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OPCAT Report

Report on an unannounced inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital, under the Crimes of Torture Act 1989

June 2021

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report of an unannounced inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital, under the Crimes of Torture Act 1989

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Executive Summary

Background

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

Between 10 and 12 March 2020, Inspectors[1] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Te Whare Ahuru Acute Inpatient Unit (the Unit), which is located in the grounds of the Hutt Hospital campus, Lower Hutt.

Summary of findings

My findings are:

- Files contained all the necessary paperwork to detain and treat clients on the Unit.
- The use of seclusion had reduced since my last inspection (June 2016).
- The use of restraint had reduced since my last inspection (June 2016).
- Clinical notes were generally comprehensive.
- Clients' views on the Unit were generally positive.
- Multi-disciplinary Team meetings were well attended by Unit staff and clinical discussions were thorough.
- Clients were positive about the smoking cessation support provisions available.
- Access to visitors was good, including in the more restrictive areas of the Unit.
- Clients had good access to primary health care services.
- The Transition Liaison Nurse role was a positive initiative.

The issues that needed addressing are:

- Seclusion rooms, and other non-designated bedrooms, were being used as bedrooms when the Unit was over occupancy. This, in my opinion, has the potential to amount to degrading treatment and a breach of Article 16 of the United Nations Convention against

[1] When the term Inspectors is used, this refers to the inspection team comprising a Senior Inspector, an Inspector, Assistant Inspector and two specialist advisors.

Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention against Torture');[2]

- Clients in de-escalation had no privacy when using the telephone;
- The Te Rangi Marie area as a whole was not fit for purpose;
- Client access to the toilet in the Te Rangi Marie area could potentially be problematic;
- Inspectors learnt of an incident where a client, unable to access any toilet, subsequently passed a bowel motion in the corridor area of Te Rangi Marie. I consider this to be of concern and the resulting outcome for the client was unacceptable;
- There was a lack of information detailing the process for voluntary clients to enter and exit the Unit;
- Leave restrictions were in place for voluntary clients and at the time of inspection they were not free to leave at will;
- Over a third of staff were out of date with the Safe Practice Effective Communication (SPEC) training;
- Sensory modulation facilities were not well advertised on the Unit or accessible to clients;
- Welcome/information packs were not routinely provided to clients on admission;
- There was no information about the complaints process on display throughout the Unit. The role of the District Inspectors was not well advertised;
- Consent to treatment forms were not routinely completed;
- Clients were not invited to their Multi-Disciplinary Team (MDT) meetings and did not regularly receive feedback on the outcomes of these meetings;
- The building was not fit for purpose;
- The standard of cleanliness and facilities maintenance was inadequate;
- Clients' private health information was compromised as a result of poor Unit design and staff not always being mindful of the issue;
- Cultural support was lacking for Māori clients;
- Clients on the acute ward were not always able to use a telephone in private; and

[2] UN Convention against Torture, Article 16(1): "*Each State Party shall undertake to prevent any territory under its jurisdiction other acts of cruel, inhuman, or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the insitgation of or with the consent or acquiesence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment*."

- The Unit had employed external security staff to increase staffing numbers, despite these staff not having mental health specific training or an adequate job description.

Recommendations

I recommend that:

1. The issue of over occupancy is addressed as a matter of urgency. Seclusion rooms and other non-designated bedrooms are never used as bedrooms.
2. Clients in de-escalation are able to access a telephone in private. **This is an amended repeat recommendation.**
3. Clients have unimpeded access to toilets at all times.
4. The Unit ensure that voluntary clients are fully informed of their right to leave the Unit at will, including through information displayed on the Unit and provided in induction material. **This is an amended repeat recommendation.**
5. Leave restrictions are not placed on voluntary clients.
6. All relevant staff are up to date with their SPEC training.
7. The Sensory Modulation Room and its use is better advertised and more accessible to clients.
8. Client welcome/information packs are provided on admission.
9. Information on the complaints process is easily visible and accessible to all clients, including information on the role of the District Inspectors. **This is an amended repeat recommendation.**
10. Client consent to treatment forms are completed. **This is an amended repeat recommendation.**
11. Clients are invited to attend their Multi-Disciplinary Team meeting, wherever possible, and routinely informed of the outcome of their review. **This is an amended repeat recommendation.**
12. The building is upgraded as a matter of urgency. **This is an amended repeat recommendation.**
13. Cleanliness and facilities maintenance issues are attended to as a matter of priority.
14. Safeguards are implemented to ensure clients' privacy is protected.
15. Cultural support and provision is made available to clients on the Unit.
16. Clients are able to conduct telephone calls in private.
17. Senior management address concerns relating to staffing levels.
18. The Unit develops a policy and job description for security staff, which includes a detailed induction and training specific to mental health care.

Follow up inspections will be made at future dates to monitor implementation of my recommendations.

Feedback meeting

On completion of the inspection, my Inspectors met with representatives of the Unit's leadership team, to outline their initial observations.

Facility Facts

Te Whare Ahuru Acute Inpatient Unit

Te Whare Ahuru[3] Mental Health Inpatient Unit (the Unit) is a 24-bed acute adult inpatient unit, providing services for people experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital setting.[4]

The inpatient service is primarily provided for people who live in the Hutt Valley region. However, people can also be admitted from the Wairarapa and wider Wellington region.

The Unit is a locked facility and accommodates clients of all genders. The Unit consists of two distinct areas, referred to as the acute ward and Te Rangi Marie (which includes the de-escalation area).

Admission to the Unit is by referral from the Crisis Resolution Service or a Community Mental Health Team. Clients can be admitted to the Unit either as a voluntary patient[5] or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

Some voluntary service users were placed in the Unit, which was a secure locked facility with controlled points of entry. Voluntary service users could not unlock external doors, required staff assistance and accompaniment to leave and in some cases were not permitted to leave without permission. The expectation was that voluntary service users' informed consent formed the basis for their placement in the Unit. However, informed consent did not change the fact that there were considerable restrictions which meant they were not free to leave the Unit at will. I discuss these issues further on page 15.

