manage risk to female patients, staff would allocate one-to-one observations on male patients who were considered a high risk to females. However, at times due to staff resourcing and low staffing numbers, this was applied to female patients instead. I have concerns that this practice may unfairly limit the freedoms and independence of female patients.

I encourage the DHB to address the lack of gender separation on the Ward, to ensure female patients are safe and are not unfairly restricted in their freedoms and independence.

Long-term patients

At the time of inspection, there were three long-term patients residing on the Ward and in the Cottage. Patient A had been on the Ward for 4,129 days, Patient H for 3,110 days and Patient I for 5,316 days.²⁶

The Service was actively seeking placement for these patients and documentation provided showed that two patients were progressing towards their transition into the community.

Senior management told my Inspectors these long-term patients had high and complex needs (HCN)²⁷ and were unable to be discharged due to barriers in the community, such as service providers having to find additional appropriate housing, service providers having to recruit additional staff to meet the complex needs of patients and ongoing negotiations between ID and mental health funding streams in relation to the cost of community placement for one patient.²⁸

²⁵ This was evidenced through Inspectors' conversations with staff, patients and on reviewing documentation and management plans.

²⁶ As of 5 May 2021.

²⁷ 'People with "high and complex needs" are a small and unique group of people with disabilities at the high end of the support needs spectrum. This group of disabled people includes those with multiple disabilities such as sensory disabilities, physical disabilities, severe intellectual disability, and serious and ongoing medical conditions. These individuals require support with self-care and basic activities of daily living. They tend to also have behaviours that require a very high level of support.' Te Pou o Te Whakaaro Nui (2013). Valuing and supported disabled people and their family/whānau. Te Pou o Te Whakaaro Nui.

²⁸ See my report: *Oversight* an investigation into the Ministry's stewardship of hospital-level secure services for people with an intellectual disability July 2021.

I acknowledge the complexity in sourcing suitable accommodation, and I was pleased to hear that recent progress had been made to transition two of these long-term patients into the care of community providers. The third long-term patient had also been identified as eligible to transfer to the Intensive Support Units (ISU)²⁹ pods at Kenepuru Hospital campus once completed.

Seclusion facilities

The Ward had one seclusion room with en-suite facilities located in the Intensive Care Unit (ICU) area of the Ward. Access to the seclusion room and ICU area was through the main Ward. Due to the physical layout, patients being admitted to the Ward for court assessment or being placed in seclusion on admission, were required to pass through the main foyer and through a long corridor on the Ward, in sight of other patients. Furthermore, new admissions from the courts or prison were brought through to the seclusion area by Corrections officers and Police, in handcuffs, which the Ward recorded as mechanical restraint.

I acknowledge that the physical layout of the Ward meant that staff had no alternative options to admitting patients to the Ward.

However, I have serious concerns that this means of admitting patients to the Ward compromised patients' privacy and dignity, and was disruptive and potentially distressing to other patients on the Ward.



Figure 1: Seclusion room



Figure 2: Seclusion/ICU courtyard

The seclusion room was stark, but was clean and well maintained. The seclusion room comprised a raised mattress on a concrete plinth and a window looking out onto the ICU courtyard. The seclusion room had heating, natural lighting, drinking water, a clock with date and time and a means of calling staff. Access to the en-suite facilities was based on individual risk assessments. Inspectors reviewed documentation that showed patients in seclusion could

²⁹ Intensive Support Units (ISUs) are currently being built on the Kenepuru Hospital campus. Construction of the ISUs commenced in September 2020, and is now expected to be completed towards the end of 2021.

access the bathroom, dependent on individual risk assessment. Patients could wear their own clothes³⁰ in seclusion and the Ward did not use anti-ligature gowns.

An external awning over the seclusion room window provided some privacy from the building above. However, the awning only partially covered the outdoor ICU courtyard. Inspectors observed patients from Ward 11³¹ looking down into the external courtyard during the inspection. The synthetic grass in the courtyard was mouldy and needed cleaning.

When the seclusion room was in use and another patient required a period of seclusion or de-escalation, the patient would be transported to ward 9a³² to use their seclusion room.

The physical environment in the ICU area was not therapeutic. The walls were bare and the lounge area was basic and stark. There was no sensory modulation equipment or comfortable seating available to patients. Staff advised the Ward was in the process of having murals of Dunedin or New Zealand icons painted on the walls as well as some games such as noughts and crosses may also be painted on the walls. There was a blind spot in the ICU area which had a 'dogleg'³³ wall leading to the outside courtyard.

The Cottage did not have seclusion facilities. In the event that a patient required seclusion, the patient was relocated temporarily to the Ward and the event would be captured in the Ward's seclusion data.

Seclusion policies and events

The DHB provided Inspectors with the *Seclusion Procedure - MHAID Service (District)* (the Seclusion Policy) (dated November 2019). The procedure did not have a review date.

Inspectors were also provided with the *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District)* (the Guidelines) (dated November 2019). The guidelines did not have a review date.

Inspectors' review of the DHBs *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District)* showed the Guidelines did not align with the MOH definition³⁴ of seclusion as set out in the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008. The DHB's Guidelines stated the definition of seclusion as: '*Where a consumer is placed alone in a designated room or area, at any time and for any duration, from which they cannot freely exit.*'

³⁰ With the removal of any items such as shoe laces, hoodie cords and trouser belts which may pose as a ligature risk.

³¹ The Ward is located in Helensburgh House which is a multi-story building which housed another Ward (Ward 11 is a 16 bed clinical rehabilitation unit) and management and administration services.

³² Ward 9a is a secure forensic mental health ward located on the Wakari Hospital campus.

³³ Means a sharp bend or turn.

³⁴ 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.

In response to my provisional report, the DHB stated they would ‘*address the discrepancy relating to the definition of Seclusion contained within its guidelines and will amend Restraint Minimisation and Seclusion Guidelines – MHAID (District) to correctly match the definition as clearly set out by the Ministry of Health*’. I was pleased to hear that this will be addressed.

I expect the DHB to use the MOH’s definition of seclusion.

Data provided by the Service indicated that from 1 November 2020 and 30 April 2021, there were 54 seclusion events, involving seven patients. In my predecessor’s report, data provided by the Service showed between March 2014 and August 2014 there were 57 seclusion events.

Table 1: Seclusion events 1 November 2020 to 30 April 2021³⁵

Month	Events	Patient numbers	Hours	Average hours
November 2020	20	3	199	9.95
December 2020	12	2	59.33	4.95
January 2021	5	4	36	7.20
February 2021	5	1	42.67	8.53
March 2021	10	5	102.45	10.25
April 2021	2	1	6	3
Total:	54	16	445.45 hours	43.88 hours

Data also showed that two patients attributed to 88.87 percent of all seclusion events.³⁶

Inspectors’ review of seclusion documentation showed paperwork was generally completed to a good standard and in a timely manner.

