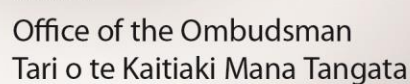
OPCAT Report

Report on an unannounced follow up inspection of Te Whare Maiangiangi Unit, Tauranga Hospital, under the Crimes of Torture Act 1989

April 2022

Peter Boshier
Chief Ombudsman
National Preventive Mechanism



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Foreword

This report sets out my findings and recommendations concerning the conditions and treatment of people detained in Te Whare Maiangiangi Acute Mental Health Inpatient Unit (the Unit), which was inspected on 16 and 17 August 2021. The Unit is located on the grounds of the Tauranga Hospital campus, Tauranga.

In the Unit, tāngata whai ora[1] receive acute mental health services provided by the Bay of Plenty District Health Board's (DHB's) Mental Health and Addiction 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 14 recommendations I made in 2018.[2] It also includes findings on the conditions and treatment of tāngata whai ora who are or may be detained in the Unit at the time of my follow up inspection on 16 – 17 August 2021, resulting in 16 recommendations.

I found that five of the 14 recommendations I made in 2018 had been achieved and nine had not been achieved.

Overall, during the follow up inspection I found that:

- Tāngata whai ora had the necessary legal documentation to be detained and treated in the Unit.
- As an alternative to smoking, vapes could now be used in the Intensive Psychiatric Care (IPC) area and were provided to tāngata whai ora at no cost. Vaping was allowed in the IPC courtyard, and education was provided on vaping and smoking.
- Visiting hours were generous and there appeared to be a measure of flexibility.

The issues that need addressing are:

- Seclusion rooms and the admissions/day room were still being used as bedrooms.
- Tāngata whai ora were being secluded in the IPC courtyard.
- The IPC area is outdated and no longer fit-for-purpose.

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1 'Tāngata whai ora' is used to refer to persons who are the subject of care, assessment and treatment processes in mental health. It means 'a person seeking health'. This term is often used interchangeably with consumer and/or service user.

2 See *OPCAT Report on an unannounced inspection to* Te Whare Maiangiangi *under the Crimes of Torture Act 1989*, for my 2018 Report findings and recommendations. The DHB has a full copy of this report.

- The number of seclusion events in the Unit was high.
- The Unit, which was designated as an open unit, was locked at the time of inspection. This was not being recorded as environmental restraint.
- The courtyard on the 'open'[3] side of the Unit was locked throughout the inspection. This was not being recorded as environmental restraint.[4]
- There was no signage for entry and exit at the Unit for voluntary tāngata whai ora (or those tāngata whai ora with approved leave) or visitors.
- Tāngata whai ora spoken with said they did not feel the Unit communicated well or engaged them in their treatment. Tāngata whai ora and their whānau were not invited to attend their multi-disciplinary team (MDT) meetings. Treatment plans viewed by Inspectors were not completed or signed.
- The complaints process was not widely understood by tāngata whai ora or accessible independent of staff.
- There were no completed Consent to Treatment forms on the files of tāngata whai ora.
- Contact details for District Inspectors were not visible on the 'open' side of the Unit or the IPC area.
- Bedroom doors could not be locked independently of staff.
- There was no discrete bedroom area for female tāngata whai ora on the Unit to ensure privacy and safety.
- The Unit was not fit-for-purpose.
- The Unit regularly ran over capacity.
- Information about visiting hours for the Unit was inconsistent.
- Adequate privacy was not provided to patients when using the telephone on the 'open' side of the Unit or in the IPC area.
- Staff recruitment was an issue for the Unit.

As a result of my follow up inspection, I make 16 recommendations to improve the conditions and treatment of the Unit's tāngata whai ora. Disappointingly, nine of these are repeat recommendations.

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[3] The 'open' side of the Unit comprises a 20 bed open unit.

[4] 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 appreciate that options for a refurbishment are under consideration. However, the current situation at the adult acute mental health service is untenable. Lack of privacy, high use of seclusion, inappropriate placements of tāngata whai ora, restrictive practices, compromised care, and limited opportunity for recovery are indicators of a Unit in crisis.

The ongoing issue of over occupancy across the Unit, and the resulting impacts, is not only unsustainable, but unsafe for tāngata whai ora and staff.

It is clear that both immediate action is required to address the current pressures, and that a long-term plan must be developed and implemented to make service wide and sustainable changes.

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

I wish to express my appreciation to the Charge Nurse Lead (CNL), tāngata whai ora, 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 Whare Maiangiangi

Te Whare Maiangiangi is an acute mental health inpatient unit, which provides assessment, treatment and care for adults experiencing an acute episode of mental illness, which cannot be provided in a community setting.

