



Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced follow up inspection of Te Toki Maurere Unit, Whakatāne Hospital, under the Crimes of Torture Act 1989

April 2022


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National Preventive Mechanism

Office of the Ombudsman

Tari o te Kaitiaki Mana Tangata





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Contents

Foreword	3
The facility	6
Te Toki Maurere	6
The inspection	8
Methodology	8
Treatment	10
Implementation of 2018 recommendations	10
Findings of 2021 inspection	13
Recommendations	16
Protective measures	17
Implementation of 2018 recommendations	17
Findings of 2021 inspection	18
Recommendations	18
Material conditions	19
Implementation of 2018 recommendations	19
Findings of 2021 inspection	20
Recommendations	21
Activities and communications	22
Implementation of 2018 recommendations	22
Recommendations	23
Health care	24
Implementation of 2018 recommendations	24
Recommendations	24
Staff	25
Implementation of 2018 recommendations	25
Findings of 2021 inspection	25
Recommendations	26
Appendix 1. Implementation of 2018 recommendations	27
Appendix 2. Recommendations	29
Appendix 3. List of people who spoke with Inspectors	30
Appendix 4. Legislative framework	31

Foreword

This report sets out my findings and recommendations concerning the treatment and conditions of people detained in Te Toki Maurere Acute Mental Health Inpatient Unit (the Unit), which was inspected between 26 and 28 July 2021. The Unit is located on the Whakatāne Hospital Campus, Whakatāne.

In the Unit, clients¹ receive acute mental health services provided by the Bay of Plenty District Health Board's (DHB's) Mental Health and Addictions Service (the Service).

This report has been prepared in my capacity as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA). Ombudsmen are designated as one of the NPMs under the COTA, with responsibility for examining and monitoring the conditions and treatment of detained people in the relevant places of detention. My responsibility includes hospital units in which people are detained.

This report examines the Unit's progress implementing the 13 recommendations I made in 2018. It also includes findings on the conditions and treatment of clients detained in the Unit at the time of my follow up inspection on 26 – 28 July 2021, resulting in 10 recommendations.

I found that five of the 13 recommendations I made in 2018 had been achieved, one had been partially achieved, and seven had not been achieved.

Overall, during the follow up inspection I found that:

- Procedures were in place to facilitate clients' access to the Sensory Modulation Room.
- All voluntary clients had signed consent to treatment paperwork on file.
- The Unit was clean and tidy.
- Access to whānau and visits was evident and strongly encouraged.
- The past high number of medication errors had been addressed.
- High staff turnover had been addressed.
- Client and staff interactions were positive and staff knew their clients well.
- Staff were regularly seen engaging with clients in a professional and respectful manner.
- Senior management was clearly visible, supportive, and engaged on the Unit.
- Kaupapa Māori practices and tikanga were well embedded on the Unit and underpinned operational practice.
- Staff demonstrated good de-escalation skills and Inspectors observed a room entry and planned restraint which were conducted in a calm and professional manner.

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

The issues that need addressing are:

- The building was not fit-for-purpose and, despite multiple and repeat recommendations in previous OPCAT reports, a number of ongoing issues had not been addressed, including:
 - The seclusion facility, including the de-escalation and seclusion room, and low stimulus area, did not provide for therapeutic care;
 - Accommodation facilities did not provide gender separation to ensure privacy and safety needs were met; and
 - Communal areas and bathroom facilities did not meet the needs of clients for comfort, privacy and personal hygiene.
- Data recording systems had not been improved to ensure the reliability and accuracy of seclusion information.
- Not all staff were up-to-date with Safe Practice Effective Communication (SPEC) training requirements.
- The Unit was regularly over occupancy, which was impacting on the safe management of the Unit.
- The Unit was not recording environmental restraint² when the front door to the Unit was locked, nor when access to the main bedroom wing was restricted.
- Information was not available or displayed on the Unit to ensure that voluntary clients were fully informed of their right to leave the Unit at will.
- Arrangements had not been implemented to ensure clients understood the complaints process.
- Treatment plans were not always signed by clients, or, where appropriate, countersigned by staff.
- While some purposeful activity was provided on the Unit, there was no formal activities programme due to an ongoing Occupational Therapist vacancy.
- Information about visiting hours was inconsistent.

As a result of my follow up inspection, I make 10 recommendations to improve the conditions and treatment of the Unit's clients. Disappointingly, five of these are repeat recommendations.

² Environmental restraint is where a service provider(s) intentionally restricts a service user's normal access to their environment, for example where a service user's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

I will be assessing the Unit's progress in implementing the recommendations in this report in the future.

I wish to express my appreciation to the Clinical Nurse Manager, clients and staff of the Unit for the full co-operation they extended to my Inspectors. I also acknowledge the work involved in collating the information they requested.

Peter Boshier

Chief Ombudsman
National Preventive Mechanism

The facility

Te Toki Maurere

Te Toki Maurere Acute Mental Health Inpatient Unit (the Unit) is a 10-bed³ acute mental health inpatient service.

