Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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24 January 2019

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**RE Official information request CDHB 9996**

We refer to your email dated 7 December 2018 requesting the following information under the Official Information Act from Canterbury DHB regarding the report following the Ombudsman's unannounced visit to Hillmorton Hospital between 23 and 27 July 2018.

- **The Ombudsman's Office have advised me to request a copy of the Ombudsman's report from the Canterbury DHB. Can you provide for me please?**

Please find attached four reports:

- OPCAT Final Report - ATR Hillmorton 2018
- OPCAT Final Report - PSAID Hillmorton 2018
- OPCAT Final Report - Te Whare Hohou Roko Hillmorton 2018
- OCPAT Final Report - Te Whare Manaaki Hillmorton 2018

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

Melissa Macfarlane
**Acting Executive Director**
**Planning, Funding & Decision Support**

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

30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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# 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.

- 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.

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.

# 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

## Last inspection

Announced visit – July 2014

Announced inspection - May 2010

Unannounced visit - July 2008

# 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

[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.

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.*

*….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:

[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.

**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].

[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.

## 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.

[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).

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.


*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

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.

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.

### 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.

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.*

## 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

# 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 | |

# 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;

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.

Ombudsman

Fairness for all

OPCAT Report

# Report on an unannounced inspection to Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit (Hillmorton Hospital) Under the Crimes of Torture Act 1989

30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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# 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 consumers in New Zealand secure hospitals.

From 23 to 27 July 2018, two Inspectors and a Specialist Advisor (to whom I have given authority to carry out visits on my behalf) visited the Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit) (the Unit) which is located in Hillmorton Hospital grounds.

## Summary of findings

- There was no evidence that any consumers had been subject to torture, or other cruel, inhuman or degrading treatment or punishment.
- Positive feedback was received from family concerning the level of care provided to their family members.
- Staff and consumer relationships appeared respectful and positive.
- Leadership in the Unit was visible and staff feedback was positive in regards to the accessibility of senior staff.
- There was good attendance and representation at the Unit Multi-Disciplinary Team (MDT) meeting, and Clinical Review meetings.
- Consumers had their own bedroom and access to showers daily.
- Generally, consumers felt the food was good.
- Consumers could receive daily visits.

Issues that need addressing were as follows:

- The entrance door was regularly locked over the course of the inspection to prevent an informal consumer from leaving the Unit.
- An informal consumer was subjected to mechanical restraint when being transported to and from school.
- Seclusion and restraint data appeared inaccurate.
- Information on the complaints process was not readily available on the Unit.
- Informal consumers did not have consent to treatment documentation on their files.
- Advocacy services were unavailable to consumers and their family/whānau.

- The building was not fit for purpose and not able to adequately accommodate the mobility and physical issues faced by some consumers.
- Access to drinking water was problematic for some consumers.
- Consumers could not access fresh air daily.
- There were limited activities/programmes available in the Unit for consumers.
- Consumers did not have free access to the telephone.
- The referral process on admission to see the Pukenga Atawhai was not always followed.
- Staff retention was problematic.

## Recommendations

**I recommend that:**

1. The practice of detaining informal consumers by locking the Unit doors should cease.
2. The practice of using mechanical restraint for the transportation of consumers without the legal authority to do so, should cease.
3. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.
4. The DHB's complaints process should be visible in the Unit and more accessible for consumers, taking in to consideration the specific needs of the population group.
5. Informal consumers have consent to treatment documentation on file.
6. Advocacy services should be available to consumers and their family/whānau.
7. The building is upgraded as a matter of urgency.
8. Consumers need to be able to easily access drinking water.
9. Consumers can freely access fresh air daily.
10. Opportunities for consumers to participate in activities and programmes are improved.
11. Consumers should be able to freely access the telephone.
12. The referral process to the Pukenga Atawhai is maintained and followed.
13. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

## Suggestions for improvements

- Clean linen should be made available to consumers without the requirement to access it through staff request.

## PSAID comments

*The suggestion for improvement was not raised with staff during their unit visit.*

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

## What was working well

There were ongoing and close relationships with consumer's community providers.

Multi-disciplinary team (MDT) meetings were comprehensive and well attended. There were innovative approaches to providing integrated pathways of care that involved other service providers, particularly for people with multiple and complex needs.

## Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection and provided an early opportunity for the Charge Nurse Manager (CNM) to offer 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 Services), Director of Nursing and the Quality Manager.

## Consultation

A draft copy of this report was forwarded to the 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.

# Facility Facts

## Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit

The Unit is a 14-bed facility providing sub-acute and rehabilitation services to those consumers with a suspected and/or confirmed intellectual disability (ID) who experience mental illness. The Unit uses a MDT approach to provide a comprehensive psychiatric assessment, monitoring and treatment of diagnosed or suspected mental illness in a person (aged 18 years and above) with an ID.

