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OPCAT Report

Report on an announced follow up inspection of Ward 6C, Dunedin Hospital, under the Crimes of Torture Act 1989

27 July 2023

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Tari o te Kaitiaki Mana Tangata

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Introduction

The following report has been prepared in my capacity as a National Preventive Mechanism (NPM), as designated under the Crimes of Torture Act 1989 (COTA). The purpose of the COTA is to enable Aotearoa New Zealand to meet its international obligations under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol (OPCAT).[1]

I am empowered to examine places of detention: where people are unable to leave at will. My designation includes health and disability facilities. Central to this is conducting visits and inspections. This has a preventive purpose, to ensure that safeguards against ill-treatment are in place and that poor practices, or systemic problems, are identified and addressed promptly.

My role is to form an independent opinion as to the conditions and treatment in these places, report my findings and if necessary make recommendations for improvement. I carried out an inspection of Ward 6C, Dunedin Hospital, on 6 and 7 September 2022.

More information

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

Overview of inspection

Inspection approach

On 6 and 7 September 2022, two Inspectors made an announced[2] two-day inspection of Ward 6C, Dunedin Hospital to follow up on recommendations made following my previous inspection in May 2021.[3] It was undertaken when all of Aotearoa New Zealand was at the COVID-19 Protection Framework (traffic light) orange setting.[4]

The follow up inspection focussed on progress in implementing the recommendations I made in 2021, and whether I consider those recommendations to have been achieved or not. To

[1] The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. More information about OPCAT and the Chief Ombudsman's National Preventive Mechanism (NPM) function can be found at https://www.ombudsman.parliament.nz/what-we-can-help/monitoring-places-detention/why-ombudsman-monitors-places-detention.

[2] The inspection, referred to as a 'follow up inspection', was announced on 24 August 2022.

[3] *Report on an unannounced inspection of Ward 6C, Southern District Health Board under the Crimes of Torture Act 1989,* (2021) Wellington.

[4] See COVID-19 Protection Framework (traffic lights) | Unite against COVID-19 (covid19.govt.nz) [accessed 20 July 2022]

ensure an evidence-based approach, my Inspectors gathered and assessed a range of information including:

- Information and documents from the Ward, including clinical records, incident reports and meeting minutes, and policies and procedures produced by the Ward and Te Whatu Ora Southern;
- Interviews with tāngata whai ora, staff and other relevant stakeholders; and
- Observations within the Ward, with a focus on issues impacting on tāngata whai ora and staff.

Te Whatu Ora – Health New Zealand and the Ministry of Health – Manatū Hauora received a copy of my provisional report and were invited to comment. I received responses from Manatū Hauora and Te Whatu Ora and I have considered their feedback when preparing my final report.

Facility facts

At the time of the follow up inspection, Ward 6C (the Ward) was located on the sixth floor of Dunedin Hospital, in the Te Whatu Ora – Health New Zealand Southern region (Te Whatu Ora Southern).[5] The Ward was a 12-bed secure mental health/psychogeriatric ward for older persons (tāngata whai ora).[6] However, staffing challenges during the COVID-19 pandemic meant bed capacity was limited to nine beds.[7]

There were eight tāngata whai ora on the Ward on the first day of the inspection. One of those people was admitted on the first day of the inspection, so they are not included for the purposes of data analysis. The average length of stay on the Ward was 30 days.

Tāngata whai ora could be admitted to the Ward by orders made under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) or on a voluntary basis. At the time of the inspection there were two voluntary tāngata whai ora on the Ward and the other tāngata whai ora had been admitted under the MHA.

References to the District Health Board

At the time of the original inspection in May 2021, the Ward was under the management of the Southern District Health Board (the DHB). On 1 July 2022, DHBs were disestablished and replaced by Te Whatu Ora – Health New Zealand (Te Whatu Ora). Te Whatu Ora manages all

[5] On 1 July 2022, district health boards were disestablished and replaced by Te Whatu Ora – Health New Zealand. For more information see: https://www.futureofhealth.govt.nz/health-nz/

[6] A person who uses mental health and addiction services. In the report on my 2021 inspection, tāngata whai ora were referred to as 'patients'.