The Unit accommodates people experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital environment. Clients are referred to the Unit by community teams and wards within the main hospital.

The Service is primarily provided for people in Eastern Bay of Plenty. However, people can also be admitted from the wider Bay of Plenty region.

The Unit is located in the grounds of Whakatāne Hospital Campus, Whakatāne.

Operating capacity

10 beds

District Health Board

Bay of Plenty District Health Board (DHB)

Region

Whakatāne, Ōpōtiki and Kawerau

Previous inspections

Unannounced inspection – September 2018

Announced inspection – March 2014

Unannounced inspection – October 2010

Occupancy at time of inspection

On 26 July 2021, the first day of the inspection, the Unit was at 150 percent capacity,⁴ with 15 clients comprising eight men and seven women. One client was on leave at the time of inspection, one client was absent without leave, and another client was receiving emergency health care in the main hospital.

³ The Unit also had one bed specific to the DHB's alcohol detoxification service, one de-escalation room, one seclusion room and two rooms in the Low Stimulus Area.

⁴ This is inclusive of clients who were not on the Unit at the time of inspection and factoring the Unit's 10 funded beds.

Of the 15 clients in the Unit at the time of the inspection:

- 13 were detained under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992.
- Two were voluntary clients.⁵

⁵ A voluntary client (sometimes called an 'informal patient') is someone who has been admitted as an inpatient to a psychiatric unit but is not detained under the MHA. This means that the client has agreed to have treatment and has the right to suspend or stop that treatment. The client has the right to leave the facility at any time.

The inspection

Between 26 and 28 July 2021, Inspectors — whom I have authorised to carry out visits to places of detention under COTA⁶ on my behalf — made an unannounced three-day follow up inspection of Te Toki Maurere (referred to in this report as ‘the Unit’).

The inspection team (the Team) comprised two Inspectors.⁷

Methodology

The team inspected all areas of the Unit, assessing:

- Treatment of clients
- Protective measures taken
- Clients’ material conditions
- Clients’ activities and communications
- Health care
- Staff

The Team looked for progress in implementing the recommendations I made in 2018,⁸ and identified any additional issues that need addressing.

During the inspection, the Team met with the Clinical Nurse Manager (CNM), and spoke with a number of staff, managers, and clients.⁹

The CNM provided Inspectors the following information:

- Data on all current clients and the legal authority under which they were being detained at the time of the inspection;
- Seclusion and restraint data from 1 January to 30 June 2021;
- Unit occupancy levels from 1 January to 30 June 2021;

⁶ See page 31 for more detail about my function as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA).

⁷ Inspectors have various expertise and backgrounds in mental health and disability, social work, aged care, and prison operation and management.

⁸ See *OPCAT Report on an unannounced inspection to Te Toki Maurere (Bay of Plenty District Health Board) under the Crimes of Torture Act 1989*, for my 2018 findings and recommendations. The DHB has a full copy of this report.

⁹ See page 27 for a list of the people the Team spoke with during the inspection.

- Data on the number of staff trained in Safe Practice Effective Communication (SPEC),¹⁰ and reasons for any training being out-of-date; and
- Incident reports relating to seclusion, restraint, and medication errors from 1 January to 30 June 2021; and
- Staff data including staffing ratios, sickness levels, and turnover from 1 January to 30 June 2021.

The Team also viewed a randomly selected sample of health records and additional documents, provided on request, during the inspection.

Feedback meeting

The Team met with representatives of the Unit's leadership team at the end of the inspection, outlining initial observations.

Consultation

The Bay of Plenty District Health Board (the BOPDHB) and the Ministry of Health received a copy of my provisional report and were invited to comment. The BOPDHB and the Ministry of Health responded, and I have given regard to that feedback when preparing my final report.

In their response the BOPDHB stated *'the leadership team have no adverse comment to make concerning the provisional report and will work with your office and the office of the Director General of Mental Health to progress implementation of the recommendations and mitigation of the areas of concern'*.

I am grateful to the BOPDHB and the Ministry for their input, which has contributed positively to my final report.

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

Treatment

Implementation of 2018 recommendations

Seclusion

In 2018 I recommended:

The seclusion facility; including de-escalation, the seclusion room and the LSA is upgraded to better accommodate the needs of patients.¹¹ **This is a repeat recommendation from two previous inspections.**

I found that my recommendation was **not achieved**:

- No changes had been made to the seclusion facility, which included a de-escalation and seclusion room, and Low Stimulus Area (LSA) comprised of two rooms and a lounge area.
- As raised in my 2018 report, the seclusion facility was not fit-for-purpose or conducive to therapeutic care. The seclusion and de-escalation rooms offered limited privacy and rooms were stark, poorly lit and oppressive in nature. Carpets in the LSA were stained in places.
- At the time of inspection, clients accommodated in the LSA did not have access to fresh air as the doors to the internal courtyard were sealed shut due to a previous incident. The Unit had made a request to an internal maintenance provider to repair this.
- There were a number of issues with the physical layout of the building, which will be discussed in more detail on page 20 of this report.
- Senior management told my Inspectors that the Ministry of Health had recently approved funding to build a new Unit as the facility was no longer fit-for-purpose.¹² Inspectors were provided a copy of the *'Single Stage Business Case for Te Toki Maurere Acute Inpatient Mental Health Unit'*¹³ (the Business Case) for the Unit rebuild. As part of the Business Case, specific consideration was given to the design of the seclusion facility. I was pleased to note that the Business Case referenced my previous recommendations and those of my predecessor, made in 2018, 2014 and 2010, to support the proposal.
- However, I am concerned that after 11 years and three inspections, my recommendations have yet to be implemented. I acknowledge that the DHB has secured funding for the Unit rebuild, and I urge the DHB to urgently progress this. I discuss this further on page 20 of this report.

¹¹ In my previous report I referred to users of the service as 'patients'; in this report I have used the term 'client' to ensure consistency with terminology used by Unit staff.

¹² Funding had been approved in March 2021.

¹³ Bay of Plenty DHB. July 2021.

In 2018 I recommended:

Data recording systems be improved to ensure the reliability and accuracy of seclusion information collected and reported.

I found that my recommendation was **not achieved**:

- Since my last inspection, data recording systems had not been improved to ensure the reliability and accuracy of seclusion information collected and reported.
- The Unit used a hard copy seclusion register, which the CNM reviewed daily and entered into the DHB's online recording system. However, it was noted that this approach left room for errors, indicated by discrepancies between the two systems.
- Inspectors' review of the hard copy register showed there were 39 seclusion events involving 19 clients for the six-month period between 1 January and 30 June 2021. Seclusion data provided by the DHB showed 39 seclusion events involving 22 clients for the same period. The total seclusion time for this period was 128.04 hours.
- Senior management told Inspectors that a Business Case for an Assistant CNM (ACNM) position was in draft and intended to improve recording systems. This proposal specified that that ACNM would support the CNM in completing administrative tasks and reporting, such as the monitoring of seclusion events. Inspectors requested a copy of the Business Case, however the Unit was unable to provide this within requested timeframes.
- I note that this is an increase from my previous inspection, with 26 episodes of seclusion involving 10 clients for the six-month period between 1 March 2018 and 31 August 2018. The total seclusion time for this period was 113.10 hours.
- However, Inspectors' review of seclusion data over the past two years showed that seclusion had generally been tracking downwards.
- Reliable and accurate recording of seclusion data is essential to ensure that the Unit continues their progress towards reducing and eliminating the use of seclusion. **I therefore recommend that the Unit improves data recording systems to ensure the reliability and accuracy of seclusion information collected and reported.**

Restraint training for staff

In 2018 I recommended:

All appropriate staff undertake Safe Practice Effective Communication (SPEC) training.

I found that my recommendation was **achieved**:

- Training records provided by the Unit indicated that all appropriate staff members had undertaken SPEC training. I therefore consider that this recommendation had been achieved.

- However, Inspectors noted that 12 out of 23 relevant staff members had not completed SPEC refresher training, and therefore were out-of-date at the time of inspection.¹⁴ Inspectors were advised that due to the impacts of COVID-19, SPEC refresher training had been significantly delayed. Refresher training had been scheduled for six staff in August 2021.
- While I acknowledge the impacts that COVID-19 has had on health services and on facilitator availability, I am concerned that half of relevant staff on the Unit were out-of-date with SPEC refresher training at the time of inspection. I consider it imperative that all staff are up-to-date with SPEC training requirements and **I therefore recommend that the Unit ensures all appropriate staff remain up-to-date with Safe Practice Effective Communication (SPEC) refresher training.**

Sensory modulation

In 2018 I recommended:

Procedures are implemented to enable patients to gain easy access to the sensory modulation room.

I found that my recommendation was **achieved**:

- Inspectors were pleased to observe the sensory modulation¹⁵ room in use during the inspection. The door was unlocked and the client using the room was unsupervised.
- The process, and information on how to access the room, for clients was informal and occurred through conversations with staff. Staff told Inspectors that the CNM conducted a daily assessment of the Unit, depending on client acuity, to determine whether the door was to be left unlocked and unsupervised during the day. Staff told Inspectors that this occurred at morning staff meetings, however, this daily assessment was not documented.
- There was no written information or signage displayed on the Unit, nor information in clients' induction material, on how clients could access the room.
- I encourage the Unit to ensure that signage and written information is made available to ensure all clients are aware of how to access the sensory modulation room and that access is easily facilitated.

¹⁴ Refresher training was required to be conducted biannually for all Unit staff.