Referrals to PSAID are usually via the outpatient service however, the Unit does accept transfers from other inpatient units within the District Health Board's Specialist Mental Health Service and after hours' admissions come via the Crisis Resolution Service. Length of stay varies significantly. Duration of stay can vary from a few days to a number of months depending on factors that have contributed to the admission. The age, and level of physical and intellectual disability of consumers can vary greatly. Many consumers admitted to PSAID have limited or no verbal communication.[1]

## Region

Canterbury

## District Health Board (DHB)

Canterbury

## Operating capacity

15 (14 operational)

## Last inspection

Announced visit – June 2009

Announced inspection – February 2014

[1] Information provided by Charge Nurse Manager.

# The Inspection

The inspection of PSAID (the Unit) took place on 23 to 27 July 2018 and was conducted by two Inspectors (the Team).

## Inspection methodology

At the commencement of the inspection the Inspectors met with the Charge Nurse Manager, before being shown around the Unit. During the inspection there were six consumers in the Unit, comprising three males and three females.

Inspectors were provided with the following information during the inspection:

- a list of consumers and the legislative reference under which they were being detained (at the time of the visit);
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in use of restraint and reasons for those not up-to-date;
- the number of complaints for the previous six months and the complaints policy;
- information for consumers on admission;
- visits policy; and
- activities programme.

## Inspection focus

The following areas were examined on this inspection to determine whether there had been any torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on consumers.[2]

### Treatment

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

Seclusion/de-escalation

Restraints

Electro-convulsive therapy (ECT)

[2] 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.

Consumers' views on treatment

Family/Whānau views on treatment

### Protective measures

Complaints process

Records

### Material conditions

Accommodation

Food

### Activities

Outdoor exercise/Leisure activities

Cultural/spiritual support

### Communications

Access to visitors

Access to the telephone

### Health care

Primary health care services

### Staff

Personnel

## Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of managers, staff and consumers. Inspectors also spoke with family and whānau.[3]

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

[3] A full list of persons spoken to over the course of the inspection can be found in Appendix 1.

# Treatment

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

There was no evidence that any consumers had been subject to anything that could be construed as torture, or other cruel, inhuman or degrading treatment or punishment.

## Seclusion

### Seclusion facilities

There was one seclusion room and one de-escalation room. Both rooms had en-suite facilities, privacy blinds, heating and ventilation, natural light and a means of raising the alarm. The clock in the seclusion room window was partly obscured meaning there was no adequate way for a consumer to remain oriented to time.

The de-escalation room (a decommissioned seclusion room) was used to accommodate consumers requiring a period of de-escalation rather than seclusion. The de-escalation lounge, which was clean and tidy, had soft furnishings and natural light, provided a low stimulus space for consumers to access. The entrance to the de-escalation area was difficult as it was through the staff corridor. There was no evidence to suggest that the seclusion room or de-escalation room were being used as consumer bedrooms.

During the inspection a consumer was observed by Inspectors in the de-escalation room following a period of unsettled behaviour. The consumer was accompanied in the area by a Health Care Assistant providing one to one care, thus ensuring the consumer was not left alone.

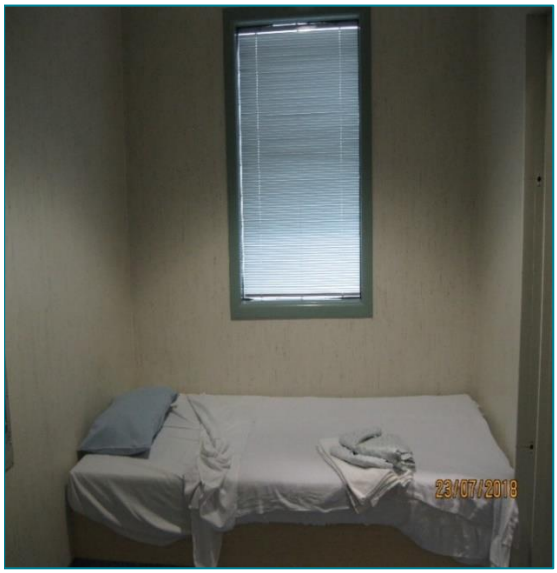


*Figure 1: Seclusion room*


*Figure 2: De-escalation area*

### Seclusion incidents and policies

A copy of the DHB's '*Seclusion*' policy was provided (April 2017). The policy did not include a review date.

Data provided by the DHB indicated that from 1 January to 20 June 2018 there had been 16 episodes of seclusion involving six consumers and a total seclusion time of 128 hours and 17 minutes. However, errors in reporting were noted by Inspectors, and attempts to clarify the data were unsuccessful.