[7] Inspectors were told capacity had increased from eight beds, and was to increase to 10 beds in the near future.

health services in Aotearoa New Zealand, through a network of regional divisions and district offices, and works in partnership with Te Aka Whai Ora – the Māori Health Authority.

Throughout this report there are references to the DHB, as the responsible body at the time of the original inspection. However, where appropriate, recommendations are made to Te Whatu Ora Southern, as the responsible agency at the time of the follow up inspection.

Key observations and recommendations

My May 2021 inspection resulted in my making six recommendations. The DHB accepted all of those recommendations.

As a result of my 2022 follow up inspection I consider that one of these recommendations was achieved, two were progressing but not yet achieved, and three were not achieved.

On the basis of my follow up inspection, I make eight recommendations. Of these, five are repeat or amended repeat recommendations from my 2021 inspection, and three are new recommendations. One of the new recommendations has resulted from an issue I identified in the report on my 2021 inspection but did not make a recommendation about at that time.

Recommendations

I make the following recommendations to the Te Whatu Ora Southern Interim Lead – Hospital and Specialist Services and management of the Ward as a result of my follow up inspection in 2022:[8]

- I recommend Te Whatu Ora Southern and management of the Ward ensure that on admission to the Ward and at other appropriate times, tāngata whai ora and their whānau are provided with relevant information in various forms, including about their legal status. Discussed on pages 4 to 6
- I recommend Te Whatu Ora Southern and management of the Ward put in place processes to enable voluntary tāngata whai ora to leave the Ward freely and safely, and inform them of their right to do so. Discussed on pages 8 to 10

I make the following recommendations to the Te Whatu Ora Southern Interim Lead – Hospital and Specialist Services:

- I recommend Te Whatu Ora Southern ensures its system to manage complaints provides for each complaint to be dealt with in a consistent way. Discussed on pages 6 to 8
- I recommend Te Whatu Ora Southern ensures policies and procedures clearly convey the rights of voluntary tāngata whai ora. Discussed on pages 8 to 10

[8] I am empowered by section 27 of the Crimes of Torture Act 1989 to make recommendations for improving the conditions and treatment of detention applying to detainees and for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

- I recommend Te Whatu Ora Southern ensures the Ward has sufficient staff to enable tāngata whai ora to spend time outdoors daily. Discussed on pages 12 and 13

I make the following recommendations to management of the Ward:

- I recommend management of the Ward ensure that each tangata whai ora has clearly identified leave arrangements documented in their care plan. Discussed on pages 8 to 10
- I recommend management of the Ward ensure that each day tāngata whai ora have access to a dedicated safe outdoor area that provides space for social interaction, engaging with the natural environment, exercise, and relaxation. Discussed on pages 10 to 12
- I recommend management of the Ward ensure that all relevant staff are up-to-date with SPEC training. Discussed on pages 13 and 14

Safety

Recommendation 1 from 2021: On admission to the Ward, patients and their whānau are welcomed appropriately, and provided with relevant information in various forms (electronic, physical, and verbal) at appropriate times to support their understanding.

- This recommendation was accepted by the DHB.
- On my follow up inspection I found that the recommendation was **progressing but not yet achieved**.

During the 2022 follow up inspection, Inspectors observed that management of the Ward had taken steps to ensure tāngata whai ora and their whānau were welcomed appropriately and provided with relevant information electronically, physically, and verbally at the time of their admission.

Inspectors were provided with copies of three admission packs – for tāngata whai ora who had dementia, had been admitted under the MHA, and were on the Ward on a voluntary basis.[9] The admission packs each contained much of the same information,[10] although additional information was available in the physical dementia pack compared to the version that was provided electronically.[11] While I appreciate the provision of this information in various forms, I expect consistent information to be provided, regardless of the format in which it is made available.

[9] Inspectors received the three admission packs electronically and reviewed a hard copy of each while on-site.

[10] The pack for voluntary tāngata whai ora did not contain two pamphlets about dementia, and information about Alzheimers NZ Otago, which the other two packs contained.