Staff told my Inspectors that they were reluctant to use seclusion except as a last resort. During the inspection, Inspectors observed several occasions where nursing staff skilfully de-escalated challenging situations with patients.

I acknowledge that work is already underway to reduce the use of seclusion across the Service. Further information provided by the Service shows that a Seclusion and Restraint group has been established and meets fortnightly. The Ward also employed the Safewards model.³⁷ The information provided demonstrated a commitment to reducing seclusion.

³⁵ Data as provided by the Service.

³⁶ Of the 54 seclusion events for the reporting period, one patient attributed for 32 events and another for 16 events.

³⁷ Safewards is a model of care, developed in the United Kingdom, designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion) in acute adult mental health

I am mindful that the physical environment and lack of appropriate de-escalation spaces in the Ward may impact on the number of seclusion events.

I encourage the Service to continue their work towards the reduction and elimination of seclusion on the Ward.

Night Safety Procedures

I was pleased to hear that the Ward and Cottage did not utilise Night Safety Procedures.³⁸

Restraint

The DHB provided Inspectors with the *Restraint Minimisation and Safe Practice Policy (District)* (the Restraint Policy) (dated November 2019). The procedure did not have a review date. Inspectors were also provided with the *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District) Southern* (dated November 2019). The procedure did not have a review date.

Data provided by the Service showed that between 1 November 2020 and 30 April 2021 there were 136 restraint events, involving eight patients. This is a marked increase from my predecessor's previous inspection, which showed 82 events between March 2014 and August 2014.

Table 2: Restraint data (exclusive of seclusion data) 1 November 2020 to 30 April 2021³⁹

	November	December	January	February	March	April
Total restraint events	40	25	14	20	22	15
Total patients restrained	4	3	4	3	5	2
Personal restraint ⁴⁰	39	22	14	20	21	15

inpatient units. For a more comprehensive description of the Safewards model, go to the Safewards website at: <http://www.safewards.net/>

³⁸ Ministry of Health. 2018. Night Safety Procedures: Transitional Guideline. Wellington: Ministry of Health. <https://www.health.govt.nz/system/files/documents/publications/night-safety-procedures-transitional-guideline-feb18.pdf>

³⁹ Data as provided by the Service.

⁴⁰ Personal restraint is when a service provider(s) uses their own body to limit a patient's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

	November	December	January	February	March	April
Mechanical restraint ⁴¹	0	0	0	0	1	0
Environmental restraint ⁴²	1	3	0	0	0	0
Number of males restrained (Māori)	0	0	1	0	0	0
Number of males restrained (Non-Māori)	1	1	1	1	2	1
Number of females restrained (Māori)	0	0	0	0	0	0
Number of females restrained (Non-Māori)	3	2	2	2	3	1
Youngest person restrained (years)	19	19	19	19	19	32
Oldest person restrained (years)	63	32	39	63	63	63
Shortest restraint episode (minutes)	1	2	1	0	0	1
Longest restraint episode (minutes)	150	110	30	15	88	25
Average restraint episode (minutes)	13	14.8	6.4	3.8	10.3	5.3

Restraint documentation was completed to a good standard.

⁴¹ Mechanical restraint is not an approved type of restraint within the DHB ID Service. The DHB ID Service will record the use of mechanical restraint occurring when a patient is escorted by Police or Corrections staff into the Ward when handcuffs/wrist restraints are used. This was the case with the recording of mechanical restraint in March 2021. There were no patients at the time of inspection that had mechanical restraint/s as part of their treatment.

⁴² Environmental restraint is where a service provider(s) intentionally restricts a service users' normal access to their environment, for example where a service users' 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.

Data provided by the Service showed that three⁴³ of the eight patients attributed to 93.4 percent of all restraint events. Less than half of all restraint events resulted in seclusion.

While I acknowledge that rates of restraint can be affected by a variety of factors, I am concerned that the use of restraint had increased since my predecessor's last inspection.

I encourage the Service to continue their work towards the reduction and elimination of restraint on the Ward.

Environmental restraint

Environmental restraint documentation was completed to a varied standard, including a number of events that met the definition of seclusion, but were recorded as environmental restraint:

- One environmental restraint was initiated but did not detail where in the Ward this occurred;
- The second event detailed that a patient was placed in their bedroom and the door barricaded. Documentation indicated that the patient was secluded in their bedroom as the designated seclusion room was in use. Documentation also showed that the patient was placed in their room until they could be taken to Ward 9a for seclusion.
- The third event involved a patient being placed in the Open Intensive Care Unit⁴⁴ (OICU) with the door locked.
- The fourth event involved a patient being locked in OICU area.

I acknowledge that there were safety concerns for the staff at the time of these events and that the Service had recorded the episodes, however three of the four documented events of environmental restraint met the definition of seclusion as defined by the Ministry of Health.

I expect that all seclusion events are accurately recorded and in accordance with the Ministry of Health definition of seclusion.

In response to my provisional report, the DHB stated they '*will ensure that all events where the clinical team has assessed that environmental restraint is required will be recorded as a seclusion event. Further liaison with the Director of Area Mental Health Services (DAMHS) will occur to ensure these events are understood and documented correctly*'. I appreciate the responsiveness to my recommendation and look forward to seeing these developments.

Use of face covering or masks during restraint

Inspectors' review of restraint documentation showed that on one occasion, staff placed a face mask on a patient during a restraint event.

⁴³ Of the 136 restraint events for the reporting period Patient A had 93 events (68.4 percent), Patient B had 20 events (14.7 percent) and Patient H had 14 events (10.3 percent).

⁴⁴ This is how the Ward referred to the ICU area when the door was left unlocked or open.

Information received from the Service showed that staff placed a N95 surgical mask on the patient's face during restraint to prevent them from spitting or attempting to bite staff.

Documentation also showed that the patient was held in partial restraint for 15 minutes, before agreeing to be escorted to their bedroom.

The documentation relating to the restraint event was poorly completed and lacked sufficient detail, particularly the duration for which the mask was in place. Additional information stated the mask was removed once the patient ceased spitting, although no timeframe was provided to my Inspectors.

Inspectors requested copies of related policies or procedures surrounding the use of surgical face masks during restraint and were advised there was no specific policy, procedure or guidelines.

The use of unapproved restraint techniques, such as a face covering or mask, has the potential to compromise a patient's safety. Furthermore, I consider this practice to have compromised the patient's dignity on this occasion.

While I acknowledge staff's safety concerns, I expect staff to adhere to approved restraint techniques and seek alternatives, such as staff applying personal protective equipment, to avoid placing face covering or masks on a patient's face during a restraint event.