The data indicates a significant reduction in the use of seclusion since a previous inspection in 2014. Comparable data for the six month period prior to the 2014 inspection showed 91 seclusion episodes involving 13 consumers and a total seclusion time of 278 hours.

There were no consumers in seclusion during the course of the five day inspection.

**Table 1: Seclusion episodes 1 January - 20 June 2018**

| Month | Events | Number of consumers | Duration (hours/minutes) | Average duration (hours/minutes) |
|---|---|---|---|---|
| January | 0 | 0 | 00.00 | 00.00 |
| February | 1 | 1 | 14.15 | 14:15 |
| March | 3 | 1 | 70.54 | 23:38 |
| April | 0 | 0 | 00.00 | 00.00 |
| May | 8 | 3 | 36:11 | 04:31 |
| June | 4 | 3 | 06:57 | 01:44 |
| Total | 16 | Actual = 6 | 128:17 | 08:01 |

## Restraints

An up-to-date copy of the DHB's '*Restraint Minimisation and Safe Practice'* policy was provided (June 2018). The policy did not include a review date.

From January to June 2018 there were 70 episodes of restraint involving 15 consumers.

Night safety orders were not in use in the Unit. Consumers were able to exit their rooms freely, and could lock their doors from the inside if they chose.

### Environmental restraint

PSAID is an open unit. Over the course of the inspection the entrance door was locked regularly to prevent an informal consumer from leaving the Unit.

The DHB's '*Restraint Minimisation and Safe Practice'* policy stated that:

'*Locking an internal or external door, whereby it restricts a consumer's normal access to their environment, is defined as environmental restraint and is a reportable event'.*

Staff on the Unit were aware of the practice of locking the entrance door to detain the informal consumer; the practice appeared to have become normalised.

The DHB's *Locking Doors in Open Units'* policy stated that:

*'Each single continuous episode of locked doors requires one Safety First Restraint Register form to be submitted for each consumer for whom environmental restraint has been deemed necessary'.*

A blanket restraint form was submitted at the beginning of each month to capture all episodes of environmental restraint. The form was inaccurate.

Inspectors also noted that the doors to the Unit were regularly locked during the course of the inspection to prevent formal consumers from exiting. Inspectors enquired as to why the doors were locked. On one occasion, staff reported the door was locked as a consumer (who had leave) was reluctant to have his depot medication.

### Mechanical restraint

Over the course of the inspection, Inspectors observed an informal consumer being restrained in a harness for daily transportation to school. The practice involved the key to the locked harness being given to the driver (out of reach of the consumer in the back seat). The arrangement had not been initiated by the Unit[4] however, he was under their care, and therefore, responsible for his treatment. Inspectors could find no documentation relating to the approval of the application of the harness.

The consumer was not subject to any form of legislation, however given the nature of his illness and intellectual functioning his ability to consent to this form of restraint was questionable. Inspectors were unable to find evidence of welfare guardianship or enduring power of attorney in place with respect to consent to treatment being made on behalf of the consumer. Inspectors were concerned by this practice and the serious health and safety implications for the consumer, particularly if an accident were to occur.

### Restraint training for staff

The Safe Practice Effective Communication (SPEC) training programme was launched in November 2016. It has been designed with service users' input, and has service users as

[4] This transportation arrangement had been set up by the consumer's school.

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.[5]

Six staff were not up-to-date with their SPEC training. However, four staff had been booked to attend training in the coming weeks, one staff member was seconded elsewhere and Inspectors were advised the remaining staff member had resigned.

## Electro-convulsive therapy (ECT)

No consumers were undergoing ECT at the time of inspection.

## Clients' views on treatment

Inspectors spoke with a number of consumers. General feedback was that consumers were bored and did not have enough to do in the Unit.

Consumers were not familiar with the complaints process and access to the District Inspectors was via staff. When wanting to contact the District Inspectors a consumer said they asked staff who would phone on their behalf.

Consumers did not have any complaints about the food and confirmed they chose their own meals from the daily menu.

A consumer advised when wanting towels or clean bedding they ask staff as the doors to the lined cupboard are locked.

## Family/whānau views on treatment

A family member spoken with by Inspectors described being, overall, impressed by the staff at PSAID and felt the family were generally kept included and informed in matters pertaining to their family member's care while in hospital. The family were invited to the three monthly clinical review meetings where in-depth discussion and treatment planning was undertaken, as observed by Inspectors.

## Recommendations – Treatment

**I recommend that:**

1. The practice of detaining Informal consumers by locking the Unit doors should cease.

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

2. The practice of using mechanical restraint for the transportation of consumers without the legal authority to do so, should cease.
3. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.