The Unit is located in the grounds of Tauranga Hospital. Te Whare Maiangiangi translates as "seek new horizons". The Unit comprises a 20 bed open unit and a four bed secure Intensive Psychiatric Care (IPC) area.[5]

The open side of the Unit has three accommodation wings for tāngata whai ora:

- Female
- Male
- Mixed wing

At the time of inspection female tāngata whai ora were accommodated in all three wings.

The Unit is a purpose built acute Mental Health inpatient Unit and opened in 2001.

Operating capacity

24 (including IPC beds).

District Health Board

Bay of Plenty District Health Board (DHB)

Region

Tauranga

Previous inspections

Unannounced inspection – September 2018

Announced inspection – March 2014

Announced visit – March 2009

Occupancy at time of inspection

On 16 August 2021, the first day of the inspection, the Unit was at 120 percent capacity with 29 tāngata whai ora, comprising nine men and 20 women. Two tāngata whai ora were on leave

[5] The IPC area comprises four bedrooms, three seclusion rooms and an admissions/day room.

at the time of the inspection and two tāngata whai ora were accommodated in seclusion rooms.

Of the 29 tāngata whai ora in the Unit at the time of the inspection:

- Twenty were detained under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992.
- Nine were voluntary tāngata whai ora.

The inspection

Between 16 and 17 August 2021, Inspectors — whom I have authorised to carry out visits to places of detention under COTA[6] on my behalf — made an unannounced two day follow up inspection of Te Whare Maiangiangi (referred to in this report as 'the Unit').

The inspection team (the Team) comprised one Senior Inspector and one Inspector.[7]

Methodology

The Team inspected all areas of the Unit assessing a range of areas, including treatment, protective measures, material conditions, activities and communications, health care and staffing.

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

During the inspection, the Team met with the Charge Nurse Lead (CNL), and spoke with a number of staff, managers, and tāngata whai ora.[9]

The Unit provided Inspectors with a broad range of information, including:

- Data for the period 1 February to 31 July 2021, including average length of stay, seclusion and restraint data, medication errors, and Safe Practice Effective Communication (SPEC) training rates;
- Relevant procedures and guidelines, including the locked door/egress and complaints policies;
- A list of tāngata whai ora, their age, gender, ethnicity, and the legal authority under which they were being detained (on the first day of the inspection); and
- Staffing data including role, gender, length of service and vacancies.

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

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6 See page 30 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. Specialist advisors have medical, cultural, disability and social expertise, and lived-in experience, or are people who have advocated on behalf of detainees.

8 See *OPCAT Report on an unannounced visit to* Te Whare Maiangiangi *under the Crimes of Torture Act 1989*, for my 2018 Report findings and recommendations. The DHB has a full copy of this report.

9 See page 29 for a list of the people the Team spoke with during the inspection.

Feedback meeting

The Team were unable to meet with the CNL at the end of the inspection to outline initial observations or seek any corrections or clarifications due to changes in COVID-19 alert levels.[10] Feedback was provided to the Unit's leadership team via video call on 3 September 2021.

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

Treatment

Implementation of 2018 recommendations

Seclusion and restraint

In 2018, I recommended:

The seclusion rooms and admissions/day room should not be used (as bedrooms) to accommodate patients. **This is a repeat recommendation.**

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

- The Unit regularly ran over capacity with tāngata whai ora regularly sleeping in the seclusion rooms and admissions/day room. Tāngata whai ora numbers in the Unit fluctuated marginally during the course of the inspection but remained over capacity throughout the inspection.
- The Service Plan reviewed by Inspectors stated:

  > *'over the FY19[11], the six IPC beds were over-capacity on 112 days, and the funded acute adult mental health beds were overcapacity on 256 days meaning that overall Tauranga Hospital's TWM unit was over-capacity on 208 days of the FY19 year'.*

- During the inspection there were tāngata whai ora accommodated in seclusion rooms, but not subject to a period of seclusion,[12] due to over-occupancy issues.
- The admissions/day room was not occupied at the time of the inspection. However, Inspectors were advised by staff the admissions/day room had been used for a lengthy period pre-inspection to accommodate a tangata whai ora with high and complex needs.
- Like my predecessor in her 2014[13] report and as I outlined in my 2018 report of the Unit, I remain concerned that seclusion rooms and admission/day rooms continue to be used to accommodate tāngata whai ora when the Unit is over capacity.
- As I have stated in a number of my inspection reports on mental health units, the use of seclusion rooms and other non-designated rooms as bedrooms may amount to degrading treatment and a breach of Article 16 of the Convention against Torture. It is unacceptable that this situation has not been remedied. **I therefore recommend that the**

[11] FY19 refers to the 2019 financial year.

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

[13] See *OPCAT Report on an unannounced visit to Bay of Plenty District Health Board's Te Whare Maiangiangi Unit under the Crimes of Torture Act 1989*. March 2014. The DHB has a full copy of this report.