In response to my provisional report, the DHB noted that *'IDS [Intellectual Disability Service] will review this practice to ensure that the patients' rights are upheld alongside seeking alternatives to ensure that staff are protected from the risk of blood/body fluid exposure because of patients spitting during restraint events'*. I am encouraged by the DHB's Mental Health, Addictions and Intellectual Disability (MHAID) directorate senior group and the Intellectual Disability Service (IDS) senior leader's response to my recommendation.

Restraint training for staff

All staff attend Safe Practice Effective Communication (SPEC) revalidation training annually. At the time of inspection all Ward and Cottage staff were up-to-date with SPEC training, with the exception of four staff members due to injury or long term ACC leave. At least four staff from the wider Intellectual Disability Service team attended monthly revalidation sessions on a regular basis to ensure revalidation is maintained within the 12 month period.

In my predecessor's report, they made a repeat recommendation that all staff should be up-to-date with their restraint training. I was pleased to see this had been achieved.

Electro-convulsive therapy

There were no patients undergoing Electro-convulsive therapy (ECT)⁴⁵ at the time of the inspection.

⁴⁵ 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.

Sensory modulation

The Ward had a Sensory Modulation Room⁴⁶ however this was not operational at the time of inspection. Staff told my Inspectors the Sensory Modulation Room had been non-operational 'all year'. The room had been converted from a former bedroom and had recently been repainted. The room was small, and there was no sensory modulation equipment. Staff told my Inspectors that a funding application had been made through a charitable trust to purchase new sensory modulation equipment, such as weighted blankets, sensory lighting, sound equipment and other sensory products.

Inspectors were advised by staff and patients that they had sensory kits available for their use. These kits were kept in the patients' bedrooms.

The staff had wanted to turn the ICU area into a sensory space, however there was no available funding to do this.

I strongly recommend the Sensory Modulation Room be made available to patients as a means of therapeutic intervention and a tool toward seclusion and restraint reduction.

In response to my recommendation the DHB noted they had recently received funding for specific Sensory Modulation equipment and resources, furthermore, the purchase of equipment was underway at the time of their response. I was pleased to hear of this progress and look forward to seeing improvement in this area.

Patients' and whānau views on treatment

Patients' views on their treatment on the Ward and Cottage were generally positive. A number of patients said they felt they were treated with respect by staff and most said that they felt safe on the Ward and Cottage. Inspectors observed respectful, positive, and warm interactions between patients and staff. Over the course of the inspection senior management were observed by my Inspectors to be active on the Ward in providing guidance and support to both staff and patients.

Whānau Inspectors spoke with had no concerns about the care and treatment provided on the Ward and Cottage to their whānau member. They said staff were respectful, the Care Managers⁴⁷ were proactive in involving whānau in their care planning and keeping them up to date. Visits were easy to book and whānau were afforded flexibility with visit times by staff.

⁴⁶ 'Sensory modulation uses a range of tools to help individuals get the right amount of sensory input. In mental health settings, sensory modulation can be used to assist distressed service users to regain a sense of calm'. Te Pou o te Whakaaro Nui. *Sensory modulation in inpatient mental health: A summary of the evidence*. Te Pou o Te Whakaaro Nui, Auckland, 2011.

⁴⁷ The role of Care Manager is to fulfil the functions and duties as set out in section 141 of the IDCCR Act, including work with the care recipient to develop a 'Care and Rehabilitation Plan' that reflects the support needs of the care recipient.

Recommendations – treatment

I recommend that:

1. Forensic patients are accommodated separately from non-forensic patients.
2. ‘Medium secure restrictive practices’ are not placed on non-forensic patients.
3. Gender separation is provided on the Ward wherever possible.
4. The DHBs *Restraint Minimisation and Seclusion Guidelines - MHAID Service (District)* use the MOH’s definition of seclusion.
5. All events which meet the definition of seclusion as set out by the Ministry of Health, are recorded as seclusion events.
6. Facial coverings or masks are never applied to a patient when they are being restrained.
7. Staff only use DHB approved restraint techniques.
8. The Sensory Modulation Room is made operational.

Protective measures

Complaints process

The DHB provided Inspectors with the *Consumer Complaints Policy (District)* (the Complaints Policy) (dated November 2019). The Complaints Policy did not have a have review date.

The DHB provided Inspectors with the *Recording and Managing Consumer Complaints (District)* (dated November 2019). The *Consumer Complaints Policy* did not have a have review date.

The complaints process was not displayed in the Ward or Cottage. ‘Tell Us What You Think’⁴⁸ leaflets were given to patients as part of their induction information on admission. This information should be in an accessible format that meets the needs of the patient group.

Staff and patients my Inspectors spoke with did not have an understanding of the DHB’s complaints process. Some staff could only speak of the patient’s right to make a complaint through the Health and Disability Commissioner. Staff did report that patients could raise a complaint or suggestions at the Mutual Help Meetings⁴⁹. The Mutual Help Meeting was part of the Safewards initiatives and enabled patients the opportunity to raise any concerns they may have.

⁴⁸ Information on how to make a complaint, compliment, suggestion or concern leaflet was contained in the *Information for Consumers* and the *Information for Family, Whānau and Support Workers* packs. These were provided to the patient on their admission to the Ward.

⁴⁹ Patient-led community meetings were held three times a week in the Ward and Cottage.

Staff were encouraged to resolve complaints at the point of contact with the complainant, where possible. Complaints could be lodged verbally and in written format with the assistance of staff, if required.

There were no complaints received between 1 November 2020 and 30 April 2021.

District Inspectors' (DI) contact details were not displayed in the Ward or Cottage, nor was information on the role and functions of the DI available on the Ward or Cottage. One DI stated that it was rare for patients to contact them, usually if they did it was in relation to the role of the DI.

Inspectors saw one poster for the Health and Disability Commissioner's *'Code of Health and Disability Service Consumers' Rights'* displayed on the Ward and Cottage. Information was not displayed in accessible or Easy Read format for the patient group.

The DHB has advised that following the feedback meeting with my Inspectors on 7 May 2021, changes have been made so that:

- the complaints process, including complaint forms, and contact details for the District Inspector, are up-to-date, well-advertised and accessible to patients independent of staff; and
- copies of the Code of Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights in Easy Read format are available throughout the Ward and Cottage.

Records

Of the seven patients on the Ward on the first day of the inspection, four were detained under the MHA and three were detained under the IDCCR Act. All but one file contained the necessary paperwork to detain and treat the patients.⁵⁰ Paperwork on patients' Welfare Guardians and Personal Orders were also on file and up-to-date.

Of the three patients in the Cottage on the first day of the inspection, two were detained under the MHA and one was under the IDCCR Act. Files contained the necessary paperwork to detain and treat the patients.

Paperwork on patients' Welfare Guardians and Personal Orders were also on file and up-to-date.

Inspectors reviewed patients' Care and Rehabilitation Plan (CARP)⁵¹, Treatment Plans, leave paperwork, behavioural plans, clinical notes, Ward Rounds notes and Case Conference records. Overall, Inspectors found that records were comprehensive, detailed and plans were individualised.