[11] The additional documents were entitled: *'What happens if you can no longer make a decision?'*; *'Gibson Day Unit Information'*; *'Information for Consumers, Family & Support Networks'*; and *'Support Services Available in the Community'*.

The three admission packs did not contain distinct information about the legal basis for each type of admission. In particular, the voluntary admission pack did not outline the right of voluntary tāngata whai ora to leave the Ward at will and any processes that provided for this. See also discussion of recommendation 5 in this report.

Inspectors were informed that the admission packs were not consistently provided electronically to tāngata whai ora and their whānau. Management of the Ward told Inspectors the process to gather email addresses was under review to address its ad hoc nature.[12]

Inspectors saw that staff used an *'Admission Checklist'* to ensure the required induction information was provided to each tangata whai ora. This included dietary notes, information about whānau visiting times, clothes and toiletries, laundry arrangements, and general orientation. The *'Admission Checklist'* was added to the file of each tangata whai ora.

One tangata whai ora told Inspectors the admission process included information being provided verbally, and their whānau was also given the opportunity to ask the clinical staff questions.

During the follow up inspection, Inspectors saw advocacy and rights notices[13] displayed in prominent positions throughout the Ward. However, District Inspectors' (DI) details were located inside the back room of the Nurses' Station, requiring tāngata whai ora to ask staff for this information.[14] In response to my provisional report, I have been advised that DI details are now displayed on the Ward.

In my 2021 inspection report, I stated, *'I expect the Ward to provide patients and their whānau with information about support services when the patient is discharged.'* Inspectors noted that information about support services available in the community was available for tāngata whai ora and their whānau.

I appreciate and encourage the Ward's ongoing efforts to provide tāngata whai ora and their whānau with relevant information in various forms and at appropriate times. However, I consider the information provided needs to clearly outline the legal basis under which each tangata whai ora is on the Ward, and how this impacts on the rights of tāngata whai ora while accommodated in the Ward. **I recommend Te Whatu Ora Southern and management of the Ward ensure that on admission to the Ward and at other appropriate times, tāngata whai ora and their whānau are provided with relevant information in various forms, including about their legal status.**

In response to my provisional report, Te Whatu Ora provided me with a newly created document which provides tāngata whai ora further information about the types of admission.

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[12] Email addresses were recorded alongside the date the admission pack was provided on the *'Admission front sheet'.* Email addresses were also recorded in the applicable *'Names notebook MHA', 'Names notebook Dementia'*, or the *'Names notebook Voluntary'.*

[13] These included posters about the 'Nationwide Health and Disability Service' and the 'Health and Disability Commissioner'.

[14] Ward management said the DI details had been taken down due to COVID-19 requirements that had led to the Ward being reconfigured to support the wider hospital's COVID-19 response.

I appreciate the prompt action taken to address this, and I hope that it will assist Te Whatu Ora Southern and management of the Ward to address my recommendation.

Recommendation 2 from 2021: The Ward ensures its complaints system is accessible and well communicated, includes the centralised recording of complaints, the corrective action taken, and a clear pathway of escalation.

- This recommendation was accepted by the DHB.
- On my follow up inspection I found that the recommendation was **progressing but not yet achieved**.

Information about how to make a complaint was accessible to tāngata whai ora on the Ward. Inspectors saw feedback brochures, suggestion boxes, and advocacy and rights posters for tāngata whai ora on the Ward. Feedback brochures were also included in the admission packs. One tangata whai ora said they would talk to their spouse if they wanted to make a complaint.

The Ward used Dunedin Hospital's complaints and incident risk management system, Safety1st, to manage complaints. This enabled the centralised recording of complaints and actions taken in response to the complaint.

It is encouraging that the complaints system was accessible to tāngata whai ora on the Ward and a centralised system was in place for managing complaints. However, I am concerned that complaints were not always being dealt with consistently. In particular, whether a complaint was made in verbal or written form may have affected how it was considered. Different policies and information provided by management also did not appear to promote consistency of practice.