Unit takes immediate steps to not use seclusion rooms and admissions/day rooms as bedrooms to accommodate tāngata whai ora.

In 2018, I recommended:

The practice of secluding patients in the IPC courtyard, or any area other than a designated seclusion room, should cease.

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

- Staff told my Inspectors that the IPC courtyard was still used, at times, for secluding tāngata whai ora.
- Inspectors reviewed a seclusion event form and the seclusion observation form from an event in February 2021. The documentation stated:

  > *'then re-secluded to courtyard…….remains secluded to courtyard – escalates with company. Hostile – verbally abusive'.*

- Records indicated that the tangata whai ora was not free to leave the courtyard at will.
- The Unit's practice of secluding tāngata whai ora in the IPC courtyard did not comply with the DHB's Mental Health & Addiction Services Seclusion Protocol MHAS.A1.45,[14] or the Mental Health (Compulsory Assessment and Treatment) Act 1992[15].
- While time outside during seclusion can be beneficial for fresh air and space, tāngata whai ora should not be secluded in the IPC courtyard. **I therefore recommend that the Unit ceases the practice of secluding tāngata whai ora in the IPC courtyard, or any area other than a designated seclusion room.**

In 2018, I recommended:

An analysis and review of the Unit's use of security staff is conducted, ensuring patients' views and experiences are canvassed.

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

- The DHB had conducted a review of the security staff trial at the Unit. A set of questions was developed by the DHB to understand whether security guards were noticed, whether they made a difference to people's experience on Unit, and how participants felt about having a security guard on the Unit.
- Inspectors observed, in this review, responses from both tāngata whai ora and staff on their experience and thoughts around having a security presence on the ward. These responses were generally positive.

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[14] The Protocol stated that the use of seclusion would be in accordance with Ministry of Health guidelines and specifically that seclusion only occur in the three seclusion rooms.

[15] Section 71(2)(b) provides that *'a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services'.*

- The review involved the Consumer Participation Coordinator attending the morning meeting at Te Whare Maiangiangi every Wednesday for a three-week period and inviting tāngata whai ora to respond to the set of questions. The Consumer Consultant Group was also invited to participate and share how they felt about security presence at the Unit.
- The majority of tāngata whai ora who participated in these sessions reported that the security staff had made them feel safer. One tāngata whai ora stated:

  "I think some of the female staff are scared of some of the patients and I think it's necessary to have security presence."

  "I think it's a good idea any presence is a good idea. It's gonna keep people safe".
- I am pleased that the Unit has complied with my recommendation and that tāngata whai ora were involved in the review. However, I am concerned about what appears to be a normalisation of the use of security guards in mental health facilities. I appreciate that a range of factors have contributed to this trend. However, there are other ways to create a safe environment for tāngata whai ora. I intend to monitor this matter nationally.

In 2018, I recommended:

The IPC facility is upgraded.

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

- No upgrades had been made to the IPC area since the previous inspection.
- The IPC area comprised four IPC bedrooms, three seclusion rooms (adjacent to each other). Inspectors found the seclusion rooms stark but each had an en-suite toilet and shower facilities, natural light, access to drinking water, and a means to call staff. A digital clock was located within sight of one seclusion room only. The singular clock did not enable tāngata whai ora in all seclusion rooms to remain oriented to time and date.
- The IPC did not have adequate areas for tāngata whai ora for the purpose of de-escalation. Staff and patients also described the IPC as an overly stimulating environment, compounded by the lack of space and regularly operating over capacity.
- There was poor line of sight from the IPC staff office through to the corridor that housed the seclusion rooms. Inspectors noted that tāngata whai ora tended to congregate in the area directly outside the staff office.
- Inspectors were informed by senior staff that funding for a refurbishment/new building remained under consideration. However, there was not a clear timeframe for the refurbishment/new building at the time of inspection.
- I remain of the view that the IPC area was outdated and not fit for purpose. I am concerned that my 2018 recommendation has yet to be implemented and urge the DHB

to take action to remedy this as a matter of urgency. **I recommend that the DHB upgrades the IPC area as a matter of urgency.**

In 2018, I recommended:

The Unit develops an action plan to reduce the high and increasing number of seclusion events.

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

- The DHB's Mental Health and Addictions Service (the Service) established a project plan in 2019 to work towards the New Zealand national target of zero seclusion. The key indicators of the project plan established six[16] key areas to support their objective.
- I acknowledge that work is underway to reduce the use of seclusion across the Service and information provided showed that a Reducing Seclusion project team has been established and meets regularly. On that basis, I consider the Unit has achieved my recommendation to develop an action plan relating to seclusion.
- However, I note the progress of work to reduce and eventually eliminate seclusion is slow and the data indicated that the work is yet to have an impact on the rate of seclusion in the Unit. I discuss these concerns in more detail below (page 12).

