Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 2
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4134
Kathleen.Smitheram@cdhb.health.nz;

13 June 2022

9(2)(a)
[redacted]

RE Official Information Act request CDHB 10882

I refer to your letter dated 18 May 2022 and received in our office on 25 May 2022 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. **Report on an unannounced inspection to the Assessment, Treatment and Rehabilitation (AT&R) Unit (Hillmorton Hospital) under the Crimes of Torture Act 1989 (October 2018) which the Chief Ombudsman sent Canterbury DHB in October 2018.**

Please refer to **Appendix 1** (attached) for the OPCAT Report. "Report on an unannounced inspection to the Assessment, Treatment and Rehabilitation (AT&R) Unit – Hillmorton Hospital, 30 October 2018".

2. **In addition, can you please send a copy of Canterbury DHB's response.**

The Canterbury DHB's response is imbedded in the report. Please refer to headings: "AT&R comments".

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

APPENDIX 1

Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced inspection to the Assessment, Treatment and Rehabilitation (AT&R) Unit (Hillmorton Hospital) Under the Crimes of Torture Act 1989

RELEASED UNDER THE OFFICIAL INFORMATION ACT

30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Contents

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Tables

Figures

RELEASED UNDER THE OFFICIAL INFORMATION ACT

RELEASED UNDER THE OFFICIAL INFORMATION ACT

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of patients in New Zealand secure hospitals.

From 23 to 27 July 2018, two Inspectors (to whom I have authorised to carry out visits on my behalf) visited the Assessment, Treatment and Rehabilitation (AT&R) Unit (the Unit) which is located in Hillmorton Hospital grounds.

Summary of findings

- There was no evidence that any patients had been subject to torture, or other cruel, inhuman degrading treatment or punishment.
- Staff were committed to providing quality care in what was often, difficult circumstances.
- The Unit had implemented initiatives to reduce seclusion and restraint events, and a positive approach to de-escalate was evident.
- Files contained the necessary paperwork to detain and treat the patients in the Unit.
- Multi-Disciplinary Team (MDT) meetings were holistic and well led.
- Patients had their own bedroom and access to showers daily.
- Cultural engagement with patients was active and visible.
- Patient's physical health was monitored throughout their admission.

Issues that need addressing were as follows:

- The location of the seclusion room and de-escalation area was problematic, and compromised seclusion practice.
- Seclusion data was inaccurate.
- The complaints process was not easily accessible in the Unit.
- Patient advocacy services were unavailable in the Unit.
- Patients were not routinely given a copy of their care plans.
- The Unit was no longer fit for purpose, and general maintenance was poor.
- The Unit was unable to provide gender specific accommodation areas.
- Patients were unable to freely access fresh air daily.
- Patients were unable to access programmes due to a number of key staff vacancies.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

- Access to the telephone was only available through staff facilitation.
- Staff were not sufficiently trained in working with high and complex needs.
- Not all staff had the necessary knowledge and skills to deal with the patient group.

I recommend that:

1. Seclusion practice, including access to the seclusion room, should be reviewed.
2. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.
3. The complaints process needs to be made available in all areas of the Unit.
4. Advocacy services needs to be made available to patients as a matter of urgency.
5. Patients should receive an up-to-date copy of their care plan in a format they can understand.
6. The building is upgraded as a matter of urgency.
7. Accommodation and facilities are provided for female patients that ensure their needs for privacy and safety are met.
8. Patients can freely access fresh air daily.
9. Opportunities for patients to participate in programmes are increased.
10. Patients should be able to freely access the telephone.
11. Staff training to increase knowledge and skills for working with patients with high and complex needs to be enhanced.

Suggestions for improvements

- Clean linen should be made available to consumers without the requirement to request it from staff.
- Carpeting in the hallway should be replaced, and minor maintenance issues addressed.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

What was working well

Patient/staff relationships were positive with respective interactions taking place.

The Unit took a proactive approach to reducing seclusion and restraint.

Cultural engagement with the Pukenga Atawahi was working well and showed a strong working relationship between the two services.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Discharge planning was well established.

Feedback meetings

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection to the Acting Charge Nurse Manager (CNM) and sought any corrections or clarifications. Prior to this meeting, the Manager OPCAT provided high-level feedback of Inspectors' initial findings for the four units inspected at Hillmorton Hospital to the General Manager (Mental Health Service), Director of Nursing and the Quality Manager.