Safety1st was governed by the *'Consumer Complaints Policy (District)'* and the *'Recording and Managing Consumer Complaints (District)'* policy. The *'Consumer Complaints Policy (District)'* included the following statements:

> *All consumer complaints, both written and verbal will be logged and maintained within Safety1st, the Quality & Risk management system. The complaint management process is linked to Safety1st to facilitate feedback and improvements.*
>
> *All consumer complaints, both written and verbal will be logged and maintained through Safety1st if the patient is seeking a formal investigation and response.*
>
> *Staff are encouraged to resolve complaints at the point of contact with the complainant, if possible. In the event a formal complaint is received and the patient/family/whanau request a formal investigation or review and response, any staff member receiving such a complaint will forward this, in writing to…*

The *'Recording and Managing Consumer Complaints (District)'* policy stated:

> *All staff are responsible for forwarding any consumer complaints received to: feedback@southerndhb.govt.nz. This will enable the complaint to be logged (on Safety1st), securely stored independently of any health care records and follow a*

> *standardised process for investigation and response. Note: All feedback (Compliments, Complaints, and Suggestions) must be stored as a confidential digital copy file within Safety1st.*

The policy did not state that a complaint had to be 'formal' to be logged in the system. However, it stated, *'Staff are encouraged to resolve issues at the point of contact with consumers, if possible. Note: If issues are raised at service level and they are resolved to the satisfaction of the consumer, no further action is required.'*

I consider these statements do not appear to promote consistency of practice. Some statements could be interpreted as requiring staff to attempt to resolve a complaint in the first instance, with no further action needed, while others suggest that all complaints are to be recorded in Safety1st. It is also unclear what constitutes a 'formal' complaint.

Management of the Ward told Inspectors that complaints received verbally were considered to be *'informal'*. These complaints were not logged in the Safety1st system, but addressed directly by Ward management. Inspectors were given two examples of informal complaints, both of which appeared to be about significant matters.[15]

Formal complaints were received in writing (including via email), and they were logged in the Safety1st *'feedback module'*. Inspectors saw there had been two Ward 6C complaints recorded in the Safety1st system between 1 August 2021 and 1 August 2022.[16]

I consider the policies and information provided by management about how complaints are managed to be inconsistent. It is unclear whether all complaints are recorded in the Hospital's Safety1st complaints system or only those received in writing, and whether this affects how each complaint is dealt with.

In response to my provisional report, Te Whatu Ora reiterated that '*complaints are managed in a formal way within Te Whatu Ora Southern*' and outlined the complaints process which is activated once a complaint is logged with Patient Affairs. I remain concerned that this does not address the present ambiguity when identifying complaints which need to be logged with Patient Affairs.

I am concerned that the way in which a complaint is made may affect the way it is considered and addressed. **I recommend Te Whatu Ora Southern ensures its system to manage complaints provides for each complaint to be dealt with in a consistent way.** To achieve this it may be necessary to review complaints policies, procedures, and guidance.

Recommendation 3 from 2021: The Ward installs a permanent, clearly identifiable suggestions box that is easily accessible to patients and their whānau.

- This recommendation was accepted by the DHB.

[15] One of the complaints related to a potential privacy breach, and the other concerned an injury.

[16] One of these complaints related to a historic incident from the 1990s and was in progress at the time of the inspection. The other complaint was about the attitude of a staff member and had been closed.

- On my follow up inspection I found that the recommendation was **achieved**.

On entering the Ward during the follow up inspection, Inspectors saw an easily identifiable suggestions box attached to the wall in a prominent position. The location of the box was easily accessible to tāngata whai ora and their whānau. At the time of inspection, Inspectors observed during a *'Community Meeting'* held on the Ward that use of the suggestions box was mentioned to tāngata whai ora as a way in which they could provide feedback. Inspectors were told the box was emptied weekly.

Decency, dignity and respect

Recommendation 4 from 2021: The Ward puts in place processes to enable voluntary patients to leave the Ward freely and safely, and informs patients of the processes.

- This recommendation was accepted by the DHB.
- On my follow up inspection I found that the recommendation was **not achieved**.