In 2018, I recommended:

All appropriate staff undertake the SPEC training.

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

- Data provided by the Service showed 56 of the 65 Unit staff were up-to-date with Safe Practice Effective Communication (SPEC) training. The remaining nine staff were either exempt or were scheduled to attend refresher training.

Findings of 2021 inspection

In addition, I found:

Seclusion events

- The Unit continued to have a high number of seclusion events. I consider that seclusion is a serious intervention with no therapeutic benefit and potentially harmful effects on tāngata whai ora.

[16] Leadership, use of data collection, workforce development, use of seclusion reduction tools, consumer/whānau support/Māori cultural support roles and debriefing techniques.

- The number of seclusion events had increased compared to my last inspection in 2018[17]. In the six-month period, from 1 February to 31 July 2021, there were 85 seclusion events in the Unit involving 34 tāngata whai ora. Thirty-three of these seclusion events lasted for a period of ten hours or more, with the longest event lasting 38.50 hours.
- I acknowledge that the total number of seclusion hours[18] had reduced significantly since my inspection of 2018, however levels remained high.
- The Reducing Seclusion project team updates included an acknowledgement that '*While seclusion hours have decreased the number of events has continued at present levels. The ethnicity of persons secluded indicates Māori are still over represented in the seclusion data'.*
- I am concerned about the ongoing high levels of seclusion at the Unit. Reducing (and eliminating) seclusion in New Zealand is one of the goals in the Ministry of Health's 2012 service development plan '*Rising to the Challenge'*.[19]
- The DHB's *Mental Health & Addictions Clinical Service Plan (Service Plan) (2020/21 – 2024/25 (date April 2021)* also stated:

  > *'Māori are over-represented in admissions to Tauranga Hospital, and in contact with community MH&A services relative to their proportion of the total Western Bay population'.*

- In my view, the Unit needs to take further action as a matter of priority and **I therefore recommend that the Unit addresses the high use of seclusion, with particular consideration given to seclusion rates of Māori.**

Environmental restraint

- The Unit, which was designated as an open unit, was locked at the time of inspection. Senior management and Unit staff told Inspectors the Unit had been locked to manage COVID requirements.
- The DHB's '*Locked Door Management in Acute Psychiatric Mental Health Protocol'* (the Locked Door Protocol) (dated November 2015) 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'*.
- The locking of the Unit was not being recorded as environmental restraint. Additionally, access to the courtyard on the 'open' side was facilitated by staff as doors to the

[17] In my 2018 Report for the period 1 March to 31 August 2018 there were 59 seclusion events totalling 1,413.50 seclusion hours.

[18] Total seclusion hours for the period 1 February to 31 July 2021 were 833.36.

[19] Ministry of Health 2017. Office of the Director of Mental Health Annual Report 2016. Wellington: Ministry of Health.

courtyard were locked throughout the inspection. This too was not being recorded as environmental restraint by the Unit.

- The Locked Door Protocol also specified *‘Restricting exit from the ward is implemented only for individual consumers who are assessed as requiring a contained ward environment to ensure the safety of themselves and others’*.
- In my view, the practice of locking the front door to the Unit and the doors to the courtyard constitutes environmental restraint and should be recorded as such.
- 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 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 tāngata whai ora about entering and exiting the Unit

- At the time of inspection, there were nine voluntary tāngata whai ora on the Unit. I expect that all voluntary tāngata whai ora should be able to leave the Unit at will. It is part of my role as NPM to monitor this because if they are not able to leave at will, this may amount to arbitrary detention.
- Inspectors did not observe information displayed on the Unit detailing the process to enter or exit the Unit, nor any written information in tāngata whai ora welcome packs explicitly stating that voluntary tāngata whai ora had the right to leave when they wished to. This increases the risk of arbitrary detention.
- The Locked Door Protocol did not provide any guidance concerning how voluntary tāngata whai ora could enter or exit the Unit. 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 tāngata whai ora are fully informed of their right to enter and exit the Unit, and how to do so.**

Tāngata whai ora views on treatment

- Some tāngata whai ora spoken with told Inspectors they did not feel the staff communicated well or engaged them in their treatment. Inspectors observed minimal interaction between staff and tāngata whai ora, except at the morning community meeting.
- During inspection, Inspectors also noted that tāngata whai ora did not attend their MDT meetings, and there was no evidence of copies of MDT minutes or decisions being provided to tāngata whai ora. Further, almost all treatment plans on tāngata whai ora files were incomplete or missing. None of the current treatment plans had been signed by the tāngata whai ora or, where appropriate, countersigned by staff.
- Effective multi-disciplinary based care in mental health services should enable tāngata whai ora to determine their level of involvement in decision-making and ensure they have a clear understanding of their recovery plan. It is my view that tāngata whai ora and their whānau should be invited to their MDT meetings wherever possible, and kept informed of the outcome of these. **As such, I recommend that the Unit ensure that tāngata whai ora, and their whānau, are involved in treatment planning, including attending their MDT and developing their treatment plan.**