¹⁵ *Sensory modulation uses a range of tools to help individuals get the right amount of sensory input. In mental health settings, sensory modulation can be used to assist distressed clients to regain a sense of calm.* Te Pou o te Whakaaro Nui. *Sensory modulation in inpatient mental health: A summary of the evidence.* (2011), Te Pou o Te Whakaaro Nui, Auckland, at page 3.

Findings of 2021 inspection

In addition, I found:

Over occupancy

- Over occupancy had increasingly become an issue for the Unit and was negatively impacting on the therapeutic care of clients, as well as reducing the staff's ability to provide optimal nursing care to clients.
- At the time of inspection, the Unit was at 150 percent capacity (including clients on leave). Data provided by the Unit indicated that the occupancy for two out the previous six months had been above 100 percent.
- During the inspection, two clients were sleeping in rooms not designated as bedrooms in the LSA. Senior management told my Inspectors that clients regularly slept in rooms not designated as bedrooms, such as in meeting rooms with a mattress on the floor and in lounges in the LSA. Clients were also regularly placed in the designated detoxification bedroom for purposes other than detoxification, due to lack of other available bedrooms.
- If clients were on leave, their beds were not reserved and would be 'backfilled' with new clients.
- The Business Case requested additional beds for the Unit rebuild in order to address the issue of over occupancy. The Business Case stated *'the [current bed numbers] is insufficient to meet current demand. Patients have been accommodated by placing mattresses on the floor, which is not clinically appropriate. The rate of Mental Health and Addictions hospitalisations at [the Unit] has been increasing since 2016/17 and projections estimate up to 17 beds could be required by 2034/35'*.
- Placing clients in rooms not designated as bedrooms, such as meeting rooms or lounge areas, presents a serious risk to clients' privacy and dignity.
- While I acknowledge the high demand in providing care in an acute inpatient setting, the issue of over occupancy is not only unsustainable, but is unsafe for clients and staff. Accordingly, **I recommend that the DHB addresses the issue of over occupancy as a matter of urgency.**

Environmental restraint

Recording of environmental restraint

- Inspectors requested a copy of the DHB's *'Locked Door Management in Acute Psychiatric Mental Health Protocol'* (the Locked Door Protocol), dated November 2015. The protocol was out-of-date, having been due for review in November 2018. The Locked Door Protocol stated that *'The locking of doors restricting consumer exit from the ward*

environment constitutes an environmental restraint'. However, at the time of inspection the Unit was locked, and this was not being recorded as environmental restraint.

- Inspectors were informed that the Unit, which was designated as an 'open unit', had been locked since March 2020. The Unit had initially been locked in response to the COVID-19 pandemic. Staff said they had noted a reduction in '*drug use, gang involvement and violence*' on the Unit, which they attributed to the door locking, and therefore the Unit had remained locked. Staff also said they felt safer with the doors locked. Inspectors requested documentation to evidence the reduction in assaults or violence, however they were advised this was not being recorded.
- I am concerned that the practice of locking the front door to the Unit constitutes environmental restraint, and yet was not being recorded or reported by the Unit as such. I also note that the Unit had remained locked for a prolonged period of time, despite the Unit being designated as an 'open unit' at the time of inspection. This concerns me and I intend to monitor this situation nationally.
- During the inspection Inspectors observed that doors to the main bedroom wing were intermittently locked to manage the individual, complex needs of a client. This prevented the client from accessing certain areas of the Unit at times. The Unit did not record this as environmental restraint.
- I acknowledge that these arrangements were in place to support a client with complex needs in a least restrictive manner. However, environmental restraint is a restrictive practice that limits clients' freedom of movement.

In response to my provisional report the Ministry of Health said '*The Ministry of Health does not consider that the additional security measures due to COVID-19 protocols constitutes environmental restraint. All Units must comply with public health measures around entering and exiting wards to keep tāngata whaiora and staff safe*'.

- I acknowledge that COVID-19 public health measures may justify restrictions on entering and exiting wards. However, the Unit was designated as an open unit but was locked at the time of inspection and clients had no independent means to enter and exit the Unit. I intend to monitor practices around routine door locking carefully, as I am generally concerned about the proportionality of blanket restrictions on detainees.
- In any case, I consider that door locking was an intervention, which limited the normal freedom of movement for clients and should have been recorded as environmental restraint. **I recommend that the Unit records and reports all instances of environmental restraint.** This includes the locking of doors, in accordance with the DHB's policy or for reasons on public health.
- The Ministry of Health noted in its response that environmental restraint is a complex issue and they would be happy to discuss this with my Office in more detail. I look forward to further engagement on this issue.