In my 2021 report, I expressed my concern regarding the limited ability of tāngata whai ora, and particularly voluntary tāngata whai ora, to leave the facility. Given the legal status of voluntary tāngata whai ora, it is my expectation that they can leave the Ward at will.

During my follow up inspection, Inspectors observed that there had been no change to leave processes since my previous inspection and there were still restrictions on the ability of voluntary tāngata whai ora to leave the Ward at will.[17] A person could exit the Ward by entering a 4-digit code into a pin-pad. However, the code was not shared with voluntary tāngata whai ora. One such person told Inspectors, *'I don't think we're allowed outside, I'd have to go with my [partner] when [they] come.'* The Ward's whiteboard confirmed this, noting *'No leave'* for the voluntary tāngata whai ora. As noted in discussion of recommendation 1 above, the information pack for voluntary tāngata whai ora did not include information about how they could leave the Ward. Similarly, there was no information displayed on the Ward indicating how voluntary tāngata whai ora could safely exit.

Manatū Hauora responded to my provisional report stating they share my concern '*that voluntary tāngata whai ora are not aware they can leave the Ward and the process of how to do so'*. They said, *'all voluntary tāngata whai ora must be fully informed of their right to enter and exit the unit, and how to do so. Services should have clear procedures for voluntary tāngata whai ora to exit locked units, and these procedures should be clearly communicated and visible in the unit. My [Director of Mental Health] office will follow up this issue with the DIs [District Inspectors] and DAMHS [Director of Area Mental Health Services].'*

In response to my provisional report, Te Whatu Ora advised that they had considered providing the door code to voluntary tāngata whai ora however they considered the risk of them sharing

[17] This was confirmed through discussions with staff and tāngata whai ora, and tāngata whai ora notes and their whiteboard.

the code with their peers was high. Te Whatu Ora stated that, instead, '*all voluntary patients are informed they can ask staff to open the door at any time.*' Additionally, a poster about the rights of voluntary tāngata whai ora has reportedly been put on the wall. I will be closely monitoring the effectiveness of this in future. It is my expectation that voluntary tāngata whai ora are aware they are able to leave at any time and that the processes put in place to facilitate this happen without delay.

Consent to voluntary admission to the Ward was recorded in the Ward's *'Consent to Voluntary Stay in a Locked Unit (Otago)'* form (*Consent form)*. However, the '*Consent form'* did not inform voluntary tāngata whai ora that they could leave the Ward at will. This information was included in the *'Leave from Inpatient Facilities – MHAID [Mental Health, Addictions and Intellectual Disability] Service (District)'* guideline (the '*Leave guideline')*. The '*Consent form'* also did not state that the voluntary tāngata whai ora could withdraw their consent at any time, and it did not note whether regular reviews would be undertaken to ensure the person's consent endured.

The '*Leave guideline'* stated that the MHAID Service could not restrict the movement of voluntary patients. It then contradicted that statement by outlining that movement could be restricted as long as voluntary patients provided their informed consent. The '*Leave guideline'* later stated, *'… leave categories will only apply to voluntary consumers who have given their informed consent. Voluntary patients who do not consent have no leave restrictions.'*

In my view, the form and guideline discussed here indicate a lack of clarity regarding the rights of voluntary tāngata whai ora. These tāngata whai ora have a fundamentally different legal status to those detained under an order, and treating them the same risks the inappropriate application of leave restrictions.

In response to my provisional report, Te Whatu Ora advised that the '*Consent form*' template has now been updated to record that the voluntary tāngata whai ora had been advised of their right to refuse treatment, their right to leave at any time and that reviews would be undertaken weekly to ensure their consent endures.

Te Whatu Ora also stated that all voluntary tāngata whai ora '*are made aware what leave status has been recommended and when it changes.*' It is my expectation that, when explaining this to voluntary tāngata whai ora, staff make explicit that this is a recommendation only and that they remain free to leave.

Voluntary tāngata whai ora are under no legal compulsion to remain in the Unit and they should be able to enter and exit the Unit at will. Appropriate policy and procedures must be in place to allow for this to occur safely. Such policy and procedures are particularly important, as voluntary tāngata whai ora are not legally protected by the District Inspectors who provide a safeguard for compulsory tāngata whai ora under the MHA.