Recommendations

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

Treatment

1. The Unit takes immediate steps to not use seclusion rooms and admissions/day rooms as bedrooms to accommodate tāngata whai ora. **This is an amended repeat recommendation.**
2. The Unit ceases the practice of secluding tāngata whai ora in the IPC courtyard, or any area other than a designated seclusion room. **This is an amended repeat recommendation.**
3. The DHB upgrades the IPC area as a matter of urgency. **This is an amended repeat recommendation.**
4. The Unit addresses the high use of seclusion, with particular consideration given to seclusion rates of Māori.
5. The Unit records and reports all instances of environmental restraint.
6. The Unit ensures voluntary tāngata whai ora are fully informed of their right to enter and exit the Unit, and how to do so.
7. The Unit ensures that tāngata whai ora, and their whānau, are involved in treatment planning, including attending their MDT and developing their treatment plan.

Protective measures

Implementation of 2018 recommendations

In 2018, I recommended:

The complaints process is readily available to patients and the process is independent of staff.

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

- Limited signage was displayed on the 'open' side of the Unit and in the IPC area explaining the complaint process. While Inspectors sighted a poster outlining the complaints process in the 'open' side and IPC area, information about the complaints process was not readily visible throughout the Unit.
- Access to complaints forms was not readily available throughout the Unit and IPC. Inspectors were told that staff would give tāngata whai ora a blank piece of paper to write their complaint on and give to a staff member, who would then forward it to the Quality and Safety Coordinator for follow up.
- When asked, staff were unable to provide Inspectors with a complaint form for tāngata whai ora to complete, and both tāngata whai ora and staff spoken with generally seemed unclear about the process for making a complaint.
- I acknowledge that the DHB has a '*Revised (2021) BOPDHB Complaints Signage and Forms – Independent of staff*' process available on their website. However, those tāngata whai ora in the Unit that did not have internet access were still reliant on staff to assist them to make a complaint. I recommend**: The Unit ensure that the complaints process is clearly advertised throughout the Unit and all tāngata whai ora are able to raise a complaint independent of staff.**

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 **not achieved**:

- The files reviewed by my Inspectors did not routinely contain Consent to Treatment documentation, including for voluntary tāngata whai ora.[20]
- I have particular concerns that voluntary tāngata whai ora did not have a signed Consent to Treatment form retained on their files. Voluntary tāngata whai ora are under no legal compulsion to remain in a locked Unit or receive treatment. There must be a robust

[20] One tangata whai ora subject to a compulsory treatment order had a section 59 consent to treatment form on file.

process to ensure their consent is routinely sought, reviewed and recorded. Failure to do this can increase the risk of arbitrary detention. **Therefore, I recommend that the Unit ensures that tāngata whai ora have a signed Consent to Treatment form retained on their file. In circumstances where a tangata whai ora is unable or refuses to sign, this is documented.**

- In response to my provisional report the Ministry of Health stated *'My expectation for voluntary tāngata whai ora is that there is documentation recording a discussion between staff and tāngata whaiora about consent to treatment on file. This is something I will request the district inspectors to monitor'*.
- I look forward to seeing this implemented and monitored at my further inspections.

Findings of 2021 inspection

In addition, I found:

- Contact details for the District Inspectors were not clearly visible to tāngata whai ora in either the 'open' side or the IPC area. Staff said that phone calls to the District Inspectors were placed by staff and not directly by the tāngata whai ora.
- It is the statutory role of District Inspectors to hear tāngata whai ora complaints and of the Facility to ensure that tāngata whai ora are informed of this.[21]
- Independent access to a District Inspector whilst tāngata whai ora are detained is essential to prevent any potential censure/ill-treatment or undue influence for making a complaint.
- Furthermore the District Inspector is a crucial safeguard in a person's legal detention under the Mental Health Act. District Inspectors have an obligation under the Act to ensure that every individual who is subject to compulsory assessment and treatment order under the Act is cared for in accordance with the statutory requirements of the Act and the principles of natural justice legislation.
- I therefore consider that it is unacceptable for tāngata whai ora not to be able to contact District Inspectors independently of staff.
- **I therefore recommend that the Unit ensures that contact details for the District Inspector are displayed on the Unit and tāngata whai ora are able to contact the District Inspector independent of staff.**

Recommendations

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

[21] Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 64(2)(g). The functions and powers of District Inspectors are located in sections 94 to 98 of the Act.