Consultation

A draft copy of this report was forwarded to the Assessment, Treatment and Rehabilitation (AT&R) Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Facility Facts

Assessment, Treatment and Rehabilitation Unit (the Unit)

The Unit, located in the grounds of Hillmorton Hospital, provides comprehensive behavioural assessments and treatment for adults with an intellectual disability, and significant challenging behaviour.

Patients who are involved in the criminal justice system or remanded by the Courts under the Intellectual Disability (Compulsory Care and Rehabilitation (IDCC&R)) Act are admitted to the Unit via the Forensic Coordination Service (Intellectual Disability) (FCS (ID)).

Individuals can also be admitted under the Mental Health (Compulsory Assessment and Treatment) Act.

The Unit was divided into two areas:

- the main Unit; and
- the Annex.

The Annex, a sectioned off area of the Unit, was introduced to assist in managing an assaultive patient.

Region

South Island

District Health Board (DHB)

Canterbury

Operating capacity

10 (although capped at seven for safety reasons). The Unit was not accepting any new admissions at the time of the inspection due to the complexity and makeup of the patient group.

Acting Charge Nurse Manager

Keith Knight

Director Area Mental Health Services (DAMHS)

Dr Peri Renison

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Last inspection

Announced visit – July 2014

Announced inspection - May 2010

Unannounced visit - July 2008

RELEASED UNDER THE OFFICIAL INFORMATION ACT

The Inspection

The inspection of the Unit took place on 23 to 27 July 2018 and was conducted by a Senior Inspector and Inspector (the Team).

Inspection focus

The following areas were examined on this occasion to determine whether there had been any torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on patients.[1]

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

Seclusion/de-escalation

Sensory modulation

Restraint

Environmental restraint

Protective measures

Complaints process

Records

Material conditions

Accommodation

The Annex

Food

Activities

Outdoor exercise/leisure activities

Programmes/therapeutic activities

Cultural/spiritual support

RELEASED UNDER THE OFFICIAL INFORMATION ACT

[1] Our 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.

Communications

Access to visitors/external communications

Health care

Primary health care services

Staff

Staffing levels/staff retention

Visit methodology

At the commencement of the visit the Team met with the Acting Charge Nurse Manager, before being shown around the Unit. On the day of the inspection there were four patients in the Unit, all male.

The Acting Charge Nurse Manager provided the following information during the visit:

- a list of patients and the legislative reference under which they were being detained (at the time of the visit);
- information for patients on admission;
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in the use of restraint and reasons for those not up to date;
- locked door policy;
- the number of complaints for the previous six months and the complaints policy;
- copies of patients' care plans and any relevant reviews;
- programmes and activities available in the Unit;
- the visitor policy; and
- staff retention and sickness data for past 3 years.

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to a number of managers, staff and patients.[2] Family and whanau were also spoken with.

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

RELEASED UNDER THE OFFICIAL INFORMATION ACT

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

There was limited opportunity for Inspectors to interview all patients as a number had communication challenges.

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any patients had been subject to any torture, or other cruel, inhuman or degrading treatment or punishment.

Seclusion/de-escalation

Seclusion facilities

The seclusion facility, separate from the main unit, had one seclusion room with en-suite toilet and shower facilities and a small de-escalation area. Patients requiring a period in seclusion were moved (often while being restrained) through the administration/staff rest area, which was not appropriate.

Although basic, the seclusion room had natural light, heating and a means of raising the alarm. Fixed windows had blinds for privacy but Inspectors found no evidence to suggest patients in seclusion were able to access fresh air on a daily basis.

There was no clock to orientate patients to time however, a white board showed the day and date. The ceiling was low enough for some patients to access the fire alarm/sprinkler system. Staff mitigated the risk by removing the mattress, which could be used to aid climbing, which was not appropriate.

Staff reported that the en-suite toilet for the seclusion room was often locked, with a cardboard receptacle (for toileting) provided instead. Reasons given were to prevent patients from damaging the en-suite and flooding the seclusion room.