⁵⁰ This was rectified during the inspection.

⁵¹ *'Care and Rehabilitation Plans'* are a requirement for care recipients under s25 (1) of the IDCCR Act.

My Inspectors also reviewed patients' files for evidence of completed consent to treatment forms. All reviewed forms except one were not signed due to the lack of 'capacity' (as noted on the form).

Staff told my Inspectors that patients were offered a copy of their CARP and/or Treatment Plan, however some patients chose to decline their copy. Patients my Inspectors spoke with confirmed they were offered a copy of their plan. A review of patient files showed the majority of CARPs and/or Treatment Plans did not record whether patients had received a copy of their plans, nor was it documented whether a patient had accepted or declined a copy of their plan. No CARPs or Treatment Plans had patient or welfare guardian signatures, with only two plans stating the reason for this.

Inspectors' review of leave plans showed that they were co-designed with patients, were comprehensive and all but one patient had some form of approved leave, accompanied by comprehensive and up-to-date risk management plans.

Patients under the IDDCR Act saw their Care Manager once a week, as evidenced in the clinical notes.

Inspectors attended one session of the Ward Rounds meeting, where an overview of the past 48 hours and the intended upcoming care and activities for each patient were discussed amongst the team. The Ward Rounds were introduced to enable all staff from other disciplines to attend and be up-to-date with patients care and activities on a regular basis. Staff told my Inspectors that this was a positive initiative and was well attended.

All patients had a three-monthly Case Conference which they attended. Whānau and any NGO⁵² providers were also invited to attend. Clinical meetings and Case Conferences could be called earlier on a case-by-case basis.

Multi-Disciplinary Team meetings (MDT) occurred fortnightly, however staff told my Inspectors that these meetings were not functioning as well as they could. A proposal had been put forward to alter both Case Conference and MDT meetings. Patients were invited to attend towards the end of both Case Conference and MDT meetings.

My Inspectors were advised that the DHB was in the process of planning the implementation of the *Good Lives*⁵³ model of care for the Intellectual Disability Service (IDS). Staff had attended a number of training sessions on the model of care. Staff would also be attending further education sessions for Positive Behaviour Support⁵⁴ (PBS) training.

Consumer Advocate

There was no independent Consumer Advocate available to patients on the Ward or Cottage. Inspectors contacted the Adult Consumer Advisor, who advised they had a minimal role with

⁵² Non-government organisation.

⁵³ See <https://www.goodlivesmodel.com/> for more information.

⁵⁴ Delivered by Explore, the PBS framework 'focuses on understanding a person's needs and supporting them and the people around them to experience a better quality of life' while reducing challenging behaviour. See www.healthcarenz.co.nz/explore-specialist-advice for more information.

Ward and the Cottage due to it being a mixed ward with dual diagnosis patients. It was reported that whilst they had no daily responsibilities in either, they did try and attend the Mutual Help Meeting, facilitate a listening group every three to six months and organise for the nationwide Health and Disability Advocacy Service to visit every three to four months.

I am concerned that the patients in both the Ward and Cottage do not have regular access to an independent Consumer Advocate and recommend that the DHB address this.

In response to my provisional report, the Service said they understood the need for independent consumer advocacy. They reported that the Nationwide Health and Disability Advocacy Service contact information posters and leaflets have been placed in clinical areas, and that *'the clinical team are aware of this important service, having supported patients in the past to seek an advocate, and are responsive to any service users wishing to make contact'*.

Recommendations – protective measures

I recommend that:

9. Independent Consumer Advocate support is available to patients.

Material conditions

Accommodation and sanitary conditions

The Ward

Physical layout

The Ward, which opened in 1992, was located on the ground floor of Helensburgh House at Wakari Hospital.

The Ward was not a purpose-built facility. Originally a nurse's home, the Ward was repurposed in the mid 2000's to include the addition of two ground floor extensions, upgrades to the clinic room and nursing station, and the creation of a whānau room. The only significant change to the Ward since occurred in 2017 to reduce bed numbers from 13 to 12, to include the Sensory Modulation Room.

There was only one point of entry to the Ward, via a secure airlock which led into a narrow corridor onto the Ward. The Ward comprised nine bedrooms, located along the corridor, with shared bathroom facilities. Three bedrooms, located off another smaller corridor leading to the ICU, had en-suite bathroom facilities.

The location of the three bedrooms near the ICU was problematic and potentially distressing for patients, due to their placement and frequent high noise level when other patients were in seclusion or placed in the ICU area.

All bedrooms had privacy screening, patients could lock their bedrooms, and bedrooms were personalised with sufficient storage space. Patients could also keep their own toiletries in their bedrooms, with the exception of spray aerosol and razors.

There were two communal lounge areas, which were dated, dreary and tired in appearance. Carpets and furnishings needed replacing. The lounge areas were sparse, comprising a TV, table and chairs, pool table and a small internal sunroom leading to the external courtyard.

Patients had supervised access to the outdoor courtyard, which contained seating and a small garden, under staff supervision. The doors to the outside courtyard were locked throughout the inspection. A small second patient lounge (or 'quiet lounge') had couches and a TV. The room was stark, had no natural light, and was also utilised for visits, assessments and staff meetings.

Access to the staff room was via the quiet lounge. Inspectors noted the staff room had a rancid smell on the first day of inspection.

The Ward kitchen and dining room was small, however patients could access the dining room independent of staff. Linen and clean bedding was accessed with assistance of staff. Laundry facilities were available for patients to do their washing.

Not fit-for-purpose

The Ward layout and design was not conducive to contemporary therapeutic or safe care. I consider the Ward to be not fit-for-purpose, as highlighted by my predecessor in their 2014 report.

In essence, the Ward comprised of two narrow corridors with a small central nursing station, two lounges and a kitchen.

All bedroom doors opened onto the corridor, presenting a safety risk to people passing through, as well as impeding line of sight for nursing staff.

The poor Ward design meant that patients could not separate from others or avoid unintended contact with other patients or staff. There was a lack of dedicated spaces for therapeutic programmes, quiet spaces, gender separation, or clinical and interview spaces.

The diverse patient mix, which included forensic and non-forensic patients, meant that separation between these patients was not possible, presenting a potential safety risk to patients (see page 19 of this report).

Staff commencing a shift on the Ward were required to pass through the main corridor to enter the nursing station, which meant that any potential risks or incidents presenting at the time would be unknown to them, placing staff at risk.

The corridor walls were also significantly damaged, due to the narrow size, as the meal trolley⁵⁵ did not adequately fit through the Ward. Doors could be opened suddenly as the meal trolley passed through the Ward, presenting a safety risk to patients and staff.

The kitchen was small and the meal trolley did not fit, which meant it had to remain in the corridor during mealtimes, blocking access and passage.