Information for voluntary clients about entering and exiting the Unit

- At the time of inspection, there were two voluntary clients on the Unit. Voluntary clients are under no legal compulsion to remain on the Unit, and, as such, should be able to enter and exit the Unit at will. To enable this, voluntary clients must be provided with information regarding their right to leave the Unit, and how they may do so.
- Inspectors did not observe any information displayed on the Unit detailing how voluntary clients could enter or exit the Unit, nor any written information in clients' induction material detailing that voluntary clients had the right to leave.
- I was concerned that there appeared to be no formal process to ensure that all voluntary clients at the Unit knew how to leave the Unit at will. I consider that information must be provided to voluntary clients to ensure that they are aware of their right to leave the Unit, and how to do this. **I therefore recommend that the Unit ensures voluntary clients are fully informed of their right to enter and exit the Unit, and how to do so.**
- In response to my provisional report, the Director of Mental Health from the Ministry of Health advised that he is concerned that this issue continues to arise and that he would reiterate to all Directors of Area Mental Health Services that this practice is not appropriate. He said he would follow up with the Director of Area Mental Health Services (DAMHS) and the District Inspectors to provide updates on addressing this issue.

Young people in adult mental health facilities

- In the six-month period between 1 January and 30 June 2021 there had been a young person accommodated on the Unit, who had been subject to a period of seclusion. I am concerned about the continued use of seclusion in mental health facilities, and particularly seclusion of young people, despite the Zero Seclusion project, which aimed to see seclusion eliminated by the end of 2020. I intend to monitor this situation closely.
- In general, I do not think it appropriate for young people to be accommodated in adult mental health settings, however I am aware that there are a range of complex factors which can result in this. I intend to explore this issue further, and will discuss this matter and that of seclusion of young people, with the Ministry of Health.

Recommendations

As a result of my 2021 follow up inspection, I recommend:

Treatment of clients

1. The Unit improves data recording systems to ensure the reliability and accuracy of seclusion information collected and reported. **This is an amended repeat recommendation.**
2. The Unit ensures all appropriate staff remain up-to-date with Safe Practice Effective Communication (SPEC) refresher training.
3. The DHB addresses the issue of over occupancy as a matter of urgency.
4. The Unit records and reports all instances of environmental restraint.
5. The Unit ensures voluntary clients are fully informed of their right to enter and exit the Unit, and how to do so.

Protective measures

Implementation of 2018 recommendations

Complaints

In 2018 I recommended:

Arrangements are implemented to ensure patients understand the complaints process and have easy access to complaints forms.

I found that my recommendation was **partially achieved**:

- At the time of inspection, complaints forms were available to clients independent of staff.
- However, there was no signage or information displayed on the Unit regarding how clients could make a complaint. Clients' induction material contained minimal information on how to make a complaint.
- I consider it essential that information about the complaints process is readily available to ensure that clients know how to make a complaint if necessary, and understand the complaints process. **I therefore recommend that the Unit implements arrangements to ensure clients understand the complaints process.**

Records

In 2018, I recommended:

Patients have a signed Consent to Treatment form retained on their file. In circumstances where a patient is unable or refuses to sign, this is documented.

I found that my recommendation was **achieved**:

- Inspectors reviewed documentation for all voluntary clients on the Unit and found that signed Consent to Treatment forms were completed and retained on their files.

In 2018, I recommended:

All treatment plans should be either signed by the patient or, where appropriate, countersigned by a member of staff to indicate that the patient has declined to sign the form, or is unable to do so.

I found that my recommendation was **not achieved**:

- Inspectors reviewed all treatment plans and found that plans were not consistently signed by the client, or where appropriate, countersigned by a member of staff.
- Senior management told Inspectors that this had been an ongoing concern and staff were regularly reminded in daily staff briefings to sign clients' treatment plans. I expect

all treatment plans to be signed by clients, or countersigned by staff if a client has declined or is unable to do so. **I therefore recommend that the Unit ensures all treatment plans are signed by the client, or, where appropriate, countersigned by a member of staff to indicate that the client has declined to sign the form or is unable to do so.**

- In response to my provisional report the Director of Mental Health from the Ministry of Health said his expectation for voluntary tāngata whai ora is that there is documentation recording a discussion between staff and tāngata whai ora about consent to treatment on file. He noted that this is something he will request the District Inspectors to monitor.

Findings of 2021 inspection

In addition, I found:

Transfer of care

- During the inspection a client from another region, who had been receiving acute inpatient mental health care from another DHB, was admitted to the Unit.
- Inspectors requested to see a copy of the client's detaining paperwork. They were informed that the Unit had submitted multiple requests to the other DHB for detaining paperwork and patient records, however this had not been provided. While the detaining paperwork was subsequently provided, Inspectors noted that the verbal information provided by the other DHB at the time of admission was inaccurate.
- While this issue was subsequently resolved, staff told my Inspectors that communication between a number of DHBs and timely transfer of care had been an ongoing issue for the Unit. Complete and accurate detaining paperwork and timely, effective communication between DHBs is critical in ensuring optimal service delivery and appropriate care for clients. I therefore encourage the DHB to explore methods to improve communication between DHBs about the transfer of care of clients.