Inspectors observed a patient vomiting on the seclusion room floor due to the bathroom door being locked, and no paper receptacle available for their use. The patient had been complaining of a sore stomach prior to being placed in seclusion. The mattress and pillow had been removed from the room, reportedly due to the patient's history of property damage, and ability to reach the sprinkler system in the ceiling. They were given a 'stitch gown' which was being used as a cover for warmth. The patient was placed on 10 minute observations which was contra' to the DHB's '*Seclusion Policy*', which stated:

> *'Where any of the following conditions exist, constant observation with direct line of sight must be implemented. Where these conditions exist seclusion may only be used with extreme caution. This level of observation may not be negotiated with the consumer.*

RELEASED UNDER THE OFFICIAL INFORMATION ACT

….Where the consumer is in need of intensive assessment and/or observation, especially where there is a history suggestive of significant trauma, ingestion of unknown drugs or substances, physical illness or organic diagnosis.'

Toilet arrangements for patients in seclusion requires a balance between safety, dignity and the physical well-being of the person. Best practice is to have an en-suite toilet facility that can be used by patients.

At times, Te Whare Manaaki [3] seclusion facility has been used to seclude patients from the Unit due to their volatile behaviour, and poor seclusion facilities in the Unit.

Figure 1: AT&R seclusion room

Figure 2: AT&R de-escalation area

Seclusion incidents and policies

Inspectors were provided with a copy of the DHB's '*Seclusion policy'* (28 April 2017), and the '*Water access in seclusion room policy'* (8 March 18). Neither policy had a review date.

During and after the inspection, Inspectors were given a number of email and computer-generated seclusion reports. Despite a number of attempts to reconcile the data, Inspectors were unable to determine which data was accurate. Inspectors had no confidence in the way the service recorded and reported seclusion events.[4]

Using the seclusion data provided at the time of the inspection, there were 19[5] seclusion incidents involving four patients and a total seclusion time of just over 174 hours for the period 1 January to 30 June 2018. This can be broken down as follows:

RELEASED UNDER THE OFFICIAL INFORMATION ACT

[3] Te Whare Manaaki is a forensic mental health unit situated on the Hillmorton Hospital grounds.

[4] Seclusion data was out by hours and minutes. Some data had been duplicated.

[5] One patient accounted for 15 seclusion incidents (79 percent).

Table 1: Seclusion episodes 1 January - 30 June 2018

Month	Events	Patients numbers	Hours	Average hours per event
January	6	2	49.30	8.22
February	3	2	10.91	3.64
March	2	1	28.38	14.19
April	3	1	34.18	11.39
May	5	2	51.40	10.28
June	0	0	00.00	00.00
Total	**19**	**Actual = 4**	**173.69**	-

In my 2014 report, I reported the average monthly seclusion hours in the Unit as 168.78. Using current figures, the monthly average was 7.95 hours – a significant reduction. Staff reported that this was due to the introduction of the 'Annex'.

Sensory modulation

The Unit did not have a dedicated sensory modulation room[6] however, sensory modulation was used as part of a number of patients' daily routine. This approach was clearly outlined in the patients' weekly planners. Inspectors witnessed the use of sensory modulation with one particular patient on a number of occasions. The service did not monitor the use of sensory modulation, or track its use against seclusion and restraint events.

Restraint

A copy of the DHB's '*Restrain Minimisation and Safe Practice*' policy was provided (19 June 2018). The policy did not include a review date.

From 1 January to 30 June 2018 there were 88 incidents of restraint involving six patients; a decrease on that reported in my 2014 report - 298 incidents involving 12 patients. Staff attribute the reduction in incidents to the development of the Annex; a closed area of the main unit introduced to assist in managing a highly assaultive patient.

A breakdown of the use of restraints is set out below:

[6] Sensory modulation is one tool that works well and supports initiatives to reduce seclusion and restraint use.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Table 2: Restraint incidents 1 January to 30 June 2018[7]

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint	Seclusion
Patient 1	29	29	00	00	00
Patient 2	2	00	1	00	1
Patient 3	17	00	3	14	00
Patient 4	2	00	00	1	1
Patient 5	30	00	12	2	16
Patient 6	8	00	1	4	3
Total	**88**	**29**	**17**	**21**	**21**

Restraint training for staff

The Safe Practice Effective Communication (SPEC) training programme was launched in November 2016. It was designed with service users' input, and has service users as trainers and members of the programme's governing body. The new initiative aims to provide national consistency and best quality, evidence-based therapeutic interventions for effectively reducing restraint and seclusion[8].