Other design issues included privacy concerns, lack of separate bathroom facilities, noise levels, maintenance issues, as well as heating and ventilation issues.

The Ward had multiple significant ligature points throughout the Ward.⁵⁶

Furnishings were old, worn, and bedrooms and other areas had damaged carpets.

Some bedrooms had domestic single beds, which posed an infection control issue. Due to the lack of dedicated spaces, the lounge areas and dining room were used for multiple purposes, which negatively impacted on patients who often had to leave an area so that a programme, MDT or Case Conference could be conducted.

The Ward's physical environment was stark and unwelcoming. There was a noticeable lack of artwork or decoration throughout the Ward. The main corridor displayed the Ward's Clear Mutual Expectations⁵⁷ notice, the staff 'Getting to Know You'⁵⁸ board and the Health and Disability Commissioner's 'Code of Health and Disability Service Consumers' Rights' on the walls. Staff advised my Inspectors that other materials had been taken off the walls due to COVID-19 to enable cleaning and support infection control.

The Ward was mostly tidy, but required a higher level of maintenance both internally and in the external grounds area of the Ward. Curtains were not fully attached to their fittings in some bedrooms, and bedroom windows had cobwebs and dirt on them. One bedroom had duct tape covering a worn area of carpet. Bedroom doors and walls were damaged and the physical appearance of the Ward in general was poor. A number of staff members described the Ward environment as a '*disgrace*' and a '*real concern*'.

Senior management had made multiple capital expenditure (CAPEX) requests to the DHB to improve aspects of the Ward and scope redevelopment. These applications included improvements to furnishings, feasibility studies, installing a rear airlock entry for the meal trolley, among other issues. Inspectors were advised that the CAPEX for redevelopment scoping and improvements to furnishings had not been approved.

⁵⁵ A Capital Expenditure application had been submitted to the DHB to provide a rear airlock entry and exit and to widen the dining room door.

⁵⁶ The DHB has completed a ligature audit across the Wakari wards which has identified multiple ligature points throughout the Ward.

⁵⁷ Is an agreed set of expectations for everyone on the Ward inclusive of staff. The Clear Mutual Expectations were agreed upon in consultation with the patients. This is for both Ward 10a and Helensburgh Cottage.

⁵⁸ Ward notice board that displays a picture of the staff members staff and something about themselves.

I consider the poor level of maintenance in the Ward at the time of the inspection unacceptable in a hospital environment. All patients are entitled, and should expect, to receive health care in a clean, safe and well-maintained setting.

In response to my provisional report, the DHB stated they were working with the Building and Property Service to address outstanding maintenance issues in the Ward. They reported that liaison with cleaning contractors regularly occurs to ensure that standards of cleanliness across all clinical facilities are maintained.

I acknowledge that multiple audits and evaluations had been undertaken to identify the state of the Ward. A 2017 audit carried out by the DHB found the environment was *'never fit for purpose'* and that *'the key issue is that this building is not fit for purpose which will never be achievable with the current structure'*.⁵⁹

Another audit, carried out in 2019, found that all mental health facilities at Wakari Hospital were considered out of scope for the Dunedin Hospital rebuild and that the purpose of the report was to generate discussion about future options.⁶⁰ My Inspectors were advised that the Service intended to prepare a business case for a new purpose-built facility either at the Wakari Hospital campus or Dunedin Hospital campus.

The 2019 report identified a number of issues with Ward 10a and stated *'the not-fit-for purpose facilities create safety risks for both patients and staff and as a result have significant negative flow-on effects to the care provided and received.'*

Staff expressed frustration and disappointment at the ongoing poor state and design of the Ward and described the negative impact the environment had on patient care, recovery and rehabilitation. Senior management told my Inspectors that they had repeatedly raised their concerns with the DHB regarding the physical environment.

I consider the poor state of repair of this Ward to be unacceptable. It is unsafe, for both patients and staff, and severely compromises the dignity and independence of patients. I am further disappointed that action has not been taken since my predecessor's inspection and I strongly urge the DHB to take immediate action to prioritise a rebuild or redevelopment of this Ward.

In response to my provisional report, the DHB stated they had recently received the outcome of an independent review which highlighted the not-fit-for purpose nature of the Ward. The DHB further stated that *'the future of the Southern DHB Intellectual Disability Services and facilities will be carefully considered along with other mental health services following this review. It is accepted that upgrades to current facilities, addressing ligature points, investment in furniture and carpets is required in the shorter term'*.

I appreciate that steps had been taken to address this issue and look forward to seeing these developments.

⁵⁹ *Status of Mental Health Addictions and Disability Directorate (MHAID) Services Facilities on Wakari Site*. June 2017.

⁶⁰ *Environmental scan of issues relating to the current MHAID facilities on Wakari site*. 28 July 2019. Sapere Research Group.

I also intend to raise my concerns on this matter with the Ministry of Health.



Figure 3: Main corridor – bedrooms on the left

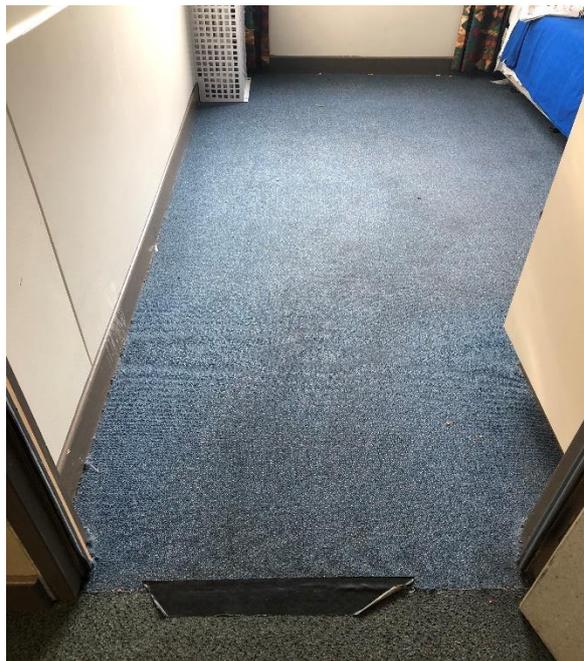


Figure 4: Carpet damage in bedroom doorway

The Cottage

The Cottage is a purpose built four-bed community secure step down facility located close to the Ward. The Cottage was in a good state of repair and was suitable to provide contemporary therapeutic and secure care. Entry was through a single secure point at the entrance to the Cottage.

The Cottage comprised two separate wings with two bedrooms and shared bathroom facilities in each. Bedrooms were reasonably large with sufficient storage space and patients were able to personalise their bedrooms. Bedrooms had plenty of natural light and curtains to afford privacy. Each wing had a large communal lounge area that opened out to a courtyard that ran around the entire cottage. Doors to the outdoor courtyard were open at the time of inspection.