## PSAID comments

Accepted recommendation 1 and neither accepted or rejected recommendations 2 and 3.

Recommendation 2 response:

*The safety restraint is used in Special Education Services taxi only. It has been prescribed by a Special Education Services Occupational Therapist and agreed to by the consumer who uses is it for his safe transport to school. The Special Education Services have been asked to provide the legal authority for this.*

*The Ministry of Health Guidelines website https://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/equipment-and-modifications-disabled-people/vehicle-modifications-disabled-people provides the following: An occupational therapist can help you to find the best way to get around the community including driving a modified vehicle, being a passenger in a modified vehicle or other options.*

- *"If you're caring for a disabled child who lives with you their safety needs as a passenger will be assessed. This may include seating, safety restraints, ramps or hoists and safe ways of transporting wheel chairs".*

NPM further response:

I remain concerned at the significant safety issues for a patient restrained in the back seat of a van without the means to extricate themselves in the event of an accident.

I am uncertain a patient with a significant intellectual disability is able to agree to this form of restraint. At the time of inspection there was no evidence of welfare guardianship in place to support this decision making on behalf of the patient.

Recommendation 3 response:

*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

The complaints process was not readily available to consumers in the Unit. The complaints process, including complaint forms, was attached to the wall behind a table and chairs and partly obscured by curtains. Given the intellectual and physical challenges often faced by consumers within the Unit the current complaint process was not easily accessible.

There had been one complaint in the previous six months. The complaint received was not responded to within DHB timeframes[6] however, the response included an apology for the delay in reply. The consumer's complaint was individualised and addressed in detail. Inspectors had no concerns with the quality of the response.

Rights and advocacy information, including induction information, was kept in the staff office and was inaccessible to consumers and their family/whānau. There was no advocacy service available in the Unit; the position had been vacant for 18 months.

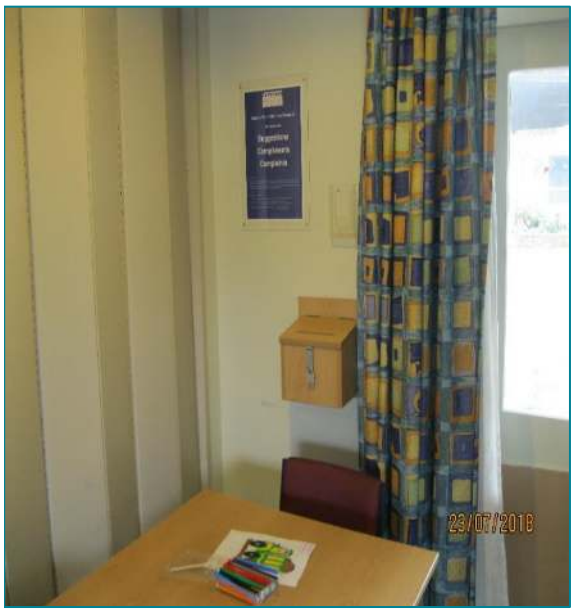


*Figure 3: Location of complaint box*


*Figure 4: Advocacy information (staff office)*

[6] The DHB Complaints Management Process states complaints will be investigated within 20 working days from the date of acknowledgement.

### Records

There were six consumers in the Unit over the inspection period (one consumer was on overnight leave during this period). Inspectors checked all of their files.

Five consumers were being detained and treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Two were informal, and therefore not required under legislation to remain on the Unit or accept treatment.

All files contained the necessary paperwork to detain and treat the consumers in the Unit who were under the Mental Health (Compulsory Assessment and Treatment) Act 1992. However, the two informal consumers did not have consent to treatment documentation on file.

### Recommendations – Protective measures

**I recommend that:**

4. The DHB's complaints process should be visible in the Unit and more accessible for consumers, taking in to consideration the specific needs of the population group.
5. Informal consumers have consent to treatment documentation on file.
6. Advocacy services should be available to consumers and their family/whānau.

### PSAID comments

Accepted recommendations 4, 5 and 6.

Recommendation 4 response:

*Forms are accessible now.*

## Material conditions

### Accommodation

The Unit, set in the grounds of the Hillmorton Hospital was generally clean and tidy however, no longer fit for purpose. Built in the 1970s, the Unit lacked space to de-escalate consumers and therefore incompatible with modern treatment practice.

The Unit was dated and tired and did not promote optimal opportunities for wellness due to its environmental constraints. Long, narrow corridors hindered good line of sight from the nurse's station, and staff felt that the physical environment was not conducive to recovery.