Recommendations

As a result of my 2021 follow up inspection, I recommend:

Protective measures

6. The Unit implements arrangements to ensure clients understand the complaints process. **This is an amended repeat recommendation.**
7. The Unit ensures all treatment plans are signed by the client, or, where appropriate, countersigned by a member of staff to indicate that the client has declined to sign the form or is unable to do so. **This is a repeat recommendation.**

Material conditions

Implementation of 2018 recommendations

Accommodation

In 2018 I recommended:

Accommodation and facilities are provided for female patients that ensure their need for privacy and safety are met.

I found that my recommendation was **not achieved**:

- No changes had been made to the Unit accommodation and facilities to provide gender separation to ensure female clients' need for privacy and safety were met.
- In an attempt to mitigate this, female clients were generally placed in bedrooms closest to the nursing station. On occasion, female clients were also accommodated in the LSA rooms, which were not designated bedrooms, to provide them with privacy.
- Both staff and clients my Inspectors spoke with said that gender separation should be a priority for the Unit rebuild.
- Inspectors reviewed a copy of the Business Case for the Unit rebuild, which covered specific requests for gender separation, as well as additional swing room options, referencing my previous recommendation in 2018.
- Staff noted that the request for additional swing rooms was also to provide flexible options and individualised care for vulnerable admissions, as well as care for those requiring intensive support.
- I support the DHB's Business Case to prioritise gender separation, as well as swing room options, in the Unit rebuild to ensure all clients are afforded privacy and safety. In response to my provisional report, the Director of Mental Health from the Ministry of Health stated that the Ministry does not require mental health units to have gender separate areas. However, he noted that there is an expectation that consideration be given to support vulnerable tāngata whai ora. I consider it imperative that all mental

health facilities have accommodation options that meet the needs of all clients groups, including women and vulnerable clients.

In 2018 I recommended:

Communal areas and bathroom facilities continue to be upgraded to meet the needs of patients for comfort, privacy and personal hygiene.

I found that my recommendation was **not achieved**:

- No changes had been made to communal areas or the bathroom facilities on the Unit.
- Inspectors reviewed a copy of the Business Case, which covered specific requests for structural changes to the communal areas and additional bathroom facilities, referencing my previous recommendations and those of my predecessor, made in 2018, 2014 and 2010.
- The Business Case stated *'bedrooms are too small and bathroom facilities are insufficient for the number of patients'*.
- I am concerned that after 11 years and three inspections, my recommendations have yet to be implemented. I acknowledge that the DHB has secured funding for a new build, and I look forward to seeing improved outcomes for clients as a result of this. I discuss this further below.

Findings of 2021 inspection

In addition, I found:

The Unit was not fit-for-purpose

- The Unit, which was built in 1945 as a nurse's accommodation, was retrofitted and repurposed in 1979 as a psychiatric mental health unit.
- Overall, the Unit was not fit-for-purpose and a number of issues with the physical layout and material conditions of the Unit had not been addressed since previous inspections, despite multiple repeat recommendations, including:
 - Upgrades to the seclusion facility, including the de-escalation and seclusion room, and low stimulus area (see page 8);
 - Accommodation facilities did not provide gender separation to ensure both privacy and safety needs are met (see page 16); and
 - Communal areas and bathroom facilities required an upgrade to meet the needs of clients for comfort, privacy and personal hygiene (see pages 16-17).
- The Business Case for the Unit rebuild stated that *'the facility was not built for purpose and has been unable to keep pace with modern clinical and community expectations'* and

that *'the layout of Te Toki Maurere presents challenges to adopting modern Model of Care practices'*.

- The Business Case also stated that the facility had significant structural and fire engineering challenges and a recent seismic assessment conducted in 2018 found the facility only achieved between 35 to 45 percent of the New Building Standard.
- Further, there were multiple ligature risks throughout the Unit and staff told Inspectors the Unit had recently discovered asbestos in the top floor of the building.
- The Business Case also highlighted that the physical environment did not meet cultural expectations and needs of Māori clients and whānau, which the Service indicated led to a *'lack of engagement with services'*. Any rebuild should consider kaupapa Māori models of care and design.
- Given the wide range of issues and physical risks on the Unit, **I recommend that the DHB urgently progresses the rebuild in line with best practice for the design of mental health facilities.**
- In response to my provisional report, the Director of Mental Health from the Ministry of Health acknowledged my comments about the condition of the unit and said that the Ministry of Health is working closely with the DHB on progressing plans for the rebuild of the Unit.

Cleanliness

- While the Unit building itself was not fit-for-purpose, I was pleased to find that the Unit was clean and tidy throughout, and the external courtyard and gardens were well-maintained.
- There were a number of maintenance issues on the Unit, however senior management had proactively taken action to address these.