Region

Hutt Valley, Wairarapa, and the wider Wellington region

District Health Board

Hutt Valley District Health Board

Operating capacity

24 (plus two seclusion rooms)

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[3] Te Whare Ahuru translates from Māori as "a sheltered haven".

[4] *Welcome to Te Whare Ahuru, Acute Inpatient Mental Health and Addiction Services. Information about Te Whare Ahuru for Clients/Tangata Whaiora and Family/Whānau.* Hutt Valley District Health Board.

[5] 'Voluntary' means that the service user has agreed to have treatment and has the right to suspend that treatment. If the service user is being treated in hospital, they have the right to leave at any time.

Last inspection

Unannounced inspection - June 2016

Unannounced inspection – May 2012

Announced informal visit – August 2008

The Inspection

Five Inspectors conducted the inspection of the Unit between 10 and 12 March 2020.

On the first day of the inspection, there were 25 clients in the Unit, comprising 16 females and nine males. Another six clients were on leave from the Unit. The average length of stay for the preceding six months was approximately 22.7 days. The average bed occupancy was 100 percent or over for all but one of the six months preceding the inspection.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Clinical Nurse Manager (CNM), before being shown around the Unit.

Inspectors requested the following information during and after the inspection:

- a list of clients and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data from 1 September 2019 to 29 February 2020, and the seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events;
- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);[6]
- client absent without leave (AWOL) events from 1 September 2019 to 29 February 2020;
- details of all sentinel events[7] from 1 September 2019 to 29 February 2020;
- complaints received from 1 September 2019 to 29 February 2020, a sample of responses and associated timeframes, and a copy of the complaints policy;
- copy of minutes of client group meetings for the previous three months;
- activities programme;
- information provided to clients and their whānau on admission;
- incident reports relating to medication errors from 1 September 2019 to 29 February 2020;
- staff sickness and retention data for the previous three years;

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

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

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

Inspection focus

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

Treatment

- Torture or cruel, inhuman or degrading treatment or punishment
- Seclusion
- Seclusion policies and events
- Restraint
- Locked door policy
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Clients' views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes

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

- Cultural and spiritual support

Communications

- Access to visitors
- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

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

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

Recommendations from previous report

The Inspectors also followed up on eight recommendations, following an inspection of the Unit in 2016,[10] which were:

a. The Intensive Care Unit (ICU) needs to be reconfigured/upgraded to fully support the needs of the clients in its care. The current lack of privacy for clients being managed in the ICU/seclusion area needs to be addressed with some urgency.

b. Clients in the ICU need to be able to access a telephone in private and contact details for the District Inspector should be easily accessible.

c. The locked door policy detailing the process for entry and exit into the Unit for informal (voluntary) clients (and visitors) should be displayed in prominent areas, including the Unit entrance.

d. The Unit should consider initiating community meetings for clients. Meeting minutes should be recorded.

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

[10] *Office of the Ombudsman report on an unannounced visit to Te Whare Ahuru Mental Health Inpatient Unit under the Crimes of Torture Act 1989*, June 2016.

e. Consent to treatment forms should be completed for all clients and filed in client files.

f. Clients should be invited to attend their MDT meetings. (**This was a repeat recommendation from 2012).**

g. Increasing the number of observable communal areas should be explored. This may involve reconfiguring the layout of the Unit.

h. The Unit should consider reviewing the weekly activities available to clients (this should be done in consultation with clients) and the recruitment of an occupational therapist should be prioritised.

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

Treatment

Torture or cruel, inhuman or degrading treatment or punishment

Over-occupancy

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

High occupancy levels were impacting on the Unit's ability to manage acutely unwell clients while continuing to maintain a therapeutic environment. The Unit was regularly operating over capacity and had done so for an extended period. The issue of over occupancy was described to my Inspectors by senior Unit staff as '*a never ending pressure'.* At the time of the inspection one client was sleeping in a lounge room that was inappropriate and unsafe for use as a bedroom. The lounge room door had no handle and could not be locked from the inside. The glass panel in the door had no curtain. A client told my Inspectors they felt unsafe and exposed in the lounge room as a result of it being unable to be locked.

Inspectors were told by Unit staff that clients were regularly accommodated in the Unit's telephone room when the Unit was operating over capacity. However, my Inspectors did not observe this occurring at the time of inspection. Clients' safety and privacy would be compromised in both rooms, as neither were designed for use as a bedroom.

I consider the accommodation of clients in rooms other than designated bedrooms has the potential to amount to degrading treatment and a breach of Article 16 of the Convention against Torture.

Seclusion

Seclusion facilities

The Unit had two dedicated seclusion[11] rooms located in a small de-escalation area within Te Rangi Marie. Both rooms had natural light, a means of raising the alarm, heating and ventilation. The rooms had a mattress on the floor and external window blinds for privacy. Both rooms were dirty, and floors and walls were discoloured following damage from a fire in 2016.

The seclusion rooms shared an en-suite bathroom which was able to be locked from either side. A small piece of cloth was taped to the seclusion room windows for privacy, however these could be lifted by anyone in the corridor, seriously compromising the privacy of clients in seclusion.

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

Clients were in seclusion each day of the inspection. One client was observed in seclusion on the first day of inspection. Inspectors observed their successful transition out of seclusion during the course of the day which resulted in the termination of the seclusion episode.

A third room in the de-escalation area was used as a bedroom. However, other than a plinth underneath the mattress, it was identical to the seclusion rooms.

Inspectors noted the de-escalation courtyard was dirty, covered in graffiti, and unwelcoming. Clients could only access the courtyard under staff supervision. Inspectors did not observe clients using the courtyard during the inspection.

In 2016, I recommended that clients in the ICU (now referred to as the de-escalation area), needed to be able to access a telephone in private. Clients in de-escalation were provided access to a landline phone located in the nurse's station. The phone was not portable, therefore clients had to make calls in the corridor in earshot of other clients and staff. This lack of privacy for clients is unsatisfactory and I am disappointed a more suitable arrangement has not been advanced from the time of my 2016 report.