There was a large central kitchen and dining area, which was warm and welcoming. Linen and laundry facilities were available to patients. Overall, the Cottage had a home-like and therapeutic feel.



Figure 5: Patients bedroom



Figure 6: Part of one lounge in the Cottage

Food

The Ward

Patients' meals were prepared at Wakari Hospital and delivered to the Ward in heated trolleys. Menus ran on a two weekly cycle. Breakfast was from around 7.30am to 9am, lunch at 12.30pm, and dinner around 5pm to 6pm. Morning tea, afternoon tea and supper were provided. During the day, patients were also provided with a range of snacks and fruits.

All patients had regular access to personal snacks, which were securely kept in a cupboard on the Ward. Patients were also able to purchase takeaway meals on community leave or during whānau visits.

There was one communal dining area where patients could have their meals. All meals were provided in the dining area, with the exception of one patient who took their meals in the ICU area due to their level of risk to others. Patients could leave the dining area once they had finished their meal and were not required to wait until all patients had finished eating.

The adjoining kitchen was locked and patients were unable to access the kitchen without staff accompanying them. As a result, patients were unable to access drinking water or hot drinks independent of staff. Patients had water bottles for cold water, which staff would assist with filling.

The 'blanket' restriction on access to the kitchen adversely impacted patients' ability to access drinking water, hot drinks and refreshments. At a minimum, patients should have access to drinking water without relying on staff.

While I acknowledge the view that the restriction exists for safety reasons, I consider the blanket restriction on access to the kitchen unreasonably restricted patients' ability to access hot and cold drinks independent of staff. I consider that patients should have access to cold drinks independent of staff and access to hot drinks should be based on individual risk and subject to regular review.

In response to my provisional report, the DHB stated *'the IDS has commenced investigations into patient independent access to drinking water. Options for a built-in drinking water fountain and stand-alone water fountain are being explored. Environmental constraints are present which only afford the Ward 10a kitchen as a suitable location for access to hot drinks. Independent access to hot drinks for patients is noted to require further work to explore feasibility'*.

I am pleased to see the IDS is taking measure to provide independent access to drinking water for patients.

The Cottage

Patients cooked their own meals with the support of staff on a roster system. Patients in the Cottage told my Inspectors that they enjoyed the meals in the Cottage. Patients' snacks were kept in a separate locked pantry. Staff said this was *'to stop patients over eating, which could often be an issue for patients with intellectual disabilities'*.

Recommendations – material conditions

I recommend that:

10. The Ward is rebuilt or at the very least upgraded, including remedying ligature points, upgrading soft furnishings, carpets and bedding. **This is an amended repeat recommendation.**
11. Cleanliness and facilities maintenance issues are attended to as a matter of priority.
12. Patients can access drinking water and hot drinks independently of staff, unless this is considered unsafe based on an individual risk assessment. If a patient is not able to access drinking water or hot drinks independently, the reasons are recorded and regularly reviewed.

Activities and programmes

Outdoor exercise and leisure activities

A number of outdoor exercise and leisure activities were available to patients.

The Ward employed two Activity Assistants (AA) who facilitated the Ward's activity schedule. At times AAs were also counted as 'on rostered numbers'. This meant that, on occasion, AAs may be required to support the staff with observations and other tasks, which could impact on the delivery of activities.

Scheduled activities were available Monday to Friday from 9am to 3pm. No scheduled activities were available on evenings or weekends. As the Ward had no dedicated activities room, activities generally took place in the communal lounge or dining room. Activities

included newspaper group, mutual help meeting, budgeting group, indoor games, cooking, 1:1 with patients, arts and crafts, grounds walks, community outings and van rides.

Activities were also available to patients in the Cottage, however these were individual programmes as scheduled on each patient's daily activity timetables.

The Ward did not have an occupational therapy kitchen, however the kitchen in the dining area was used for cooking activities.

Patients also had access to a range of puzzles, books, television, PlayStation, pool table, table tennis table and personal TVs in their bedrooms.

The Ward's courtyard was spacious, with adequate seating and shade; it had a basketball hoop and a vegetable garden. Patients could only access the courtyard under staff supervision.

The outside area for patients in the Cottage was pleasant. It had a basketball hoop and a vegetable garden, seating and shade. Access to this area was independent of staff.



Figure 7: Outside area on the Ward



Figure 8: Outside area at the Cottage

Each patient had their own tailored weekly programme, which was individualised and included both group and 1:1 activities. The individual activities programme included swimming, shopping, grounds walks, library, external literacy programme, time and activities with external support workers,⁶¹ and van rides or community outings.

Nearly all patients had some form of leave,⁶² and staff were proactive in facilitating leave as part of their transition plans.

Patients in the Ward and the Cottage were also working with their proposed community providers during the week. This involved outings to their proposed discharge accommodation, shopping, banking and other meaningful activities that promoted community social inclusion.

In response to my provisional report, the DHB noted the senior leadership group forum would discuss my recommendation to extend the activities programme to evenings and weekends.

⁶¹ Those patients who were transitioning to community providers.

⁶² One patient who had recently been admitted, did not have leave at the time of inspection.

Programmes

At the time of inspection, the DHB had a vacancy for a 1.5 full-time equivalent (FTE) Clinical Psychologist. As a result, there were no psychological therapeutic programmes occurring on the Ward or Cottage at the time of inspection. Staff and patients considered this vacancy was negatively impacting on programmes and individual therapy sessions. My Inspectors were advised that a new Clinical Psychologist was due to commence employment in July 2021.

The Service employed two FTE Occupational Therapists (OTs). One OT worked with patients in the Cottage and the other worked with patients in the Ward, however at the time of inspection the Ward's OT was on maternity leave. This position had not been filled as no suitable applicants had applied for the position. The OT for the Cottage was providing cover in the Ward at the time of inspection.

The Social Worker provided a budgeting programme in conjunction with the OT.

Cultural and spiritual support

The Kaioranga Hauora Māori⁶³ position for the Ward and the Cottage had been unfilled since the start of the year. Due to the vacant position and a limited work force at Te Oranga Tonu Tanga⁶⁴ they had not been able to provide Māori Cultural Intervention within the Ward since the position became vacant.

The Service had re-advertised the position in order to recruit a new person for this role for some time. My Inspectors were advised that interviews were being conducted in June 2021 for the position.

In response to my provisional report, the DHB noted that active recruitment for vacant positions was underway. I acknowledge the efforts made to recruit and the difficulties faced by facilities across the country in doing so.

The Wakari Hospital Chaplaincy Team was available to patients in both the Ward and Cottage, and requests to see them could be made through staff. One patient received regular visits from a hospital Chaplain each Friday and the Care Manager had recently made a request for a patient in the Ward.

Sunday service was available at the hospital for those patients with approved leave.

⁶³ Māori cultural worker.