Recommendations

As a result of my 2021 follow up inspection, I recommend:

Material conditions

8. The DHB urgently progresses the rebuild in line with best practice for the design of mental health facilities.

Activities and communications

Implementation of 2018 recommendations

In 2018 I recommended:

There needs to be an increase in the amount of leisure/purposeful activity available to patients in the Unit. **This is a repeat recommendation.**

I found that my recommendation was **not achieved**:

- At the time of inspection, there was no formal activities programme occurring on the Unit.
- There was no Occupational Therapist (OT) on the Unit, despite recruitment efforts. The Unit was actively advertising the role at the time of inspection.
- The Unit employed a full-time equivalent (FTE) OT Assistant who provided leisure and purposeful activities for clients, however, they were on leave during the inspection. The OT Assistant worked Monday to Fridays and activities were not available on the Unit during evenings or weekends.
- Inspectors were provided a copy of the Unit activities schedule, which included daily karakia, craft, cards, movies and outings. Staff told Inspectors that the Unit facilitated external outings and trips, such as fishing trips or plant foraging in the area.
- I acknowledge there were some activities taking place on the Unit, however I did not see any evidence that this had increased since my last inspection.
- I encourage the Unit to develop a more formal and varied activities programme, including seeking clients' views. Accordingly, **I recommend that the Unit increases the amount of leisure/purposeful activities available to clients.**

In 2018 I recommended:

Formal visiting hours for the Unit be consistently referred to in all information available to patients and visitors.

I found that my recommendation was **not achieved**:

- There was conflicting information regarding the formal visiting hours in information provided to clients.
- Signage at the entrance to the Unit indicated visiting hours were between 3:30pm to 8pm Monday to Friday and 10:30am to 8pm for weekends and public holidays.
- Unit induction material, however, indicated that visiting hours were only between 3pm and 8pm Monday to Friday. There were no visiting times stated for weekends or public holidays.

- Further, when speaking with staff and senior management, visiting hours were different again. Inspectors were advised that visiting hours were flexible and could be booked any time between 9am and 8pm.
- I am pleased to hear that visiting hours are flexible and was also pleased to find that whānau were able to stay overnight for visits, which was facilitated in the LSA. Access to whānau and visits was evident and strongly encouraged and Inspectors observed visitors on the Unit throughout the inspection. However, **I recommend that the Unit ensures that formal visiting hours are consistently referred to in all information available to clients and visitors.**

Recommendations

As a result of my 2021 follow up inspection, I recommend:

Clients' activities and communications

9. The Unit increases the amount of leisure/purposeful activities available to clients. **This is an amended repeat recommendation from two previous inspections.**
10. The Unit ensures that formal visiting hours are consistently referred to in all information available to clients and visitors. **This is an amended repeat recommendation.**

Health care

Implementation of 2018 recommendations

In 2018 I recommended:

Procedures are implemented to ensure the reliability of data for medication incidents.

I found that my recommendation was **achieved**:

- The DHB stated in response to my 2018 recommendation that an FTE senior Pharmacist and junior Pharmacist would be dedicated specifically to mental health and addiction services and would attend multi-disciplinary team (MDT) meetings to provide educational support to staff.
- My Inspectors attended an MDT and I was pleased to find that the Pharmacist regularly attended these meetings.
- Inspectors also reviewed a copy of the Unit's weekly medication audits, which had been implemented to ensure the reliability of data for medication incidents. This data was reviewed by both the CNM and the Pharmacist.
- Between 1 January and 30 June 2021 there was only one medication error, an improvement from my previous inspection which showed eight medication errors between 1 March and 31 August 2018.

Recommendations

I have no recommendations to make.

Staff

Implementation of 2018 recommendations

Staff resignations

In 2018 I recommended:

The reasons for staff resignations from the Unit should be analysed and, where necessary, appropriate remedial action be implemented

I found that my recommendation was **achieved**:

- In my last report I noted a significant number of staff resignations. My Inspectors were informed that the DHB had implemented a number of initiatives to encourage staff involvement and engagement with the view to reduce staff turnover. This included embedding initiatives such as 'Creating our Culture' and 'Speak Up'. Inspectors observed posters for these initiatives in staff areas.
- Inspectors requested a copy of staff turnover data, however the DHB was unable to provide this within requested timeframes. However, senior management and staff spoken with told Inspectors that staffing had not been an issue on the Unit for a number of years and described the Unit has having a 'stable workforce' and positive working culture. Furthermore, there was only one 1.4 Registered Nurse vacancy at the time of inspection. I am therefore satisfied that this recommendation has been achieved.
- Senior management told Inspectors that the Unit had prioritised recruitment of new graduates, receiving 17 new graduates between 1 January and 30 June 2021. Senior management also told my Inspectors that approximately 88 percent of nursing staff were Māori.

Findings of 2021 inspection

In addition, I found:

Staff culture

- I was pleased to observe a team of highly cohesive and supportive staff, with strong collaborative working relationships with the community mental health team.
- Staff demonstrated good de-escalation skills and Inspectors' observation of a room entry in seclusion and planned restraint was conducted in a calm and professional manner.
- Client and staff interactions were positive and staff knew their clients well. Staff were regularly seen on the Unit and engaging with clients in a professional and respectful manner. Senior management was also clearly visible, supportive, and engaged on the Unit.