Copies of training records indicated that five (out of 28) staff were out-of-date with their SPEC training however, all five staff were on work-related ACC.

Environmental restraint

The DHB's Restraint Minimisation and Safe Practice policy states:

> *'Where a service provider intentionally restricts a patient's/consumers normal access to their environment. For example, where a patient's/consumer's normal access to their environment is intentionally restricted by locking devices on doors.'*

The doors between the main unit and the Annex were locked during the day and unlocked again later in the evening. The Annex protocol stated that: '*the dividing doors will be locked on B and D shifts and unlocked on A shift'.* However, this was not captured as environmental restraint in the restraint data provided[9].

RELEASED UNDER THE OFFICIAL INFORMATION ACT

[7] Inspectors note that restraint data provided by the DHB is incomplete in that the number of seclusion events recorded is fewer than those provided for seclusion episodes in Table 1.

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

[9] The patient located in the Annex at the time of the inspection was unable to access the main unit throughout the day (16 hours and 20 minutes). The doors were unlocked between 10.50pm until 6.30am although the patient appeared to be unaware of it.

Recommendations – Treatment

I recommend that:

1. Seclusion practice, including access to the seclusion room should be reviewed.
2. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.

AT&R comments:

Accepted recommendation 1 and no response to recommendation 2.

1. *Accepted 1.*
2. *Two robust systems are in place. These are the South Island Safety1st for reporting an event and Healthlinks the clinical information system which records the hours of an event. Both are necessary for appropriate checking. Monitoring is undertaken by Informatics staff. Safety 1st and Healthlinks are not connected therefore human error can occur.*

Protective measures

Complaints process

Access to the complaints process, including access to a complaint form, was not readily available to patients in the Unit. However, contact details for the District Inspectors were available. Staff advised Inspectors that the complaint box was situated in the Charge Nurse Managers office since being pulled off the wall by a patient.

Health and Disability Rights posters were not displayed in the Unit. Again, staff reported this was due to patients destroying them.

There were two complaints for the reporting period 1 January 2018 to 30 June 2018. Inspectors reviewed the two complaints and subsequent responses. Whilst responses were within the required timeframes, the response content of one complaint did not fully address the content of the complaint.

An information kit (for consumers and family/whanau) was available to both patients and their whanau at reception. The information kit provided information on the Unit as well as patients' rights and available support services. A Unit admission booklet in easy read/pictorial format was also given to the patients.

There was no patient advocacy service in the Unit. The position had been vacant for 18 months.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Records

There were four patients in the Unit on the day of the visit and the Inspectors checked all of their files.

Three patients were being detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and one patient under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

All files contained the necessary paperwork to detain [and treat] the patients in the Unit.

All patients had Welfare Guardians and medical Enduring Power of Attorney.

Care plans and daily file note entries were evident. Care plans were thorough and tailored to the individual patient's needs. Three patients had very clear and informative behavioural management plans; although patients did not routinely receive a copy of their plan. Family/whanau, however, did receive a copy of the plan.

The O'Brien's Principles[10] were the adopted model for guiding care in the Unit.

There were weekly patient review meetings in the Unit, as well as three monthly MDT review meetings. Inspectors observed a three monthly clinical review and found it to be organised, well led and informative and included cultural representation. Patients did not attend their MDT review. The Unit also conducted weekly incident reviews.

Family/whanau were invited to attend the clinical review meetings, and were routinely contacted after any incidents.

All patients had access to Unit leave.

Recommendations – Protective measures

I recommend that:

3. The complaints process needs to be made available in all areas of the Unit.
4. Advocacy services needs to be made available to patients as a matter of urgency.
5. Patients should receive an up-to-date copy of their care plan in a format they can understand.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

[10] John O'Brien's Five Essential Service Accomplishments were aimed at focusing and guiding staff in their work. The accomplishments describe worthy consequences of supported activities. The five accomplishments are choice, competence, relationships, respect and community presence.

AT&R comments:

Accepted recommendations 3, 4 and 5.