The Unit had lost a portion of its floor space to the neighbouring Assessment, Treatment and Rehabilitation (AT&R) Unit. This was to provide a separate annex area for a high and complex needs patient.[7] The reduction of floor space was felt by staff to have had a negative impact on an environment already restricted in space. There were inadequate areas for individual consumers to have space and time to themselves other than their bedrooms.

Although basic, bedrooms were clean and had sufficient storage space for personal items. Bedroom doors could be locked; alarms alerted staff when consumers exited their room during the night.

Although there were adequate bathroom facilities for the number of consumers, shower rooms were small and mechanical aids such as hoists difficult to manoeuvre.

There were several lounges and a shared dining room/kitchen with the AT&R Unit.

Consumers had access to laundry facilities on the Unit.


*Figure 5: Typical bedroom*

*Figure 6: Main lounge*

## Food

Consumers had a daily choice of meals which were transported from the main hospital kitchen. Food was of a satisfactory standard. It was apparent to the Inspectors that individual consumer's tastes and dietary requirements were considered and accommodated for with evidence of individualised meal plans, including preferences, within files. The dietician had

[7] AT&R Unit refer to consumers as patients.

been involved in the development of individual meal plans (Dietary Prescriptions) for consumers.

Inspectors noted the water fountain was not easily accessible for people with mobility issues and there were no cups available within easy reach.

Breakfast was scheduled for 8.00am, lunch at 12.00pm and dinner was served at 5.30pm.

### Recommendations – Material conditions

**I recommend that:**

7. The building is upgraded as a matter of urgency.
8. Consumers need to be able to easily access drinking water.

### PSAID comments

Accepted recommendation 7 and neither accepted or rejected recommendation 8.

Recommendation 7 response:

*Access to funding for significant building upgrades/rebuilds is governed by national capital processes. Canterbury DHB acknowledges that these buildings are substandard and intends to develop a facilities case for the Hillmorton campus within the next 12 months.*

Recommendation 8 response:

*There is access to cold water. Consumers are regularly offered hot drinks and are provided with hot drinks when they request one. Boiling water is not freely available due to the potential risk to consumers and staff.*

NPM further response:

A water fountain without cups was considered problematic by my Inspectors for those patients with mobility issues.

## Activities and programmes

### Outdoor exercise/leisure activities

The opportunity for outdoor exercise was limited due to the regular practice of locking the courtyard doors and entrance door. The internal courtyard was locked at the commencement of the inspection due to a reported rodent infestation, however it was unlocked on the second day of inspection and then locked again on subsequent days.

The courtyard itself was stark, poorly maintained, had limited furniture and limited shade for protection from the sun. Inspectors were of the view that the courtyard was not promoted or facilitated for consumer use and was therefore rarely used. However, consumers were able to walk around the hospital grounds as their leave status and staffing allowed.


*Figure 7: External garden*


*Figure 8: Internal courtyard*

Leisure activities appeared to be restricted to completing jigsaw puzzles and watching television in the communal lounge area. The extended absence of the Occupational Therapist (OT) appeared to be impacting on opportunities for consumers to access purposeful activities and programmes.

The occupational therapy room was large with a kitchen, laundry, computers and various materials available for creative activities.

A neighbouring unit had a gym that consumers were reportedly welcome to use however, it was not clear to Inspectors how often the gym was utilised by consumers from the Unit.

Despite not having an OT during the course of the inspection period it was pleasing to observe an interactive art programme taking place which was organised by nursing staff. Consumers appeared to be enjoying the opportunity to participate.

## Programmes

There were limited programmes available to consumers due to the vacant psychologist position; which had been vacant for over 12 months.

## Cultural/spiritual support

The specialist Māori mental health service: Te Korowai Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health service for Māori. Ngā Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori consumers. Their role was specific to providing cultural assessments that sat alongside the clinical assessment and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work.[8]

The Pukenga Atawhai is employed one and a half days a week within the Intellectually Disabled Persons Health Service (IDPH). Part of the role is to engage with people who identify as Māori who are admitted to the Unit. Inspectors reviewed a number of admission checklists and noted one consumer had not been referred by the Unit to the Pukenga Atawhai.

Inspectors were pleased to hear that the Pukenga Atawhai felt the role was respected and valued by clinical teams within the service.

There was a part-time chaplain (three days a week) available at Hillmorton Hospital. The chaplain did not have a set timetable for visiting the Unit. Staff report the chaplain would visit the Unit if requested. The contact information for the chaplain was kept in the staff office and inaccessible to consumers. Chaplaincy services were not well developed in the Unit.

[8] A holistic health model developed by Professor Mason Durie encapsulating a Māori view of health and wellness.