I recommend Te Whatu Ora Southern and management of the Ward put in place processes to enable voluntary tāngata whai ora to leave the Ward freely and safely, and inform them and their whānau or authorised representative of their right to do so.

I also recommend Te Whatu Ora Southern ensures policies and procedures clearly convey the rights of voluntary tāngata whai ora.

In response to my provisional report, Te Whatu Ora advised that the Leadership Team of the Mental Health, Addictions and Intellectual Disability Directorate will ensure all policies and procedures are reviewed to ensure they clearly convey the rights of voluntary tangata whai ora by 30 June 2023.

Recommendation 5 from 2021: Each day patients are provided with the opportunity to leave the Ward, escorted where necessary, including to access an outdoor area that provides space for social interaction, engaging with the natural environment, exercise, and relaxation.

- This recommendation was accepted by the DHB.
- On my follow up inspection I found that the recommendation was **not achieved**.

During the follow up inspection, Inspectors observed that access for tāngata whai ora to a suitable outdoor area, as described in my 2021 recommendation, had not improved. A solution had not been found to address the Ward's challenging location on the sixth floor of Dunedin Hospital, or the provision of fresh air and a safe outdoor space.[18] As a result, the ability of tāngata whai ora to leave the Ward to engage with a natural environment remained considerably limited.

One tangata whai ora told Inspectors they had been outside for a walk once in two weeks. I consider such limited access to outdoor areas to be unacceptable. Staff told Inspectors that where possible they '*rely on families to take their loved ones outside for fresh air and a break away from the Ward'.* Staff told Inspectors that escorted leave (where staff took tāngata whai ora outdoors) could compromise staffing levels on the Ward, and the safety and dignity of tāngata whai ora.

In responding to my provisional report, Manatū Hauora said they share my concerns *'regarding the lack of progress on improving outdoor access for tāngata whai ora since your May 2021 inspection.'* They noted, *'the challenging location of Ward 6C within Dunedin Hospital, and the impact that less access to fresh air and a safe outdoor space has on tāngata whai ora.'* They said they would *'follow the progress of this issue with interest and will seek updates from the DAMHS.'*

There appeared to be little clarity on the Ward about leave entitlements for tāngata whai ora, despite the existence of the guideline, *'Leave from Inpatient Facilities – MHAID Service (District)'.* This stated, *'All consumers will have a clearly identified level of leave (as defined below), documented in their treatment/care plan in the clinical file.*' Inspectors did not see any documentation by clinical staff about leave considerations in the five tāngata whai ora files they reviewed, and the Ward did not have a centralised record of leave. The whiteboard for

[18] Management of the Ward told Inspectors that consideration had been given to relocating the Ward to Wakari Hospital. However, the medical needs of older persons meant a move away from Dunedin Hospital was not considered appropriate.

tāngata whai ora also had no leave status recorded for more than half (six of nine) of the tāngata whai ora.

I consider that access to leave is essential to the wellbeing of tāngata whai ora, especially considering the lack of access to outdoor areas on the Ward. I therefore expect that leave arrangements for each tangata whai ora are considered and clearly documented. **I recommend management of the Ward ensure that each tangata whai ora has clearly identified leave arrangements documented in their care plan.** I expect any arrangements to be reviewed regularly and updated accordingly.

In response to my provisional report, Te Whatu Ora advised that '*a new leave recording form has been developed and implemented for each patient since the inspectors' visit. This is reviewed at least weekly at the multidisciplinary team meeting.*' I am pleased to hear of this initiative, and I hope that this will help the Ward achieve my recommendation.