Protective measures

8. The Unit ensures that the complaints process is clearly advertised throughout the Unit and all tāngata whai ora are able to raise a complaint independent of staff. **This is an amended repeat recommendation.**

9. The Unit ensures that tāngata whai ora have a signed Consent to Treatment form retained on their file. In circumstances where a tangata whai ora is unable or refuses to sign, this is documented. **This is an amended repeat recommendation.**

10. The Unit ensures that contact details for the District Inspector are displayed on the Unit and tāngata whai ora are able to contact the District Inspector independent of staff.

Material conditions

Implementation of 2018 recommendations

In 2018, I recommended:

Patients are able to lock their bedroom doors at any time, to improve their privacy and safety.

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

- Bedroom doors still could not be locked by tāngata whai ora from the inside to improve their privacy and safety. Tāngata whai ora still required staff to lock and unlock their bedroom doors.
- Tāngata whai ora advised my Inspectors that they could not lock their bedroom doors at night as they were told staff needed to be able to check on them throughout the night. While I appreciate that tāngata whai ora safety is a high priority, I am concerned that tāngata whai ora are not able to lock their bedrooms at night.
- Until such time as a rebuild occurs (see pages 10 – 11), I consider that an arrangement such as that operated at Te Toki Maurere[22] would enhance the safety of tāngata whai ora, without compromising safety and staff access to tāngata whai ora during the night. In particular, the locking system on the bedroom doors could be adjusted to prevent anyone entering a bedroom at night without the assistance of a nurse, but tāngata whai ora would still be able to freely leave their rooms. **I recommend that the DHB takes immediate steps to ensure that tāngata whai ora are able to lock their bedroom doors at any time, to improve their privacy and safety.**

In 2018, I recommended:

Defined accommodation is provided for female patients that ensure their need for privacy and safety are met.

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

- Although there was a dedicated female wing on the Unit, the number[23] of female tāngata whai ora on the Unit at the time of inspection meant that female tāngata whai ora were accommodated across all three wings in the 'open' unit, along with two female tāngata whai ora being accommodated in seclusion rooms.
- As noted above, the proposed rebuild of the Unit had not been completed.

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[22] The Bay of Plenty DHB Mental Health Acute Inpatient Unit located at Whakatane. The locking system on the bedroom doors prevented anyone entering a bedroom at night without the assistance of a nurse, but tāngata whai ora could freely leave the room.

[23] There were 20 female tāngata whai ora on the Unit on the first day of inspection.

- Female tāngata whai ora were therefore unable to be accommodated in a separate area.
- 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. In my view, the placement of female tāngata whai ora continued to pose a risk to their privacy and safety. The DHB needs to prioritise gender separation to ensure all female tāngata whai ora are afforded privacy and safety. **As such, I recommend that the DHB ensures that accommodation is provided for female tāngata whai ora for privacy and safety.**

Findings of 2021 inspection

In addition, I found:

The Unit was not fit-for-purpose

- Overall, the Unit was not fit-for-purpose and a number of ongoing issues had not been addressed despite multiple repeat recommendations, including:
    a. Seclusion rooms and the admissions/day room were used as bedrooms (see page 8);
    b. The Unit regularly operated over capacity (see page 8);
    c. The IPC area had not been upgraded (see page 10);
    d. Bedroom doors could not be locked (see page 18); and
    e. There was a lack of gender separation in the Unit (see page 18).
- These issues created risks for the privacy, safety and dignity of tāngata whai ora. They were also exacerbated by the Unit regularly running over capacity. Occupancy data provided by the DHB showed for the six-month period[24] preceding the inspection the Unit was operating over capacity every month.
- The Service Plan provided to my Inspectors stated that:

    'demand for inpatient beds exceeds supply…… Tauranga Hospital will require 13 more beds, increasing from 24 current beds to a required 37 beds'.

- Staff told my Inspectors that there had been plans for a rebuild of the Unit, but that these had been impacted by reallocation of funding. The focus for the Unit was now on a refurbishment.
- Given the issues noted above, it is clear that a long-term plan must be developed and implemented to make service wide and sustainable changes. I consider that the

[24] February 2021 24.75 percent over capacity, March 2021 25.5 percent, April 2021 25.25 percent, May 2021 25.5 percent, June 2021 25.5 percent and July 2021 25.19 percent.

refurbishment of the Unit will not address the concern that the facility is fundamentally not fit for purpose. For example, a refurbishment does not seem likely to meet the growing demand for inpatient care and treatment in the region.

- I expect the DHB to urgently resume planning for a rebuild of the Unit, considering the issues I have raised here and in previous reports. Steps should also be taken to address the matters raised as much as is possible within the current building constraints. **I recommend that the DHB urgently resumes planning for a new build in line with best practice for the design of mental health facilities.**

Recommendations

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

Material conditions

11. The DHB takes immediate steps to ensure that tāngata whai ora are able to lock their bedroom doors at any time, to improve their privacy and safety. **This is an amended repeat recommendation.**
12. The DHB ensures that accommodation is provided for female tāngata whai ora for privacy and safety. **This is an amended repeat recommendation.**
13. The DHB urgently resumes planning for a new build in line with best practice for the design of mental health facilities.