My 2016 report identified the need for the de-escalation environment to be upgraded and for the lack of privacy for clients to be urgently addressed. Neither of these issues had been improved upon at the time of the inspection. While I am aware the DHB has secured funding for a significant refurbishment or rebuild of the Unit, construction may not commence for several years. Therefore, I consider it unacceptable that some of the Unit's most unwell clients continued to receive care in an environment that was not fit for purpose.

Figure 1: Seclusion room

Figure 2: Seclusion en-suite

Te Rangi Marie

Te Rangi Marie was located on a single corridor separated from the de-escalation area and the acute ward by two doors, both of which were locked during the inspection. Te Rangi Marie contained a treatment room, two bedrooms, a shower and toilet, a TV room, and a lounge. The lounge was in use as a bedroom throughout the inspection to accommodate a client as a result of the Unit running over capacity. As identified on page 12 of the report, this use was inappropriate and potentially unsafe.

The Te Rangi Marie area as a whole was not fit for purpose. I consider the environment was inappropriate for clients who required intensive mental health care. There was limited access to a toilet for clients, their privacy was compromised due to overcrowding and clients were unable to access fresh air independently of staff. These are not acceptable living conditions for clients.

Clients accommodated in Te Rangi Marie had no independent access to either the acute ward courtyard or the de-escalation courtyard when both sets of doors were locked, meaning they had no access to any outside areas. Inspectors were told the doors between Te Rangi Marie and the acute ward could be opened to provide two extra bedrooms on the acute ward. However, the doors remained locked throughout the inspection.

Client access to bathrooms in Te Rangi Marie

Client access to the toilet in Te Rangi Marie could also potentially be problematic. One of the bedrooms in Te Rangi Marie had direct access to the toilet through a connecting door, however this was the only toilet in the area and was used by all clients accommodated in Te Rangi Marie.

I was disturbed to learn of an incident where a client was unable to access the Te Rangi Marie toilet due to the door being locked, and subsequently passed a bowel motion in the corridor area. This incident occurred despite requests made by the client, to staff, for the door to the toilet to be unlocked. It was my understanding, on review of the clinical documentation, that staff would not unlock the toilet door as they were alone in the nurse's station. The client themselves described feeling '*humiliated*' as a result of the event.

Following the inspection, I was advised by the Unit that 'the toilet was in use by another client when the client concerned tried to access the toilet (i.e. it was not locked by staff)' and that the clients' urgency to use the toilet appeared to not be appreciated by those involved. The Unit also stated that clients have unimpeded access to toilets at all times and that they had taken the opportunity to remind all staff of this.

While I appreciate the additional information, the circumstances giving rise to this event are concerning to me and the resulting outcome for the client involved is unacceptable.

Seclusion policies and events

The Unit provided Inspectors with its *TWA Seclusion* Policy (issue date May 2004). The policy had a review date of July 2017 and was out-of-date at the time of inspection.

Inspectors reviewed the Unit's seclusion register. During the six month period between 1 September 2019 and 29 February 2020 there were a total of 25 seclusion events. The events included one client experiencing five seclusion events and another client three seclusion events.

Seclusion paperwork was generally completed to a good standard and in a timely manner. However, on review of the paperwork it appeared some seclusion episodes were longer than necessary. Seclusion documentation reviewed by my Inspectors clearly stated that, on

occasion, overcrowding, short staffing, and the inadequate de-escalation environment were a causative factor in the use of seclusion. I am concerned that over occupancy on the Unit, short staffing, and environmental constraints had resulted in clients experiencing a seclusion event that may otherwise have been avoided.

Data provided by the Unit, which aligned with the seclusion register, indicated that between 1 September 2019 and 29 February 2020 there were 25 seclusion events involving 21 clients. This is broken down as follows:

Table 1: Seclusion events 1 September 2019 – 29 February 2020[12]

Month	Events	Client numbers	Hours	Average hours
September	7	6	101.4	14.4
October[13]	3	2	208.6	81.0
November	4	4	541.7[14]	126.8
December	3	3	109.3	36.4
January	4	3	87.3	21.8
February	4	3	62.9	15.7
Total:	**25**	**21**	**1111.2**	**44.4**

The Unit was facing a number of challenges, most notably an environment that is not fit for purpose and issues relating to over occupancy. However, it is encouraging to note a reduction in seclusion hours of nearly one third when compared with the data from my report of 2016.

Restraint

The Unit provided Inspectors with its *Restraint Minimisation and Safe Practice* Policy (issue date February 2018). The policy had a review date of February 2021.

Data supplied by the Unit indicated that between 1 September 2019 and 29 February 2020 there were 17 restraint events involving 15 clients. This is broken down as follows:

[12] Data as provided by the Unit.

[13] One seclusion event starting 31 October and ending 2 November was counted in the October events total, however the total hours are allocated over both October and November.

[14] Total hours include one seclusion event totalling 321.7 hours.

Table 2: Restraint data (exclusive of seclusion data) 1 September 2019 - 29 February 2020[15]

	September	October	November	December	January	February
Total restraint episodes	3	3	4	3	2	2
Total clients restrained	2	3	4	3	2	2
Personal restraint[16]	3	3	4	3	2	2
Number of males restrained	0	1	2	0	1	0
Number of females restrained	2	2	2	3	1	2
Number of Māori restrained	0	1	1	1	1	1
Number of non-Māori restrained	2	2	3	2	1	1
Youngest person restrained (years)	30	25	37	36	23	37
Oldest person restrained (years)	40	35	69	56	64	41

Restraint data from my 2016 report showed there were 150 restraint events over a 12 month period, with an average of 12 restraint events per month. The Unit had achieved a substantial reduction in the use of restraint in the period between the two inspections. I applaud the significant change in practice that would have been required to achieve this reduction.

[15] Data as provided by the Unit.

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

I am pleased to note that no clients in the preceding six months were subject to physical restraint.[17]

Locked Door Policy and environmental restraint of voluntary clients

Inspectors were provided with a copy of the DHB's *TWA Locked Door Policy* (dated September 2010). The policy had a review date of September 2012 and was out-of-date at the time of inspection.