### Recommendations – Activities and programmes

**I recommend that:**

9. Consumers can freely and regularly access fresh air.
10. Opportunities for consumers to participate in activities and programmes are improved.
11. Referral process to the Pukenga Atawhai is adhered to.

### PSAID comments

Accepted recommendations 9, 10, and 11.

## Communications

### Access to visitors/external communication

Visiting times on the Unit were 10am to 8pm however, these times appeared to be flexible. There was no requirement to book visits in advance.

Inspectors were concerned that consumers were unable to access the phone independently of staff as the telephone was based in the staff office.

Consumers could send and receive mail daily.

### Recommendations - Communications

**I recommend that:**

12. All consumers should be able to freely access the telephone.

### PSAID comments

Accepted recommendation 12.

Recommendation 12 response:

*Consumers currently have access to a mobile phone. Options to have a phone accessible to all is challenging in the current environment due to the need for a private area.*

NPM further response:

The mobile phone is accessible through staff only. I support changes to the environment to facilitate improved independence and privacy for patients when using the telephone.

# Health care

The Consultant Psychiatrist had a comprehensive knowledge of the consumers' primary health care needs. MDT meetings were well attended and referrals for further investigations were actioned. A house surgeon saw new admissions for a physical examination and an on call house surgeon could review consumers for acute physical health issues.

A General Practitioner (GP) was employed one day per week providing cover to five units on the hospital campus including PSAID. Consumers could ask to be seen by the GP by notifying the Unit staff. The GP would see consumers predominantly for longer-term health issues and health promotion.

The hospital had a dentist onsite who reviewed consumers in the Unit. Any required treatment was carried out in the dental department.

## Recommendations – Health care

- I have no recommendations to make.

# Staff

## Personnel

A theme of the inspection was the positive feedback received from staff in relation to the leadership on the Unit, accessibility and approachability of senior staff, and the in-depth knowledge senior staff had of consumers in the Unit which in turn promoted continuity and consistency of care.

Sick leave within the Unit was high. In the 2017/2018 financial year, of the 22.67 full time equivalent (FTE) staff employed, there was 152.39 hours per FTE of sick leave equating to over 3.8 weeks per staff member. An increase in 1.5 weeks from the previous financial year.[9]

Staff turnover within the Unit was trending upward from 12 percent in the 2015/2016 financial year, 31 percent in 2016/2017 to 36 percent in the 2017/2018 financial year.

Inspectors were concerned the high level of sick leave taken by staff and the upward trend of staff turnover had the potential to negatively impact on consumer's care and treatment.

[9] The 2015/2016 financial year recorded 112.19 hours per FTE of sick leave per year or 2.8 weeks.

Unit staff advised they were, on occasion, re-deployed to other units within the hospital at short notice. This practice was observed by Inspectors during the visit when a supernumerary manager was required to take a consumer caseload to cover the staffing shortfall.

The Unit routinely accepted sleepovers[10] reportedly with little notice. Staff spoken with describe this as unsettling for both consumers and staff.

### Recommendations – Staff

**I recommend that:**

13. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

### PSAID comments

Accepted recommendation 13.

## Acknowledgement

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

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

[10] Sleepovers involve consumers having to move to other units to sleep; returning to their ward in the morning.

# Appendix 1. List of people who spoke with the inspectors

**Table 2: List of people who spoke with Inspectors**

| Senior Managers | Unit staff | Others |
|---|---|---|
| General Manager (MHS) | Consumers | Customer Services - Complaints |
| Quality Improvement Manager | Registered Nurses | Chaplain |
| Pou Whirinaki | Enrolled Nurses | Quality and Patient Safety Team |
| Director Area Mental Health Services | Health Care Assistants | Learning and Development |
| Director of Nursing | Housekeeper | Consumer Advisor |
| Director of Allied Health | Occupational Therapist | Family Advisor |
| People and Capability Advisor | Family/Whānau | NZNO local delegate |
| Clinical Director – Intellectually Disabled Health Persons Health Service | Psychiatrist | NZNO Regional Officer |
| Nursing Director - Forensic and IDPHS | Ngā Pukenga Atawhai | |
| Clinical Director – Canterbury Regional Forensic Service) | Union Representative | |
| | General Practitioner | |
| | District Inspector | |
| | Social worker | |
| | Care Managers | |

# 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:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
    a. for improving the conditions of detention applying to detainees;
    b. for improving the treatment of detainees;
    c. 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;

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.

Ombudsman

Fairness for all

OPCAT Report

# Report on an unannounced inspection to Te Whare Hohou Roko (Extended Care Secure Unit) (Hillmorton Hospital) Under the Crimes of Torture Act 1989

30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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# Executive Summary

## Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the general conditions and treatment of clients in New Zealand secure hospitals.