Recommendations – activities and programmes

I recommend that:

13. The activities programme is extended to evenings and weekends.
14. Regular and ongoing access to Kaioranga Hauora Māori supports is provided.

Communications

Access to visitors

There was a small visits room at the front of the Ward. This room also operated as a quiet lounge for patients. Patients were able to receive visitors daily between the hours of 2pm and 8pm, however flexibility was applied to times outside of these hours. Visitors were encouraged to make appointments but there was no time limit on the visit. Staff may be required to supervise the visit, however this was determined on a case-by-case basis.

Visits took place in the Cottage.

For patients with unescorted community leave, visits could be conducted off-site.

Access to external communication

The Ward

The patients' cordless telephone was in a locked cupboard located next to the nurses' station and offered no privacy or independent access for patients. My predecessor recommended that patients be able to make phone calls in private. I was disappointed to hear this had not been achieved.

Some staff said they would allow patients to use the staff office to take sensitive calls, but other staff and patients spoken with said this was not the case. This included lawyers and DIs calls being made at the nurses' station, in hearing of staff and other patients.

Due to poor Ward design, patients would often congregate around the nurses' station. When a patient wanted to make a phone call, other patients were asked to leave the area. Staff listened to all patient phone calls regardless of the patient's legal status. Staff told Inspectors this was due to the multiple different patient groups on the Ward and the need to provide consistent rules across the Ward (see page 21 of this report). However, patients under the MHA have no legislative requirement to have their phone calls monitored.

Mobile phones were not permitted on the Ward, and were only approved for use if there was clear therapeutic benefit to the patient. Again, this disadvantaged those patients under the MHA due to the medium secure care designation of the Ward. MHA patients were under the same restrictions as forensic patients.

There were no prescriptive times for patients to access the telephone.

The Cottage

Patients in the Cottage had regular access to phone calls and Zoom calls with whānau. Patients also had access to tablets, mobile phones and the internet. Access to phone content and tablets was monitored by staff on a regular basis. Again, the blanket monitoring of MHA patients' phone and tablet use disadvantaged these patients.

Patients did not raise any concerns with Inspectors about their ability to send and receive mail.

My predecessor recommended patients be able to access the telephone in private. This recommendation had not been achieved.

In response to my provisional report, the DHB have advised that the Service's senior leadership and clinical team had commenced investigations into feasible options that can be implemented to afford safe private use of the telephone for patients.

Recommendations – communications

I recommend that:

15. Patients in the Ward and Cottage can make a telephone call in private and independent of staff. **This is an amended repeat recommendation.**

Health care

Primary health care services

Patients received a physical assessment on admission. Assessments included obtaining a medical history, taking routine blood tests, and addressing any physical concerns. A Psychiatric Registrar was available to the Ward and Cottage.

Patients would be taken to the General Practitioner (GP) for general medical needs as part of promoting social inclusion in the community. If patients needed emergency treatment, they would be taken to Dunedin Hospital.

Patients had good access to podiatrists, dieticians and dental services, which was evidenced in patient files.

A treatment room was available on the Ward for physical examination and storage of medications, including controlled drugs. Staff advised my Inspectors that patients did not enter this room due to safety concerns as there were no exit points. Staff told my Inspectors that assaults had previously occurred in the treatment room. As a result, staff would dispense medication on the Ward.

Controlled drugs were stored securely and audited regularly.

Patients were aware of their medications and education sessions were provided by the Ward and Cottage staff, with input from the Pharmacist. The Pharmacist provided advice and support to the team and attended MDTs for both the Ward and Cottage. The Pharmacist would respond to any questions outside of the MDT by email or telephone.

There were no documented medication errors between 1 November 2020 and 30 April 2021.

Patients did not raise any concerns with Inspectors regarding access to primary health care services.

Recommendations – health care

I have no recommendations to make.

Staff

Staffing levels and staff retention

Inspectors observed a supportive and cohesive team environment and culture. Staff my Inspectors spoke with felt supported by and complimentary towards leadership, who appeared to be actively involved on the Ward. Over the course of the inspection senior management were observed by my Inspectors to be active on the Ward in providing guidance and support to staff.

I was pleased to hear staff's professional approach to patient care was not compromised by the multiple complexities of the Ward, and my Inspectors observed that staff were caring for a number of patients with HCN in the least restrictive manner possible.

Data provided by the Service showed a multi-disciplinary staff complement of one CNM, one Acting Charge Nurse Manager (ACNM), one Clinical Nurse Specialist (CNS), 15 Registered Nurses (RNs), eight Enrolled Nurses (ENs), 11 Mental Health Assistants (MHAs), two OTs, one 0.5 FTE Social Worker, two AAs, three part-time Consultant Psychiatrists and one 0.5 FTE Psychiatric Registrar.⁶⁵

There were 3.8 FTE nursing staff vacancies and 1.5 FTE Clinical Psychologist vacancies at the time of inspection, however 1 FTE Clinical Psychologist was due to commence employment in July 2021.

⁶⁵ One OT was on maternity leave at the time of inspection.

Nursing staff worked a three-shift roster,⁶⁶ with designated staffing level⁶⁷ on each shift.

Data⁶⁸ provided by the Service indicated that between 2017/18, 2018/19 and 2019/20, staff sickness rates decreased for RNs, increased for ENs and remained similar for MHAs.

Table 3: Overtime hours data 1 November 2020 to 30 April 2021

Role	November	December	January	February	March	April
RN	219.92	329.67	240	183.17	127.25	123.75
EN	39.92	15	12	23.75	17.25	8.5
MHA	479.93	429.25	301.5	195.25	125.53	38.5
Total	739.77	773.92	553.5	402.17	269.83	170.75

The IDS had three casual pool staff (MHAs) attached to the Service. They worked exclusively in the IDS as casual staff to aid in filling roster gaps. The IDS casual pool staff had collectively worked a total of 688.00 hours during the period 1 November 2020 to 30 April 2021 in the Ward and Cottage.

Data also showed that between 2017 and 2020, staff turnover rates had decreased for RNs and MHAs and remained at 0 percent for ENs.

All new staff members received a four week orientation to the Service, Ward and Cottage. During this period staff were supernumerary and supported by a preceptor⁶⁹ team. The orientation package Inspectors reviewed was comprehensive.

Clinical supervision was actively promoted and staff were supported to attend.

⁶⁶ **Ward 10a:** Monday to Thursday - AM shift from 7am to 3:30pm with 3.75 RNs, 1 EN and 1 MHAs; Friday to Sunday - AM shift from 7am to 3:30pm with 4 RNs, 1 EN and 1 MHAs; Monday to Tuesday - PM shift from 2:30pm to 11.00pm with 4 RNs, 1.5 EN and 1 MHAs; Wednesday – PM shift from 2:30pm to 11.00pm with 4 RNs, 1.6.2 EN and 1 MHAs; Thursday to Sunday - PM shift from 2:30pm to 11.00pm with 4 RNs, 1.75 EN and 1 MHAs; and Monday to Sunday - Night shift from 10:45pm to 7:15am with 1 RNs 1 EN and 1 MHAs.