The locked door policy stated that clients who were admitted to the Unit either as a voluntary patient or under the MHA will '*be treated in the least restrictive manner'* and *'that the rights of access and egress are not compromised'.*

Staff and senior management consistently described the Unit as an open unit, however it was locked throughout the inspection. My Inspectors were told by a number of clients and staff that the doors to the Unit were locked at all times.

At the time of the inspection, there were four voluntary clients on the Unit. Voluntary clients are under no legal compulsion to remain on the Unit. Informed consent provides the lawful authority for a voluntary client to remain in the Unit and receive treatment. Consent may be revoked at any time by voluntary clients and they should be able to enter and exit the Unit at will. Appropriate procedures must be in place to allow for this to occur. Such procedures are particularly important as voluntary clients are not protected by the other legal safeguards for clients under the MHA, such as oversight of the District Inspectors (DIs).[18]

However, there was no information available which detailed the process for entry to and exit from the Unit for voluntary clients or visitors. I made a recommendation relating to this matter in 2016 and I am disappointed that this had not been remedied.

The main entrance doors to the Unit were operated by an administrator during business hours Monday to Friday. The entrance to the acute ward was though a locked door. In order to leave the acute ward staff operated the door unlock system from within the nurse's station, from where the door was visible. Inspectors observed clients and visitors waiting for staff to be available to unlock the ward door. Inspectors noted that signage explaining the system of exit from and entry to the ward was absent. At one point during the inspection the locking system failed and entry to and exit from the acute ward took place through a side room.

On review of client files there was also evidence that voluntary clients had leave restrictions placed on them, including file entries from staff stating '*no leave for first 48 hours'.* Voluntary clients were therefore effectively subjected to the same restrictions as people subject to an

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

[18] District Inspectors are lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act).

order under the MHA. Given these circumstances, I consider that, at the time of inspection, voluntary clients were not free to leave at will.

I acknowledge that the Unit requires a process to identify and manage absences from the Unit, for example by requesting that voluntary clients notify staff before they leave the Unit. However, in my view, voluntary clients have a fundamentally different legal status to people detained under an order and should not be treated the same. Leave restrictions, in particular, are fundamentally incompatible with voluntary status.

Restraint training for staff

Information provided by the Unit showed that 12 out of 31 staff were out-of-date with their Safe Practice Effective Communication (SPEC) training, which provides strategies to reduce the use of restraint.[19] A member of the Unit leadership team said the high number of staff who were out-of-date with their training was mainly due to rostered training being cancelled as a result of staffing shortages on the Unit.

I am concerned by the number of staff who were out of date with the SPEC training. SPEC training is a key component in reducing the use of restraint. Support from the Unit leadership team will be required to ensure staff are released to attend SPEC training and remain up to date.

Electro-convulsive therapy

There was one patient undergoing electro-convulsive therapy (ECT)[20] on the Unit at the time of the inspection. The client was voluntary and there was evidence of client consent on the clinical file and whānau involvement in the treatment plan discussion.

Sensory modulation

The Unit had one Sensory Modulation Room[21] located in the acute ward. The room was well equipped, clean, and tidy.

The room was locked, and its purpose and process to access was not well advertised. There was no signage informing clients of its location or how to access the room should they want to do so.

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[19] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques.

[20] Electroconvulsive therapy is used mainly in the treatment of severe depressive episodes. It involves the passage of an electric current across the head of a person to produce a convulsion. https://www.health.govt.nz/publication/electroconvulsive-therapy-ect

[21] A room in which sensory modulation is practised. 'Sensory modulation uses a range of tools to help individuals get the right amount of sensory input. In mental health settings, sensory modulation can be used to assist distressed persons to regain a sense of calm'. Te Pou o te Whakaaro Nui (2011). *Sensory modulation in inpatient mental health: A summary of the evidence*. Auckland. Te Pou o te Whakaaro Nui.

My Inspectors did not observe clients accessing the Sensory Modulation Room during the inspection.

Clients' views on treatment

Clients' views on their treatment on the Unit were generally positive. Clients described Unit staff as '*patient', 'helpful',* and *'empathetic'* and said they felt that they were treated with respect by staff. Clients spoke positively of the provision of smoking cessation support.

Clients who spoke with Inspectors had not received a welcome pack on admission to the Unit, which limited their understanding of Unit processes and complaints information. The welcome booklet provided to Inspectors by staff was dated and difficult to read. Inspectors were told that a new client welcome pack was in draft. I look forward to a new, user friendly welcome pack being provided as a matter of routine to all clients.

My report of 2016 identified that '*the Unit should consider initiating community meetings for clients. Meeting minutes should be recorded'.* A community meeting took place once a week on the Unit. However the meeting was dependent on the Occupational Therapist (OT) facilitating it and was not well advertised. Inspectors did not observe the community meeting occurring during the inspection and were unable to review the meeting minutes. I encourage the Unit to better promote and advertise community meetings to facilitate client involvement.

Recommendations – treatment

I recommend that:

1. The issue of over occupancy is addressed as a matter of urgency. Seclusion rooms and other non-designated bedrooms are never used as bedrooms.
2. Clients in de-escalation are able to access a telephone in private. **This is an amended repeat recommendation.**
3. Clients have unimpeded access to toilets at all times.
4. The Unit ensure that voluntary clients are fully informed of their right to leave the Unit at will, including through information displayed on the Unit and provided in induction material. **This is an amended repeat recommendation.**
5. Leave restrictions are not placed on voluntary clients.
6. All relevant staff are up to date with their SPEC training.
7. The Sensory Modulation Room and its use is better advertised and more accessible to clients.
8. Client welcome/information packs are provided on admission.

Te Whare Ahuru comments

The DHB accepted recommendations 2, 6, 7 and 8.

The DHB partially accepted recommendation 1, 4, 5.

The DHB rejected recommendation 3.