On the 25 and 26 July 2018, two Senior Inspectors and a Specialist Advisor (to whom I had given authority to carry out this visit on my behalf) visited Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit), which is located in Hillmorton Hospital grounds.

## Summary of findings

- There was no evidence that any clients had been subject to torture, or other cruel, inhuman or degrading treatment or punishment.
- Paperwork was up to date and well maintained.
- Files contained the necessary authorisations to detain and treat the clients in the Unit.
- Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns.
- Inspectors observed good client/staff relationships with respectful and meaningful interactions taking place.
- Clients had their own bedroom which they could lock, if they chose to and had access to clean bedding.
- Clients could access the external garden/courtyard throughout the day.
- The Unit was clean, tidy and reasonably well maintained.
- There was a selection of programmes/activities on offer to clients.
- Clients were invited to attend weekly resident's meetings to discuss Unit issues.
- Clients received a copy of their multi-disciplinary team (MDT) minutes.
- Clients were afforded privacy when using the telephone.
- Clients had ready access to refreshments.

The issues that need addressing were as follows:

- There was insufficient hot water for showers due to a faulty hot water system.
- There was no separation between male and female accommodation.

## Recommendations

**I recommend that:**

1. The hot water system in the Unit is repaired or replaced to ensure it operates efficiently.
2. Accommodation and facilities are provided for female clients that ensure their need for privacy and safety are met.

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

## What was working well

All recommendations from my 2016 inspection report had been implemented to a high standard.

The Unit worked collaboratively with clients and their family and whānau. The Unit utilised a whānau travel fund to support families travelling significant distances to visit clients; this assisted maintenance of important family connections.

The Responsible Clinician (psychiatrist) was based in the Unit which facilitated effective and timely communication with staff and clients. The Responsible Clinician also accompanied clients on ground leave. Inspectors supported the move from a primarily medicalised model to more person-centred and holistic approach to client care.

There was evidence of good working relationships with community organisations and the Probation Service.

The Unit employed interpreter services when required and provided English language courses.

The Unit was proactive in supporting healthy food options, whilst allowing clients the autonomy to make their own decisions.

All clients had some form of Unit leave.

There was evidence of ongoing cultural input and responsivity. Nga Pukenga Atawhai supported some clients through the admission process and throughout their recovery (which involved transitioning to less restrictive units).

A part-time General Practitioner (GP) was based in the Unit to address client's physical health needs.

## Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection and provided an early opportunity for the Acting Charge Nurse Manager (CNM) to offer 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 (Mental Health Services) to the General Manager, Director of Nursing and the Quality Manager.

## Consultation

A draft copy of this report was forwarded to Te Whare Hohou Roko (Extended Care Secure 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.

# Facility Facts

## Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit)

The Unit is one of three Regional Forensic Psychiatric Service Mental Health Inpatient Units on the Hillmorton Hospital grounds. The Unit assesses and treats people that have either acted violently in the context of mental disorder or who may be at risk of doing so. It also caters for prisoners that require inpatient treatment.

The Unit provides specialist ongoing treatment for clients who have a diagnosed severe and enduring mental illness. The Unit's Service Provision Framework provides for rehabilitation opportunities depending on clinical, legal and individual assessment for clients to develop skills that promote positive life change.

Te Whare Hohou Roko is a locked unit. The average length of stay is three to four years.

## District Health Board (DHB)

Canterbury

## Operating capacity

Nine

## Clinical Nurse Manager (CNM)

Kathryn Woodall

## Director Area Mental Health Services (DAMHS)

Dr Erik Monasterio

## Last inspections

Unannounced inspection – April 2016

Unannounced inspection – August 2012

Announced visit – May 2008

# The Inspection

The inspection of Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit) took place on 25 and 26 July 2018 and was conducted by two Senior Inspectors and a Specialist Advisor (the Team).

## Inspection methodology

At the commencement of the visit the Team met with the Acting Clinical Nurse Manager before being shown around the Unit. During the inspection, there were nine clients in the Unit comprising seven males and two females.

Inspectors were provided with the following information during the visit:

- a list of clients and the legislative authority under which they were being detained (at the time of the visit);
- details on the use of seclusion and restraint for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in the use of restraint and reasons why some staff training was not up to date;
- the number and a sample of complaints for the previous six months and the complaints policy;
- information for clients on admission;
- the activities programme; and
- staff retention and sickness for the past three years.

## Inspection focus

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

### Treatment

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

Seclusion

Restraints

Electro-convulsive therapy (ECT)

[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.