Activities and communications

Implementation of 2018 recommendations

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**:

- Formal visiting hours for the Unit were not consistently referred to in all information available to tāngata whai ora and visitors. For example:
  a. Signage at the entrance to the Unit indicated visiting hours were between 3:30pm to 8pm.
  b. Unit induction material indicated that visiting hours were between 8am and 8pm daily.
  c. Inspectors were told by staff and senior management that, in practice, visiting hours were flexible and could be booked any time between 9am and 8pm.
  d. Staff advised Inspectors that due to COVID-19 visitors were required to phone before visiting and limits were placed on the number of visitors.
- I was pleased to hear that visits were flexible and that the Unit was putting in place COVID-19 safety measures. However, for clarity's sake I encourage the Unit to ensure that visiting hours are consistently referred to in all information and signage. **I therefore recommend that the Unit takes steps to ensure that visiting hours to the Unit are consistently referred to in all information available to tāngata whai ora and visitors.**

In 2018, I recommended:

Arrangements be made to ensure greater privacy for patients when using the telephone in the open unit and IPC.

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

- The tāngata whai ora telephone in the 'open' side was located in the area directly outside the nurses' station and was available for tāngata whai ora to use up to 8.00pm. The location of the telephone did not offer any privacy as it was a busy, public area.
- Tāngata whai ora in the IPC area did not have access to a dedicated phone. Tāngata whai ora placed calls using the staff telephone located in the office of the IPC.
- Staff remained in the office when tāngata whai ora were using the telephone. This not only compromised tāngata whai ora independent access to a telephone, but also their privacy.

- Staff told Inspectors the Unit had been trialling the independent use of tāngata whai ora personal mobile phones. Mobile phone assessments and contracts were held on tāngata whai ora files, though not all had been completed.
- Tāngata whai ora who had mobile phones could use these on the 'open' side of the Unit and in the IPC area. Tāngata whai ora were able to access the hospital Wi-Fi.
- While I acknowledge the introduction of tāngata whai ora having use of their personal mobile devices, I remain concerned that privacy and independence is not afforded to those tāngata whai ora who use the Unit's telephone. I expect the Unit to take further action to remedy this matter. **I recommend that the Unit makes arrangements to ensure privacy for tāngata whai ora when using the telephone in the 'open' unit and IPC area.**

Recommendations

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

Activities and communications

14. The Unit takes steps to ensure that visiting hours to the Unit are consistently referred to in all information available to tāngata whai ora and visitors. **This is an amended repeat recommendation.**
15. The Unit makes arrangements to ensure privacy for tāngata whai ora when using the telephone in the 'open' unit and IPC area. **This is an amended repeat recommendation.**

Staff

Implementation of 2018 recommendations

In 2018, I recommended:

The reasons for staff resignations 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.[25] 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.
- The CNL reported that historically staff turnover had been problematic, however turnover had reduced since the previous inspection of 2018 with the attrition of only 1.8 Full Time Equivalent (FTE) in the past two years.
- Data provided by the Service showed staff turnover had reduced significantly from the 2018/19 period.
- Data provided to Inspectors showed that, at the time of inspection, there were 9.34 Registered Nurse vacancies, 3.30 Health Care Assistants (HCAs) vacancies and 1.0 Social Worker vacancy on the Unit. The high level of staff vacancies was not due to staff turnover, but rather due to increased staffing allocation for the Unit, internal transfers of staff, parental leave, and fixed term positions ending that resulted in vacancies.
- The Service was advertising to try to fill these vacancies.
- It was reported to my Inspectors that staffing levels were not ideal and the Unit needed more staff but had been unable to fill the roles. The Service was aware of the national challenge faced in filling RN shortages across the country**.** Given the importance of staffing to conditions and treatment, **I recommend that the DHB works with relevant agencies to develop and implement a workforce strategy to ensure appropriate staffing for the Unit.**

In 2018, I recommended:

A dedicated mental health pharmacist is part of the MDT.

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

[25] Data provided by the Service showed during the period 2016/17 to 2017/18, staff turnover on the Unit increased from 7.5 percent to 25 percent.