Recommendation 1 response:

The DHB provided an extensive response to the recommendation and highlighted the constraints faced by a lack of adequate community options and the high demand on high acuity secure resources. The DHB also noted that work was underway to address the issues of high occupancy. In particular, the DHB referenced the Acute Crisis Continuum Group which look at alternatives to admission and increasing the range of acute care options. Among other initiatives, the DHB also raised that the Mental Health Addictions and Disability Services are engaged with the Care Capacity Demand Management programme to help DHBs better match the capacity to care with patient demand, through use of tools such as the Over Census Policy and the Variance Indicator Score, which provided staff with a feedback and escalation framework to prioritise resources.

In their response, the DHB also provided copies of a December 2020 Briefing Paper on the Acute Care Continuum Project, a copy of the Over Census Policy and Variance Escalation Score Flip Chart.

The DHB stated that *'Whilst we do our utmost to avoid using seclusion rooms and other non-designated bedrooms, this will occasionally occur when the service experiences peak demands. However, at those times there is always strong focus from the team, including managers and the clinical lead to remedy the situation as soon as possible'.*

Ombudsman response:

I acknowledge and support the work currently underway to address the issue of over occupancy on the Unit and across the wider Service.

However, I remain concerned that over occupancy has not been addressed as a matter of priority. I reiterate that recommendations relate to the conditions and evidence my Inspectors found during the time of inspection. Inspectors' observations, and information provided by the Service, show that high occupancy levels were an ongoing issue at the time of inspection, adversely affecting the clients in the unit.

I emphasise my expectation that seclusion rooms and other non-designated bedrooms should never be used as bedrooms. It is my view that acutely unwell persons are entitled to a bedroom while inpatients, and that placement in non-designated bedrooms has the potential to be degrading.

Recommendation 3 response:

> *We note that the Ombudsman refers to an incident relating to a client not being able to access the Te Rangi Marie toilet, due to the door being locked by the staff, and the client subsequently passing a bowel motion in the corridor. We have been unable to identify further details of this alleged incident.*
>
> *There are two toilets in this area and they are unlocked for clients to access as* needed.

Ombudsman response:

Following the inspection, I received additional information regarding this incident. I also provided the Unit with the documentation showing that this incident did occur and that it was highly distressing for the client involved.

While I appreciate the additional information on the specifics of this incident, I remain of the view that the resulting outcome for the client involved to be completely unacceptable.

Recommendation 5 response:

> *MHAIDS notes that persons admitted informally to Te Whare Ahuru does so in the knowledge that they are consenting to engage in an assessment and treatment programme where they will be required to reside in the facility to receive this care. Leave arrangements are an agreed activity between the treating psychiatrist and the informal person. The fact that a client has met criteria to be admitted to an adult inpatient unit would indicate that there were serious concerns either about their own or someone else's health and safety. It is important therefore that should*

informal clients wish to leave that they discuss this with a member of staff, and we strongly encourage this.

*Since the Ombudsman's visit MHAIDS has developed a '**Planned leave from the adult inpatient unit**' protocol. (Attached: 4 MHAIDS Planned leave from the adult inpatient units). In relation to voluntary clients it states:*

*"**Voluntary persons**: People who are admitted on an informal/voluntary basis (including those persons subject to community provisions of the MHA but who are voluntarily admitted) cannot be detained against their will as inpatients. Nonetheless, consideration must be given to fitness for leave from the unit.*

There may be cases where the Responsible Clinician/admitting psychiatrist and the person agree that no leave from the ward is the most clinically appropriate action, in which case the person can be put on 'No Leave' status. This needs to be clearly documented by the treating psychiatrist at the time of admission. In these cases, if the person subsequently wants or demands to leave and that it is not felt clinically appropriate to approve that, the RC must meet with the person and may:

Adjust the treatment plan determining how leave will be permitted, if leave is seen as central to their inpatient treatment;

Discharge the person if their recovery and risk management does not require remaining on the inpatient unit;

Consider using the provisions of the Mental Health Act to manage the risk associated with the potential to leave the ward without permission. This may require use of section 111 of the Mental Health (CAT) Act."

In addition all clients now have leave stickers in their files that are updated at a minimum of once per week and sooner if the leave status changes within that time. These stickers can only be completed by the medical staff. This process is mandatory and ensures that leave considerations occur frequently for all clients.

Ombudsman response:

I reiterate my view that voluntary clients are under no legal compulsion to remain on the Unit. Informed consent provides the lawful authority for a voluntary client to remain in the Unit and receive treatment. Consent may be revoked at any time by voluntary clients and they should be able to enter and exit the Unit at will. Appropriate procedures must be in place to allow for this to occur. Such procedures are particularly important as voluntary clients are not protected by the other legal safeguards for clients under the MHA, such as oversight of the District Inspectors (DIs).

Protective measures

Complaints process

A copy of the DHB's *Consumer Feedback Policy* (dated February 2020) was provided to Inspectors. The policy had a review period of 36 months.

Up-to-date contact details for District Inspectors (DIs) were visible in both the acute ward and de-escalation area. However, further information was not adequately advertised or accessible. A number of clients who spoke with my Inspectors were uncertain of the role of, or how to obtain contact information for, the DIs. The welcome booklet contained DI information, however the contact details were out-of-date. Posters for the Health and Disability Commissioner's '*Code of Rights*' were displayed on the Unit.

The complaints process was not independent of staff. Clients were required to give completed complaint forms to Unit staff. Inspectors noted a lack of accessible complaint information on the Unit and clients told Inspectors they were uncertain of the complaints process.

The Unit received 24 complaints between 1 September 2019 and 29 February 2020, including one complaint made to the Health and Disability Commissioner. Written responses to complaints were individualised and courteous in tone. However, the majority of complaints were closed with the comment '*the client had been spoken to and the complaint can be closed'*. While I concur with the Policy statement that *'complaints be resolved at the lowest level possible'* the lack of a documented outcome impedes the opportunity for quality improvement. The Policy states that using analysis of complaint outcomes supports service delivery and drives continuous quality improvement. I encourage the Unit to document outcomes of complaints more regularly and robustly to allow for analysis and quality improvement as per the DHB Policy.

Records

Of the 25 clients on the Unit on the first day of inspection, 21 were detained under the MHA. The other four clients had voluntary status. All files had the necessary paperwork for clients to be detained and treated on the Unit.

There was no evidence of clients receiving copies of their MHA paperwork.