Helensburgh Cottage: Monday to Sunday - AM shift from 7am to 3:30pm with 1 RNs or EN and 1 MHAs or EN; Monday to Sunday - PM shift from 2:30pm to 11.00pm with 1 RNs or EN and 1 MHAs or EN; and Monday to Sunday - Night shift from 10:45pm to 7:15am with 1 RNs or EN⁶⁶ and 1 MHAs or EN

⁶⁷ Staffing levels based upon minimum core staffing for 100% Ward occupancy. Figures do not include Senior RNs (CNM, ACNM, CNS) Monday to Friday.

⁶⁸ Between 2017/18, 2018/19 and 2019/20, staff sickness rates decreased from 1569.5 hours, 1048 hours for RNs to 795 hours and increased from 207.5, 265.08 hours to 288 hours for ENs and remained similar from 1080 hours, 1181.8 hours to 1083.83 hours for MHAs.

⁶⁹ A preceptor is defined as an experienced and skilled nurse who provides specific teaching and learning opportunities for a beginner nurse over a defined period of time, within a specific clinical context. See: <https://healthcentral.nz/preceptorship-grounding-and-growing-the-next-generation/>

Security personnel

The DHB provided Inspectors with the *Security - (District) 54701* Version 3 (dated 17 November 2016). The document did not have a review date. Inspectors were also provided with the *ID Security Service Guidelines (The Guidelines) Ward 10a*. The *Guidelines* were specific to a particular patient in the Ward at the time of inspection.

The Ward had recently⁷⁰ contracted external security personnel as an additional safety measure and to offer reassurance to staff in relation to a recent patient's readmission to the Ward.⁷¹ The contract was for an assessment period only.

Security personnel did not receive SPEC training and were not involved in seclusion or restraint events. The Ward was working towards a staged withdrawal of security personnel at the time of inspection.

There were limits on the involvement of security personnel outlined in the *Guidelines*. For example, the *Guidelines* stated that security personnel would be only be involved in a restraint at the direction of the RN in an emergency.

Two security personnel were in attendance on the Ward daily 24/7. They were non-uniformed and assigned to a specific patient as outlined in the *Guidelines*. They had received written information from the senior management team in relation to their role, which they provided to my Inspectors.

Security personnel and Ward staff Inspectors spoke with had a clear understanding of their role and its limitations. Security personnel were very clear with Inspectors they were not involved in any restraint events.

Workforce training

Ward and Cottage staff attended general workforce training sessions with staff from other wards.

The CNS spent time upskilling and educating staff members working in Ward and Cottages. Specific 'in-service training' was arranged by the leadership team of Ward. This included inviting guest speakers or experts in specific areas as well as the CNS or other staff to present topics of interest or need. Additional training, such as PBS, was available. In service training was scheduled each fortnight in the quiet lounge of the Ward.

Inspectors were provided with information and schedules for all mandatory training, specific mental health mandatory training and in-service training. All staff were up-to-date with all mandatory training with the exception of four staff members due to injury or long term ACC leave. The senior management team ensured staff were released from the floor to attend training.

⁷⁰ Contract started 29 April 2021.

⁷¹ Patient was admitted 29 April 2021 and had on a previous recent admission seriously assaulted a staff member.

Staff and senior management told my Inspectors that there was a lack of ID specific training available. Senior management raised concerns that this was a national issue and a lack of psychopaedic or ID trained nurses meant that services had to source expertise and recruitment internationally. Staff told my Inspectors that *'there is basically no ID training for nurses in New Zealand'*, experience is gained *'on the job'*.

After the Inspection I wrote to the Ministry of Health to enquire as to what specific ID training is currently provided to nursing staff, and how the Ministry of Health engages with the Nursing Council and DHBs to deliver training specific to ID. In their response they acknowledged that there were significant workforce pressures within the sector, including the ongoing attrition of suitably qualified ID nurses. The Ministry of Health also stated:

'The Ministry does not directly provide training. Under the terms of the RIDSS contract the provider is required to provide professional development, adequate training, and support for all staff.'

The Ministry of Health said they would continue to engage with DHBs around these issues in and provide additional resources for training, such as PBS training.

I also wrote the Nursing Council of New Zealand to enquire about the training, education and guidance provided to nurses (enrolled and registered), specific to ID. In their response they stated:

'The Council does not provide training or education for student nurses who are seeking to become registered. That is the role of education institutions. It may be useful for you to contact schools of nursing (listed on our website) to understand the education they provide that is specific to Intellectual Disability. The Council's role is to accredit and monitor those education institutions'.

'The Council does not provide short courses or deliver specific professional development training which may relate to specialisation in the Intellectual Disability field. These specific training courses are usually set by the service providers in that specific area. It would be a requirement of the employer to require professional development to ensure that nurses have the relevant training and skills to practise in that area'.

Further, I asked the Nursing Council of New Zealand whether they engaged with the Ministry of Health and District Health Boards in providing training, specific to ID. In their response they stated:

'As stated above, the Council does not provide training to nurses..... we also engage with the Ministry of Health regarding workforce development issues'.

Southern DHB in their response stated:

'Southern District Health Board would welcome further work being done in this area. The Ministry of Health and the Nursing Council of New Zealand are the overall policy leaders in relation to workforce development and Registered Nurse competency, respectively, nationwide and as such could set expected standards of

education in this area for Undergraduate Nurse training programmes and the wider Intellectual Disability sector’.

‘The Southern District Health Board Intellectual Disability Service recognises the skills shortage and addresses this through a comprehensive orientation programme for new staff, in-service education and ongoing supervision and support for staff to develop their knowledge and experience. A number of Registered Nurses have already attended Positive Behaviour Support training, provided by Explore, and plans are being made for all Intellectual Disability Service staff members to attend this training in the near future’.

I am concerned at what appears to be a lack of clarity in ownership of standard setting for training and support for nurses providing care for people with Intellectual Disabilities. I will continue to engage with the Ministry of Health and others, as relevant, on this matter.

Recommendations – staff

I have no recommendations to make.

Acknowledgements

I appreciate the full co-operation extended by the patients, Charge Nurse Manager and staff to the Inspectors during their inspection of the Ward and Cottage. 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	Unit staff	Others
Director of Area Mental Health Services (DAMHS) General Manager	Charge Nurse Manager Associate Charge Nurse Manager Charge Nurse Specialist Nurse Educator Registered Nurses Enrolled Nurses Mental Health Assistants Consultant Psychiatrist Psychiatric Registrar Occupational Therapists Social Worker Pharmacist	Patients Whānau District Inspectors Cultural Advisor 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.