My 2021 report included comment from the DHB about plans to improve the poor access to outdoor areas in the design of the new Dunedin Hospital, *'… these restrictions have been addressed, with three planned large outdoor areas available for patients and whānau to use'.* On 17 October 2022, Te Whatu Ora Southern provided the following update along with a *'functional design brief'* and *'floor plan for the layout of the Mental Health Services Older Person inpatient unit in the new Dunedin Hospital'*:

> *The issue of a designated outdoor space for patients in the new Older Persons Mental Health ward has been a consideration throughout the planning for the rebuild. [...] You will note there is a space identified as 'MH Outdoor' which is accessed from the internal component of the ward. The other outdoor spaces on the floor may also be accessed via the inpatient ward. These spaces will be appropriately landscaped as part of the project work plan.*
>
> *Te Whatu Ora Health New Zealand Southern, is confident these plans address the concerns regarding access to an appropriate outdoor space identified in the 2021 OPCAT report.*

While I appreciate the planned new Ward includes an outdoor space, and that other outdoor areas are included in the design, I understand the new Dunedin Hospital inpatient building is not scheduled for completion until mid-2028.[19] As such, I remain concerned about the ability of tāngata whai ora to access outdoors spaces in the meantime. I maintain that tāngata whai ora must have regular access to an appropriate, safe outdoor area, and that failure to provide this may result in a decline in the physical and mental health, independence, and wellbeing of tāngata whai ora on the Ward. **I recommend management of the Ward ensure that each day tāngata whai ora have access to a dedicated safe outdoor area that provides space for social interaction, engaging with the natural environment, exercise, and relaxation.**

[19] See: The New Dunedin Hospital | New Dunedin Hospital [accessed 28/10/22]

Leadership and culture

Recommendation 6 from 2021: The Ward ensure it has sufficient staff to enable patients to spend time outdoors daily.

- This recommendation was accepted by the DHB.
- On my follow up inspection I found that the recommendation was **not achieved**.

My discussion of recommendation 5 above identifies that the physical constraints of the Ward were the main obstacle to tāngata whai ora spending time outdoors. However, sufficient staff are also needed to ensure tāngata whai ora can spend time outdoors daily, including by escorting them outdoors.

In response to my 2021 report, the DHB stated that the Ward would be provided with additional staff to ensure it was safely staffed and to support patient activities. During my follow up inspection, Ward management confirmed that the Ward had received approval for 6.31 FTE (fulltime equivalent) roles.[20] However, at the time of my follow up inspection, staff had not yet started in these roles. In response to my provisional report, Te Whatu Ora advised they continue to actively recruit to current vacancies but that *'there are insufficient qualified and suitable staff to fill the vacant roles at this time.'*

During my 2021 inspection, I found that Ward staff were regularly re-deployed to other hospital wards, making it difficult for staff on the Ward to provide therapeutic activities for tāngata whai ora. Ward management said that since my 2021 inspection, there had been a significant reduction in Duty Managers re-deploying their staff to other wards. As part of the follow up inspection, Inspectors were provided with information showing that between 1 February 2022 and 31 July 2022, six Ward staff were re-deployed on a total of six occasions.

Despite this reduction in staff re-deployment, Ward management told Inspectors that staffing pressures as a result of the COVID-19 pandemic had seen the Ward's capacity reduced (see 'Facility facts' above), and resulted in '*what felt like the constant recruitment of staff*' due to staffing turnover. Staff also said that staffing pressures had meant they were sometimes unavailable to accompany tāngata whai ora on escorted leave.

Manatū Hauora responded to my provisional report stating they agree with my concerns, *'regarding sufficient staff levels within the unit to ensure the unit is safely staffed and to support patient activities. I [Director of Mental Health] understand some of these issues may be linked as a result of the COVID-19 pandemic, with the unit's capacity reduced. Staffing challenges have been brought to my attention through regular statutory reporting, and we continue to monitor this issue.'*

[20] These included 4.2 FTE RN [registered nurse] roles, 1.44 FTE EN [enrolled nurse] roles, and 0.67 FTE HCA [health care assistant] roles.