On review of client files my Inspectors located only one consent to treatment form for clients subject to a compulsory treatment order.[22] My 2016 report recommended '*that consent to treatment forms should be completed for all clients and filed in client files'*. I am disappointed that my previous recommendation relating to the issue of consent to treatment has not been actioned. Clients' Wellness Plans were often either blank or not completed.

[22] Despite a compulsory treatment order, section 59 of the MHA requires clinicians to make efforts to obtain clients' consent to treatment wherever possible. See *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health. 2008.

Inspectors attended a Multi-Disciplinary Team (MDT) meeting which was well attended with contributions from each of the disciplines present. Each client was discussed at length, with a focus on barriers to discharge followed by a specific and actionable plan.

Clients were not invited to their MDT meetings, contrary to my recommendation following the inspection in 2016. Inspectors also did not see any evidence that clients were routinely or proactively provided with feedback about the outcome of the MDT.

Effective, multi-disciplinary based care in mental health services should enable clients to determine their level of involvement in decision-making and ensure clients have a clear understanding of their care plan. On that basis it is my view that the default position be that clients are invited to their MDT.

Recommendations – protective measures

I recommend that:

9. Information on the complaints process is easily visible and accessible to all clients, including information on the role of the District Inspectors. **This is an amended repeat recommendation.**
10. Client consent to treatment forms are completed. **This is an amended repeat recommendation.**
11. Clients are invited to attend their Multi-Disciplinary Team meeting, wherever possible, and routinely informed of the outcome of their review. **This is an amended repeat recommendation.**

Te Whare Ahuru comments

The DHB accepted recommendations 9 and 10.

The DHB partially accepted recommendation 11.

Recommendation 11 response:

> *The Ombudsman reported his inspectors attended a Multi –Disciplinary meeting, which was well attended with contributions from each of the disciplines present. It was also reported that each client was discussed at length with a focus on barriers to discharge followed by a specific and actionable plan.*
>
> *MDTs provide a means for a large group of staff to discuss the possible plans for a significant number of clients in a timely manner.*
>
> *Prior to the MDT at least one member of the MDT will usually have met with the client (and possibly their family/whānau) to ascertain their concerns and expectations of the admission. This information will be brought to the MDT for consideration.*

Following the MDT meeting key unit and CMHT staff as appropriate will meet with the client and whānau, (where appropriate) to discuss what was proposed by the MDT.

It is not practical to involve clients, whānau and relevant community mental health clinicians in the MDT. However, we continue to seek ways to balance the MDT process to ensure it is efficient yet person-centred. One way we have achieved this is through our Complex Care Review meeting (CCR). The CCR is a dedicated discussion across multiple agencies involved in a person's care. The use of CCRs was introduced in 2015, and was traditionally held exclusively for the care teams. We have recently piloted dividing this meeting into two parts: the first allows services to clarify which role each of them will play in supporting the person. The second is attended by the person and their whānau. During this section of the meeting, we discuss with them their needs and the roles of the various services that will be involved to meet those needs. The feedback from these meetings has been universally positive.

Ombudsman response:

I consider clients should be invited to attend their MDT meetings, where appropriate, and that feedback of the outcome is provided and documented.

I am pleased to hear that following the MDT meeting key unit and CMHT staff will meet with the client and whānau to discuss what was proposed by the MDT. However, Inspectors did not see any evidence that clients were routinely or proactively provided with feedback about the outcome of the MDT at the time of inspection.

I am also pleased to see that the Complex Care Review meetings have sought to involve clients and their whānau.

My Inspectors' observations are that, where clients are invited to their MDT, this further facilitates the development of ongoing, individualised care and support for the clients. While not all clients may wish to attend, taking a case-by-case approach in inviting clients to attend their MDT supports clients to decide their level of involvement in their own care.

Material conditions

Accommodation and sanitary conditions

The Unit, which opened in 1995, was no longer fit for purpose. The standard of cleanliness was a significant issue and maintenance was not being attended to within acceptable timeframes. Carpet in communal areas was observed by Inspectors to be badly stained and in a state of disrepair. One client told Inspectors they had to open a window in the acute ward TV lounge due to the overwhelming smell of the soiled carpet. I note that the Unit received two written complaints from clients in the six months preceding my inspection concerning the poor standard of Unit cleanliness.

Of the 20 bedrooms, two had en-suite facilities. Inspectors observed graffiti on bedroom walls, which were in need of a repaint.

Clients could lock their bedrooms from inside. There was no mechanism for clients to lock their bedrooms when not in use, so clients required staff to lock and unlock their bedroom doors for them.

The acute ward comprised a separate 'male' and 'female' wing. Inspectors were told that the separation of genders could not be adhered to when Unit was over capacity.

Client privacy was an issue. Staff conversations in the nurse's station could be heard outside the office by clients and visitors. My inspectors overheard conversations about clients between staff, and within hearing of clients. Inspectors noted staff in the nurse's station often spoke loudly about clients and were easily heard in the client area. Inspector's observations were reinforced by clients' reporting they could hear staff speaking about clients in the nurse's station. It is my opinion that this issue was a result of poor Unit design that was not fit for purpose, but further compounded by staff not being as mindful as they could have been in managing this.

The acute ward courtyard was bleak and institution-like with little in the way to soften the environment aside from some pot plants and wooden furniture. The courtyard was covered in a mesh top, installed in 2019 reportedly to '*stop pigeons making a mess*' but which further added to the institution-like atmosphere.

Figure 3: Te Rangi Marie Bedroom.

Figure 4: Soiled carpet in communal lounge

My Inspectors were told by a number of staff, including members of the Unit's leadership team, that the process to have maintenance issues attended to in the Unit was slow. The poor level of maintenance and cleanliness in the Unit at the time of the inspection is unacceptable in a hospital environment.

One staff member commented to Inspectors that clients who had a number of admissions to the Unit did not usually comment negatively on the Unit's physical environment. However, the same staff member observed that clients admitted for the first time would often be critical of the poor physical condition of the Unit. This is of significant concern to me. Mental health

clients are entitled, and should expect, to receive health care in a clean and well-maintained hospital environment.