3. *Safe alternatives are being investigated to address this recommendation.*
4. *Accepted 4.*
5. *Accepted 5.*

Material conditions

Accommodation

Main unit

Set in the grounds of Hillmorton Hospital, the Unit can accommodate 10 patients, although it seldom has more than six due to the high and complex needs of the individuals being cared for. Two beds were permanently blocked as a result of the Annex development (see Annex section below). At the time of the inspection it was reported to Inspectors that the Unit was closed to any new admission. The temporary suspension of admissions was a directive from the Ministry of Health.[11]

All patients had their own room with sufficient bathroom facilities within easy access to bedrooms. One room had en-suite facilities which could be used when a female patient was admitted. If there was more than one female, staff advised that this would be problematic as there was no ability to provider gender separation in the Unit. Bedroom doors are locked from the outside and alarms register in the office however, patients can unlock their rooms at night from the inside, if they wish.

Food

Meals were prepared in the main hospital and bought to the Unit in a trolley. Patients had a choice of meals from a daily menu. The quantity and quality of the food during the inspection was satisfactory.

Special dietary requirements were catered for and dieticians had been involved in the development of some patients' diets.

Breakfast took place from 7.30 to 8.00am, lunch at 12pm and the evening meal from 5pm. Times could change as the dining room was shared with PSAID unit.

Morning and afternoon tea was available, as was supper.

[11] MHAIDS-Forensic Coordination Service (Intellectual Disability) Quarterly Report to Ministry of Health. Reporting period (01 April 2018-30 June 2018).

RELEASED UNDER THE OFFICIAL INFORMATION ACT

There were no concerns with regards to the quality or quantity of meals.

Recommendations – Material conditions

I recommend that:

6. The building is upgraded as a matter of urgency.
7. Accommodation and facilities are provided for female patients that ensure their needs for privacy and safety are met.

AT&R comments:

Accepted recommendations 6 and 7.

Activities and programmes

Outdoor exercise/leisure activities

At times, the dynamics between the patients in the Unit could be volatile therefore, the majority of patients were unable to mix with each other, which added another layer of complexity for staff trying to provide care and activities on a day-to-day basis. In some instances, interventions were based on containment and management rather than rehabilitation.

All patients had leave which allowed for individual planned outdoor activities such as: trips to the hospital café, walks, tennis, van rides, cricket or outings to McDonalds.

There were two outdoor exercise areas; an internal court yard and a grassed area leading from the Occupational Therapy (OT) lounge. Both external areas had secure fencing in place. The internal courtyard was in need of cleaning and maintenance.

Access to both the internal and external courtyards was conducted under the supervision of two staff. Inspectors had concerns that patients were not able to freely access fresh air on a daily basis.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

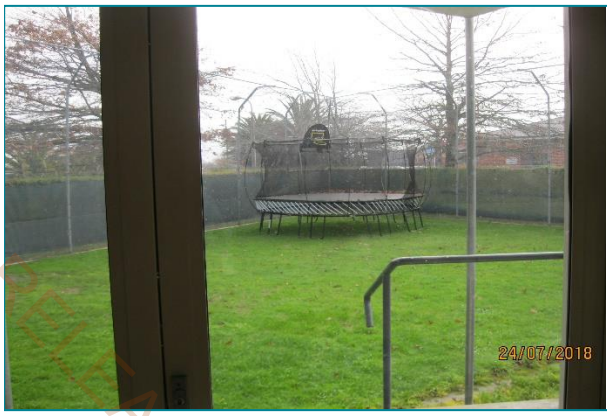

Figure 3: Outside area

Figure 4: Internal courtyard

Programmes/therapeutic activities

A fulltime OT provided a comprehensive weekly timetable of activities, Monday to Friday, such as: pet therapy, individual cooking sessions and sensory modulation. Most activities were 1:1 due to the complexity of the patient group.

Each patient had a sensory profile report and a comprehensive weekly plan which included sensory activities.

The Unit did not have a behavioural specialist or a psychologist, although recruitment was underway for both positions.