In addition to impacting on the ability of tāngata whai ora to access outdoor areas, Inspectors saw in the notes of one tangata whai ora that staffing levels had not permitted a *'patient watch',* and appeared to have contributed to a decision to use restraint.[21]

In response to my provisional report, Te Whatu Ora stated that '*This was an exceptional situation related to staffing levels and high acuity at the time of the incident. The decision taken was considered the best option at the time to ensure all patients on Ward 6C were safe at that time.*'

I acknowledge the need for staff to ensure the safety of all tāngata whai ora. However, I do not consider that the use of restraint is an acceptable alternative to adequate staffing levels on the Ward. I intend to monitor this matter.

I am pleased that approval has been granted to increase the number of staff on the Ward and the re-deployment of Ward staff to other wards has decreased. Unfortunately, these positive developments do not appear to have improved tāngata whai ora access to the outdoors. My previous two recommendations make clear my expectations about leave and the opportunity for tāngata whai ora to spend time outdoors. Staff are integral to the achievement of positive outcomes for tāngata whai ora, and I expect there to be sufficient staff to support the therapeutic needs of tāngata whai ora to spend time outdoors daily. **I recommend the Chief Executive of Te Whatu Ora Southern ensures the Ward has sufficient staff to enable tāngata whai ora to spend time outdoors daily.**

Additional observation from 2022 follow up inspection

In my 2021 inspection report I stated,

> *Inspectors were informed that 15 of the 36 staff members had not yet received the required Safe Practice Effective Communication (SPEC) training or refresher training. There was a plan in place that meant all staff would be up to date with their SPEC training by November 2021. Staff told Inspectors that if a staff member was required to assist in a physical restraint situation, that person would be expected to intervene, even if they were not up to date with their SPEC training. Having staff who are not fully trained intervening in restraint situations is not acceptable. I expect only staff with up to date SPEC training are involved in restraint practice.*

During the follow up inspection, Inspectors were provided with information showing that of 33 staff, only 10 were up-to-date with their SPEC training requirements.[22] Ward management told Inspectors that SPEC training was conducted every second month,[23] however they found it

[21] Notes stated that the tāngata whai ora was placed into a rotation chair with a table, as they were considered to be a high-fall risk and 'refusing' to stay in bed. The notes went on to state that there were not enough nurses to watch them *'due to other ward commitments'.*

[22] Of the remainder, 16 were out of date, six of whom had been 'booked in' for training. Five staff were listed as 'new staff' and hadn't been scheduled for training, and there was no information about a further two staff.

[23] The initial training was four days and the annual refresher training was one day.

difficult to balance staffing requirements on the Ward with attendance at training. Inspectors were told that the SPEC trainer intended to hold an interim session focused on the restraint training needs of the Ward. Ward management said that generally staff would only be *'hands on'* where personal care or an intramuscular injection were required, and to assist tāngata whai ora into the rotation chair with table-top.

In response to my provisional report, Te Whatu Ora advised me that Mental Health Service Older Persons management actively work to ensure all staff are SPEC trained and revalidated. Te Whatu Ora also provided me the schedule of SPEC training and revalidation sessions for 2023. On the basis of this schedule, I remain concerned at the length of time it will take for staff to complete their initial training or be revalidated.[24]

Manatū Hauora responded to my provisional report acknowledging the decrease in staff with up-to-date SPEC training at the time of my follow up inspection. They said they will, *'follow up on this concern with the DAMHS and expect to be updated on this in the DAMHS' quarterly report'*.

In my 2021 report, I made clear my expectation that only staff with up-to-date SPEC training are involved in restraint practice. I am concerned that since my inspection in 2021 there has been a decrease in the number of staff up-to-date with SPEC training. Therefore, **I recommend management of the Ward ensure that all relevant staff are up-to-date with SPEC training.** I also reiterate my expectation that only staff who are up-to-date with SPEC training are involved in the restraint of tāngata whai ora.

Acknowledgement

I appreciate the full co-operation extended by management and staff to the Inspectors during my inspection of the Ward. I acknowledge the work involved in collating the information requested. My thanks to the tāngata whai ora for their participation and assistance.

Peter Boshier

Chief Ombudsman
National Preventive Mechanism

[24] The majority of staff are scheduled to complete their initial training or overdue refresher training by September 2023, although three casual staff members were not yet scheduled to receive initial training.

Appendix 1. 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 …"*

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.