A lack of communal spaces and visiting areas was evident during the inspection and both clients and staff stated there were an inadequate number of communal and visiting spaces. This matter was addressed in my 2016 report and a recommendation was made to increase the number of observable communal areas.

Food

Clients were able to choose their own meals from the hospital menu. The menu catered to a range of dietary requirements and preferences. Breakfast was served at approximately 8am, lunch at 12pm, and dinner at 5pm.[23] Meals were delivered from the main hospital on a food trolley.

There was a dining area on the acute side of the Unit where clients could have their meals. While the kitchen on the acute ward was locked, there was a kitchenette for clients to access hot drinks during the day independently of staff. The kitchenette space was dirty and poorly maintained. The kitchenette could be locked off if there were imminent risk issues with access to boiling water, however remained open during the inspection.

Clients in de-escalation and Te Rangi Marie areas did not have access to a dining room or a kitchenette. Meals were eaten in bedrooms or the lounge area. Hot drinks were provided by staff on request.

Clients said the food was '*good*' and one stated it had '*improved a lot*' compared with meals from previous admissions to the Unit.

Recommendations – material conditions

I recommend that:

12. The building is upgraded as a matter of urgency. **This is an amended repeat recommendation.**
13. Cleanliness and facilities maintenance issues are attended to as a matter of priority.
14. Safeguards are implemented to ensure clients' privacy is protected.

Te Whare Ahuru comments

The DHB accepted recommendations 12, 13 and 14.

[23] *Welcome to Te Whare Ahuru, Acute Inpatient Mental Health and Addiction Services. Information about Te Whare Ahuru for Clients/Tangata Whaiora and Family/Whānau*. Hutt Valley District Health Board.

Activities and programmes

Outdoor exercise and leisure activities

Outdoor spaces were limited to a large courtyard in the acute ward and a smaller courtyard in the de-escalation area. As described earlier in my report, the courtyard in de-escalation was small, institution-like and unwelcoming.

The acute side courtyard was kept open until 10:00pm daily. The de-escalation courtyard was accessible to clients only when accompanied by a staff member. Inspectors did not observe clients using the courtyard in de-escalation.

There were no organised activities observed during the inspection. The activities programme was poorly advertised and generally clients struggled to articulate what activities were offered in the Unit.

There was one full time equivalent (FTE) Occupational Therapist (OT) employed on the Unit at the time of inspection. The OT role appeared under-resourced.

Figure 5: De-escalation courtyard

Figure 6: Book selection

Programmes

There was a notable lack of structure and activities for clients during the inspection. One client was able to describe in detail what the OT activities programme was. This included Buddies, K9 visits, music group, mindfulness walks, and high tea which occurred once a week. However, the majority of clients were unable to identify what activities were available to them on the Unit. Boredom was often cited as an issue by clients who spoke with Inspectors.

The Unit had a 0.5 FTE vacancy for a psychologist, however Inspectors were told this was a long-standing vacancy that the Unit had been unable to fill.

I recommended in my 2016 report '*that the Unit should consider reviewing the weekly activities available to clients and the recruitment of an occupational therapist should be prioritised'.* I

was pleased to note the Unit employs one full-time OT, and a number of activities were available to clients. However, clients knowledge of and participation in the Unit's activities programme was limited.

Cultural and spiritual support

The Unit did not employ a cultural advisor. Inspectors were told that a proposal had been put forward to the Mental Health, Addictions and Intellectual Disability Service (MHAIDS) to allow the development of a cultural advisor role for the Unit. Inspectors were told the Māori health team could visit the Unit from the main hospital and would visit by referral for new admissions and whānau issues.

A hospital Chaplain visited the Unit once a week, and visits could include the de-escalation area. The Chaplain Service provided a Christian church service on the Unit for 30 minutes for any clients wanting to participate. Clients were able to contact the Chaplaincy Service through the hospital switchboard.

There was no consumer advisor role for the Unit. However a consumer advisor positioned elsewhere in the DHB was a member of the Unit's *Zero Seclusion project*, and was observed on-site during the inspection.

Recommendations – activities and programmes

I recommend that:

15. Cultural support and provision is made available to clients on the Unit.

Te Whare Ahuru comments

The DHB accepted recommendation 15.

Communications

Access to visitors

Visits could take place on the Unit from 2.30pm to 8pm, however there was some flexibility with these times. Inspectors saw visits on the Unit occurring over the course of the inspection.

Clients told Inspectors that having visitors on the Unit was difficult due to the lack of suitable spaces. One client said that due to the lack of appropriate spaces for visiting, her visits had to take place in her bedroom. The Unit had a large whānau room for visiting. However this was located in the corridor between the reception area and the acute ward, which meant it was not easily accessible for clients and their visitors.

Access to external communication

Clients' access to a telephone was through the telephone room located in the acute ward. Inspectors were told this room was routinely used as a bedroom when the Unit was over capacity. When this happened the phone would be placed on the floor in the Unit corridor, resulting in no privacy for clients using the phone.

Inspectors observed clients using the nurse's station landline phone which, on request, was passed through a gap in the office window. This process afforded no privacy to the client as calls were made at the office window in full hearing of staff and other clients.

Clients in the acute ward were able to keep their cell phones in their possession. The phones were removed only if there was a clinical need to do so. In the de-escalation area clients were not permitted to hold their personal cell phones.

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

Recommendations – communications

I recommend that:

16. Clients are able to conduct telephone calls in private.

Te Whare Ahuru comments

The DHB accepted recommendation 16.

Health care

Primary health care services

Clients' physical health care needs appeared to be well met. Evidence in clinical notes demonstrated comprehensive physical examinations being undertaken, including for newly admitted clients and clients who required more urgent physical assessment and treatment.

The Unit had access to after-hours medical cover. This cover ensured clients were able to receive assessment and treatment on the Unit if they experienced a deterioration in their physical health outside of business hours, in keeping with practices in the general medical wards.

Controlled drugs were stored securely and audited regularly.