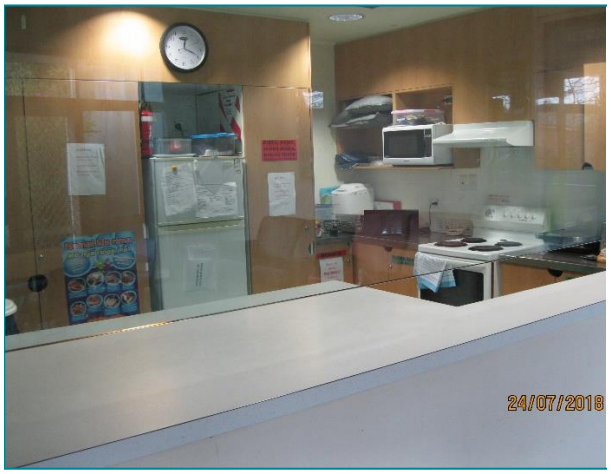

Figure 5: OT kitchen

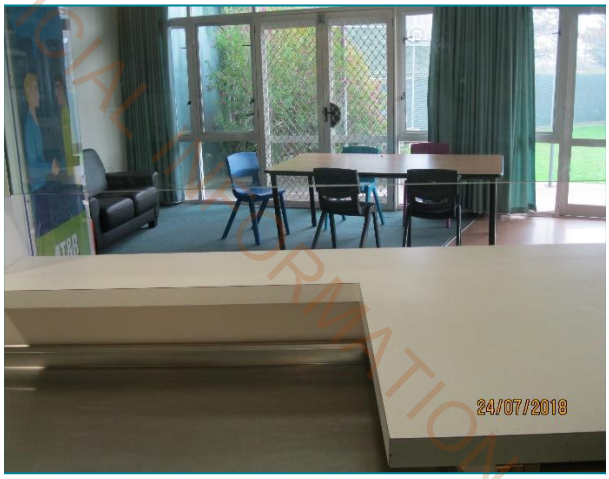

Figure 6: OT lounge

Cultural/spiritual support

The specialist Māori mental health service - Te Korowi Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health services for Māori. Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori patients. Their role was specific to providing cultural assessments that sat alongside the clinical assessment

RELEASED UNDER THE OFFICIAL INFORMATION ACT

and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work. Māori Hauora plans were discussed with the patient and their whānau if appropriate.

Pukenga Atawhai attended the Unit to work with patients that identified as Māori. The Unit advised the Pukenga Atawhai when a person identifying as Maori either had been admitted to the Unit or when an existing Maori patient was placed in seclusion.

Pukenga Atawhai were in attendance at a three month clinical review meeting that Inspectors attended. Pukenga Atawhai reported that they felt their cultural input was valued and staff afforded them the professional respect and responsiveness to their cultural interventions with patients.

A limited chaplaincy service was available for patients in the Unit, although finding suitable accommodation to speak in private was often a challenge. Inspectors noted the chaplain in the Unit during the course of the inspection.

Recommendations – Activities and programmes

I recommend that:

8. Patients can freely access fresh air daily.
9. Opportunities for patients to participate in programmes are increased.

AT&R comments:

Accepted recommendations 8 and 9.

8. Accepted 8.

9. Individualised programmes are in place. An increase in staff is required to increase outings.

Communications

Access to visitors/external communication

Patients could receive visitors if they chose. Visiting hours were from 10.00am to 8.00pm Monday to Sunday and needed to be pre-arranged to ensure adequate resourcing to support the visit. There was some flexibility around visiting times depending on the visitors' personal circumstances. If visitors arrived without prior arrangements staff would complete a risk assessment of the Unit environment to see if it was safe for the visit to proceed.

Visits took place in the main lounge area offering limited privacy. All visitors were provided with a wrist alarm.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

The Annex had its own visitor's protocol. Visiting times were structured and time limited. Patient A's family were regular visitors to the Annex and were very receptive to the new environment.

Due to the nature of the Unit, children under 16 years were not permitted.

Although there was no phone located in the Unit, patients could access a cordless phone through staff. Inspectors were advised that calls were supervised by staff and were for approved numbers only. Cell phones are not permitted in the Unit.

One patient had access to web browsing on the Unit computer under staff supervision (the patient was not able to directly access the computer as it was behind Perspex). Staff would access web pages for a period of 30 minutes and then print the web pages for the patient. This was part of the patients' daily routine.

Patients in the Unit could send and receive mail. Restrictions on a patient's mail were placed on their file by the Care Manager.