- Kaupapa Māori practices and tikanga was well embedded on the Unit and underpinned operational practice. As part of the DHB's Te Toi Ahorangi Strategy,¹⁶ the Unit employed a Te Pou Koriki Cultural Support role, who provided a wide range of cultural support practices on the Unit.
- The Te Pou Koriki Cultural Support role included liaising with local iwi and non-governmental organisations, engaging with the Tohunga, chaplain and whānau Kaumātua, providing cultural input at MDT meetings, blessing rooms within the Unit, leading and supporting staff with karakia, whānau hui, and mihi whakatau, as well as daily activities for clients on the Unit.
- Overall, my Inspectors observed staff working in a calm and professional manner, which appeared to reflect the tone of the Unit as a whole.

Recommendations

I have no recommendations to make.

¹⁶ 'Te Toi Ahorangi' is the Toi Ora Strategy determined by Te Rūnanga Hauora o Te Moana a Toi, the mandated Te Tiriti o Waitangi partner of the Bay of Plenty District Health Board. For more information see <https://www.bopdhb.health.nz/te-pare-%D0%BE-toi/te-toi-ahorangi-2030/>

Appendix 1. Implementation of 2018 recommendations

Listed below are all the recommendations I made in 2018, the Unit response at that time to my recommendations, and my 2021 findings regarding the implementation of those recommendations:

2018 recommendation	2018 response ¹⁷	2021 finding ¹⁸
1. The seclusion facility; including de-escalation, the seclusion room and the LSA is upgraded to better accommodate the needs of patients. This is a repeat recommendation from two previous inspections.	Accepted	Not achieved
2. Data recording systems be improved to ensure the reliability and accuracy of seclusion information collected and reported.	Accepted	Not achieved
3. All appropriate staff undertake Safe Practice Effective Communication (SPEC) training.	Accepted	Achieved
4. Procedures are implemented to enable patients to gain easy access to the sensory modulation room.	Accepted	Achieved
5. Arrangements are implemented to ensure patients understand the complaints process and have easy access to complaints forms.	Accepted	Partially achieved
6. Patients have a signed Consent to Treatment form retained on their file. In circumstances where a patient is unable or refuses to sign, this is documented.	Accepted	Achieved
7. All treatment plans should be either signed by the patient or, where appropriate, countersigned by a member of staff to indicate that the patient has declined to sign the form, or is unable to do so.	Accepted	Not achieved
8. Accommodation and facilities are provided for female patients that ensure their need for privacy and safety are met.	Partially accepted	Not achieved

¹⁷ Accepted, Partially accepted, Rejected

¹⁸ Achieved, Partially achieved, Not achieved

2018 recommendation	2018 response ¹⁷	2021 finding ¹⁸
9. Communal areas and bathroom facilities continue to be upgraded to meet the needs of patients for comfort, privacy and personal hygiene.	Partially accepted	Not achieved
10. There needs to be an increase in the amount of leisure/purposeful activity available to patients in the Unit. This is a repeat recommendation.	Accepted	Not achieved
11. Formal visiting hours for the Unit be consistently referred to in all information available to patients and visitors.	Accepted	Not achieved
12. Procedures are implemented to ensure the reliability of data for medication incidents.	Accepted	Achieved
13. The reasons for staff resignations from the Unit should be analysed and, where necessary, appropriate remedial action be implemented.	Accepted	Achieved

Appendix 2. Recommendations

Listed below are all my recommendations following the 2021 inspection of the Unit:

Recommendation	Repeat
1. The Unit improves data recording systems to ensure the reliability and accuracy of seclusion information collected and reported.	Repeat amended
2. The Unit ensures all appropriate staff remain up-to-date with Safe Practice Effective Communication (SPEC) refresher training.	
3. The DHB addresses the issue of over occupancy as a matter of urgency.	
4. The Unit records and reports all instances of environmental restraint.	
5. The Unit ensures voluntary clients are fully informed of their right to enter and exit the Unit, and how to do so.	
6. The Unit implements arrangements to ensure clients understand the complaints process.	Repeat amended
7. The Unit ensures all treatment plans are signed by the client, or, where appropriate, countersigned by a member of staff to indicate that the client has declined to sign the form, or is unable to do so.	Repeat amended
8. The DHB urgently progresses the rebuild in line with best practice for the design of mental health facilities.	
9. The Unit increases the amount of leisure/purposeful activities available to clients.	Repeat amended
10. The Unit ensures that formal visiting hours are consistently referred to in all information available to clients and visitors.	Repeat amended

Appendix 3. List of people who spoke with Inspectors

List of people who spoke with Inspectors:

Clients

Clinical Nurse Manager

Clinical Nurse Manager – Community Mental Health

Consultant Psychiatrists

Health Care Assistants Pharmacist

Registered Nurses

Security staff

Appendix 4. 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.