The Unit employed a part-time pharmacist who maintained a presence on the Unit and attended the twice weekly MDT meetings. The pharmacist was responsible for medication reconciliation. Clients were not routinely provided with written information about the medication they were prescribed and this was confirmed by Unit staff. I consider it is beneficial

for clients to receive accessible written information about the medication they are prescribed and encourage the Unit to incorporate this practice

Recommendations – health care

I have no recommendation to make.

Staff

Staffing levels

Recruitment within the Unit was an issue. Vacancies at the time of inspection included four Full Time Equivalent (FTE) Registered Nurses, one FTE MHSW, one FTE OT, and a 0.5 FTE psychologist position.

Staff shortages were evident during the inspection. A number of staff were working double shifts. Senior Unit staff were taking a case load of clients as well as undertaking, or putting aside, their substantive roles to fill the gaps in the roster.

While I acknowledge the Unit staff for their commitment, I consider it is untenable for an acute mental health inpatient unit to rely so heavily on staff working overtime, or alongside their substantive roles.

It is important to reiterate that some seclusion events on the Unit were attributed, within the seclusion documentation, to staffing shortages.

Staff described not feeling heard by senior management regarding the continued pressure to admit over capacity and spoke of a lack of senior leadership and support.

Despite the issues with staffing levels Unit staff were described by visitors and external staff as friendly and welcoming, observations which were largely shared by clients who spoke with inspectors.

Transition Liaison Nurse

The role of the Transition Liaison Nurse was introduced on the Unit approximately five years ago. The role was tasked with ensuring clients on leave, and their support people, had a consistent point of contact in the Unit. The Transition Liaison Nurse attended the MDT and discharge planning meetings and provided follow up for clients for seven days post discharge from the Unit. The role included liaison with Community Mental Health Teams and General Practitioners to ensure a safe and seamless transition from the Unit. I was pleased to note that feedback for the role of the Transition Liaison Nurse was overwhelmingly positive.

Security staff

The Unit had employed external security staff, referred to as Environmental Security Officers (ESOs), to increase staffing ratios when the Unit was over occupancy, or depending on acuity

levels. However, the ESOs did not consistently receive Unit specific training such as SPEC, or have relevant mental health experience to provide support to staff and clients on the Unit. A senior staff member told Inspectors that the employment of security staff on the Unit was '*masking the unit's HR problems.*' There was some confusion among Unit staff regarding the boundaries of the role of the ESOs and what the job description entailed.

Inspectors were told that security staff were only present on the Unit to assist RNs and Health Care Assistants (HCAs) in general observations, and to provide a sense of security for staff and clients on the Unit. However, security staff were observed by Inspectors working closely with clients in de-escalation, in a role traditionally reserved for RNs and HCAs. Inspectors were told by a member of staff that security staff had administered medication under the delegation of a RN.

The acute mental health inpatient environment is a specialised area and I have significant concerns that security staff are working on the Unit without appropriate training or an adequate understanding of the nature of the environment in which they are working.

Recommendations – staff

I recommend that:

17. Senior management address concerns relating to staffing levels.
18. The Unit develops a policy and job description for security staff, which includes detailed induction and training specific to mental health care.

Te Whare Ahuru comments

The DHB partially accepted recommendation 17.

The DHB accepted recommendation 18.

Recommendation 17 response:

> *Hutt Valley DHB is implementing the Care Capacity Demand Management Programme and FTE calculations have been completed to determine the FTE establishment based on acuity data. This week we have been notified that approval has been given to recruit to the CCDM recommendations. We will begin our recruiting process immediately. Meanwhile we monitor the roster gaps and fill these with casual staff, in addition to closely monitoring the use of overtime to ensure the health and wellbeing of our staff is not impacted.*
>
> *While the inspectors reported vacancies at the time of their visit, including nursing vacancies (four at the time), there are currently only two vacancies. These are currently being recruited into, noting that recruitment has not generally proven difficult for the nursing positions. What is more challenging is filling the 1.7 FTE allied health vacancies (1.0 FTE Occupational Therapist (OT) and 0.7 FTE Psychology*

role). Allied Health positions are generally more difficult to recruit to. To mitigate the shortfall in OT provision the Clinical Nurse Manager is currently looking at seconding one of the unit's Mental Health Support Workers into an OT assistant role, and the Mental Health Support Worker role will be back filled. The service actively recruits to fill vacancies.

Although the inspectors comment specifically on staffing levels in Te Whare Ahuru, the overall workforce challenges in mental health is widely recognised in New Zealand a well as overseas. MHAIDS has implemented several strategies to attract more staff to the service. This includes the expansion of the New Entry to Specialist Practice (NESP) programme from an initial 10 places to the present 50 places per year. We also provide scholarships and encourage administrators and mental health support workers, with a special programme for Māori to join the nursing programme.

Ombudsman response:

I am pleased to hear that the Service has recently been given approval to recruit additional staff as per the Care Capacity Demand Management Programme recommendations. I also acknowledge the overall workforce challenges faced in mental health services in New Zealand and I look forward to seeing the outcomes of the several strategies mentioned above to attract more staff to the Service.

Acknowledgements

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

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Managers	Ward staff	Others
Operations Manager Quality Coordinator	Clinical Nurse Manager Associate Clinical Nurse Manager Clinical Nurse Specialist Registered Nurses Consultant Psychiatrist Occupational Therapist Health Care Assistants House Officer Security staff	Clients Family/whānau Chaplain Consumer Advisor

Appendix 2. Legislative framework

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – health and disability facilities

Section 16 of COTA defines a "place of detention" as:

> *"…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(d) a hospital*
>
> *(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003…"*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

The *New Zealand Gazette* of 6 June 2018 sets out in further detail the relevant places of detention:

> *"…in health and disability places of detention including within privately run aged care facilities; …"*

Carrying out the NPM's functions

Under section 27 of COTA, an NPM's functions, in respect of places of detention, 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.

Under sections 28-30 of COTA, NPMs 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 designated places they want to visit and the people they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

- require the production of any information, documents, papers or things that, in the Ombudsmen's opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
- at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman's NPM function, inspection powers, and read his reports online: ombudsman.parliament.nz/opcat.