The Inspectors had no concerns with patients' access to family and friends. The Unit took a pro-active approach to maintaining family/whanau contact.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Recommendation - Communications

I recommend that:

10. Patients should be able to freely access the telephone.

AT&R comments:

Accepted recommendation 10.

10. Access is facilitated.

Risk management may result in restriction for some consumers making phone calls. This is managed on a case by case basis.

Health care

Primary health care services

All patients were seen by the house surgeon on admission and could access a house surgeon as required via Unit staff.

A General Practitioner (GP) was employed to cover a number of Units at the hospital. They worked one day a week. Staff would make contact with the GP as needed. Patients could request to see the GP via staff in the Unit.

Records indicated that physical examinations were undertaken, and there was ongoing monitoring of patients physical health.

Inspectors had no concerns in relation to the provision of healthcare to patients.

Recommendations – health care

I have no recommendations to make.

Staff

Personnel

The Unit was operating on a six staff per shift regime during the day and two staff during the evenings. The team was made up of a range of disciplines, with staff from a variety of ethnic backgrounds. Roles included medical staff, nurses and mental health support workers and an occupational therapist.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

There were five nurses on ACC due to serious work related injuries. Strategies have been put in place to maintain staffing levels for the Unit through using pool staff and a short-term staff secondment to assist in continuity of care. Staffing shortages, sickness and work related ACC was having an impact on service delivery. Staff reported feeling overwhelmed at times and were often covering double shifts to ensure coverage for staff shortages. Two staff went on sick leave during the inspection following an assault by a patient.

The Unit had seven vacancies at the time of the inspection (four registered nurses, one enrolled nurse, one behavioural specialist and one psychologist). Active recruitment was taking place, however the position had been vacant for a considerable period of time.

At the time of inspection, the staff mix was 86 percent female to 14 percent male, and was making rostering difficult.

Staff retention was stabilising after a difficult period. In 2016/2017 staff retention figures were at 17 percent however, in 2017/2018 staff retention was tracking down at 10 percent. Staff reported to Inspectors that the team were more cohesive since the reduction in assaults. They also reported that the management team was really good on the Unit; they had an open door policy and a holistic approach to both patients and staff.

A number of staff, particularly new staff, commented on the lack of training provided to deal with patients with an intellectual disability and challenging behaviour. Staff reported that they did not have team planning days.

Recommendations – Staff

I recommend that:

11. Staff training to increase knowledge and skills for working with patients with learning disabilities and challenging behaviour needs to be enhanced.

AT&R comments:

11. Accepted recommendation 11.

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Acknowledgement

I appreciate the full co-operation extended by the Acting Charge Nurse Manager and staff to my Inspectors during their visit to the Unit. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Management and other service providers	AT & R Unit and other
General Manager	Patients
Quality Improvement Manager	Clinical Nurse Specialist
Pou Whirinaki	Registered Nurses
DAHMs	Enrolled Nurses
Director of Nursing	Health Care Assistants
Director of Allied Health	Housekeeper
People and Capability Advisor	Occupational Therapist
Clinical Director – Intellectually Disabled Persons Health Service	Psychiatrist
Nursing Director - Forensics and Intellectually Disabled Persons Health Service	Family/whānau
Clinical Director – Canterbury Regional Forensic Services	Pukenga Atawhai
Customer Services Coordinator– Complaints	Visiting General Practitioner
Chaplin	NZNO local delegate
Quality and Patient Safety Team	NZNO Regional Officer
Learning and Development	Communication with District Inspectors
Coordinating Consumer Advisor	
Coordinating Family Advisor	

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Appendix 2. Overview of OPCAT – Health and Disability places of detention

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. 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 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

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

(a) to examine the conditions of detention applying to detainees and the treatment of detainees; and

(b) to make any recommendations it considers appropriate to the person in charge of a place of detention:

  (i) for improving the conditions of detention applying to detainees;

  (ii) for improving the treatment of detainees;

  (iii) for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector's (COTA). This is to ensure that there is a clear distinction between the Ombudsmen's preventive monitoring function under OPCAT and the Ombudsmen's investigation function under the Ombudsmen.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

RELEASED UNDER THE OFFICIAL INFORMATION ACT

2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

RELEASED UNDER THE OFFICIAL INFORMATION ACT