- 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 MDT meetings to provide educational support to staff.
- The Unit had hired a 1 FTE Pharmacist and 1 FTE junior Pharmacist dedicated to the Unit.
- I was pleased to note that the Pharmacist attended weekly MDT meetings.
- I also noted that all medication errors were reviewed by the Pharmacist, the CNL, and the Associate Clinical Nurse Manager. My Inspectors reviewed the '*Medication Incident Reports'* for the nine medication error events between 1 February and 31 July 2021. The reviews were thorough and provided opportunity for lessons learnt which were communicated to staff.
- Additional data provided to my Inspectors showed the Unit had shown an improvement in the reduction of medication errors from the previous two years.[26]

Recommendations

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

Staffing

16. The DHB works with relevant agencies to develop and implement a workforce strategy to ensure appropriate staffing for the Unit.

[26] There were 43 medication errors for the period 1 January to 31 December 2019 and 31 medication errors for the period 1 January to 31 December 2020.

Appendix 1. Implementation of 2018 recommendations

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

2018 recommendation	2018 response[27]	2021 finding[28]
1. The seclusion rooms and admissions/day room should not be used (as bedrooms) to accommodate patients. **This is a repeat recommendation.**	Accepted	Not achieved
2. The practice of secluding patients in the IPC courtyard, or any area other than a designated seclusion room, should cease.	Partially accepted	Not achieved
3. An analysis and review of the Unit's use of security staff is conducted, ensuring patients' views and experiences are canvassed.	Accepted	Achieved
4. The IPC facility is upgraded.	Accepted	Not achieved
5. The Unit develops an action plan to reduce the high and increasing number of seclusion events.	Accepted	Achieved
6. All appropriate staff undertake the SPEC training.	Accepted	Achieved
7. The complaints process is readily available to patients and the process is independent of staff.	Accepted	Not achieved
8. 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	Not achieved
9. Patients are able to lock their bedroom doors at any time, to improve their privacy and safety.	Accepted	Not achieved
10. Defined accommodation is provided for female patients that ensure their need for privacy and safety are met.	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

[27] Accepted, Partially accepted, Rejected.

[28] Achieved, Partially achieved, Not achieved.

2018 recommendation	2018 response[27]	2021 finding[28]
12. Arrangements be made to ensure greater privacy for patients when using the telephone in the open unit and IPC.	Accepted	Not achieved
13. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.	Accepted	Achieved
14. A dedicated mental health pharmacist is part of the MDT.	Accepted	Achieved

Appendix 2. Recommendations

Listed below are all my recommendations following the August 2021 inspection of Te Whare Maiangiangi:

Recommendation	Repeat
1. The Unit takes immediate steps to not use seclusion rooms and admissions/day rooms as bedrooms to accommodate tāngata whai ora.	Repeat amended
2. The Unit ceases the practice of secluding tāngata whai ora in the IPC courtyard, or any area other than a designated seclusion room.	Repeat amended
3. The DHB upgrades the IPC area as a matter of urgency.	Repeat amended
4. The Unit addresses the high use of seclusion, with particular consideration given to seclusion rates of Māori.	
5. The Unit records and reports all instances of environmental restraint.	
6. The Unit ensures voluntary tāngata whai ora are fully informed of their right to enter and exit the Unit, and how to do so.	
7. The Unit ensures that tāngata whai ora, and their whānau, are involved in treatment planning, including attending their MDT and developing their treatment plan.	
8. The Unit ensures that the complaints process is clearly advertised throughout the Unit and all tāngata whai ora are able to raise a complaint independent of staff.	Repeat amended
9. The Unit ensures that tāngata whai ora have a signed Consent to Treatment form retained on their file. In circumstances where a tangata whai ora is unable or refuses to sign, this is documented.	Repeat amended
10. The Unit ensures that contact details for the District Inspector are displayed on the Unit and tāngata whai ora are able to contact the District Inspector independent of staff.	

Recommendation	Repeat
11. The DHB takes immediate steps to ensure that tāngata whai ora are able to lock their bedroom doors at any time, to improve their privacy and safety.	Repeat amended
12. The DHB ensures that accommodation is provided for female tāngata whai ora for privacy and safety.	Repeat amended
13. The DHB urgently resumes planning for a new build in line with best practice for the design of mental health facilities.	
14. The Unit takes steps to ensure that visiting hours to the Unit are consistently referred to in all information available to tāngata whai ora and visitors.	Repeat amended
15. The Unit makes arrangements to ensure privacy for tāngata whai ora when using the telephone in the 'open' unit and IPC area.	Repeat amended
16. The DHB works with relevant agencies to develop and implement a workforce strategy to ensure appropriate staffing for the Unit.	

Appendix 3. List of people who spoke with Inspectors

List of people who spoke with Inspectors

Charge Nurse Lead

Charge Nurse Specialist

Family/ whānau

Family/ whānau Advisor

Pharmacist

Quality & Safety Coordinator

Consultant Psychiatrist

Registered Nurses

Security staff

Tāngata whai ora

Te Pou Kōkiri

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:
  a. for improving the conditions of detention applying to detainees;
  b. for improving the treatment of detainees; and
  c. 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.