Clients' views on treatment

### Protective measures

Complaints process

Records

### Material conditions

Accommodation

Food

### Activities

Outdoor exercise

Leisure activities

### Communications

Access to visitors

Access to the telephone

### Health care

Primary health care services / medication

## Evidence

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

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

# Treatment

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

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

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

## Seclusion

### Seclusion facilities

The Unit did not have a seclusion facility. If a client required seclusion they would be moved to a seclusion room in Te Whare Manaaki (which was located in the building next to the Unit). There was no record of any client being placed in seclusion in the previous 12 months.

## Restraints

There were no reported incidents of restraint for the previous 12 months.

From the information provided, it appeared that the majority of staff in the Unit were up to date with their Safe Practice and Effective Communications (SPEC) training. Three staff had been unable to attend the training due to sickness, however they were scheduled to undertake training in September 2018.

## Electro-convulsive therapy (ECT)

There were no clients undergoing a course of ECT treatment in the Unit at the time of the inspection.

## Clients' views on treatment

Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns. Inspectors observed good client/staff relationships with respectful interactions taking place.

Clients reported that they were treated with respect and their privacy was maintained. Clients had their own bedroom, which they could lock if they chose to. Staff were observed knocking prior to entering bedrooms.

Clients could access the external garden/courtyard during the day. There were no complaints to Inspectors about the food, access to clean bedding, laundry facilities, the telephone or access to family or friends. Clients were positive about the programmes and leisure activities available to them, which included daily walks, art sessions, education and horticulture. Some clients attended the Alcohol and Other Drugs (AOD) and Emotions Programmes.

Unit community meetings were scheduled to occur twice a week. These meetings were minuted. Planned Unit activities as well as cooking rosters were discussed. Meetings covered a range of issues from new arrivals, food quality and activities, as well as discussion of current affairs.

Clients had access to both the Consumer Advisor and Family Advisor. The Unit was pro-active in maintaining and strengthening family and whānau contact.

### Recommendations – Treatment

I have no recommendations to make.

## Protective measures

### Complaints process

A copy of the DHB complaints process was provided to Inspectors. Details of the complaints process were readily available in the Unit and contact details for District Inspectors were displayed in an area easily accessible to clients. The Health and Disability Commission's advisory posters were visible throughout the Unit.

There were ten recorded complaints made by four clients in the Unit for the six months preceding the visit. A sample of these complaints were reviewed; they were dealt with in a timely and satisfactory manner.

### Records

There were nine clients in the Unit on the day of the visit. Inspectors reviewed all client's files.

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

Section 76 Mental Health Act reviews (Certificate of Clinical Review of Conditions of Patient Subject to Compulsory Treatment Order) were in date.

All files contained the necessary documentation authorising the detention [and treatment] of the clients in the Unit.

Client's family and whānau contacts and associated levels of disclosure were comprehensive and clearly documented on file and signed by both the client and staff.

The Inspectors attended multi-disciplinary team (MDT) meetings and case conferences and considered them to be comprehensive, well-attended and well-documented. An effective multi-disciplinary approach with client involvement was apparent.

### Recommendations – Protective measures

I have no recommendations to make.

# Material conditions

## Accommodation

Set in the grounds of Hillmorton Hospital, the Unit, both inside and out, was clean and tidy and had an open, spacious feel to it. However, aspects of the Unit's infrastructure such as heating and the hot water system were reportedly not operating at optimal level. Both staff and clients reported that the hot water system was not functioning effectively, resulting in a lack of available hot water for showers for clients.

There were nine bedrooms (all with en-suite facilities). Rooms were of a reasonable size with adequate storage and natural light. Bedrooms could be locked from the inside and had curtains for privacy. The Unit did not use Night Safety Orders.[3]

There was no separate accommodation area for female clients, which presented challenges for both clients and staff. Although female clients were in rooms in close proximity to one another, this provision did not adequately address issues around safety and privacy.

Clients had access to clean bedding on request and laundry facilities at their disposal.

*Figure 1: Typical bedroom*

*Figure 2: En-suite bathroom*

There were several quiet areas and three TV lounges which consisted of a general lounge and separate female and male lounges. All were well-maintained.

[3] Night Safety Orders - the practice of locking the service users' bedroom door overnight for security/safety reasons.

## Food

Meals were prepared in the main hospital and brought to the Unit in a trolley. Clients had a choice of meals from a daily menu. The quantity and quality of the food during the visit was satisfactory. Clients with whom we spoke did not raise concerns about the meals.

Breakfast took place from 8.00 to 8.30am, lunch at 12pm and the evening meal from 5pm. Supper was also provided. Clients had access to refreshments at all times. All meals were served in the dining area.

The Acting Charge Nurse Manager reported that the Unit hosts BBQ and take away evenings on a regular basis.

## Recommendations – Material conditions

I recommend that:

**I recommend that:**

1. The hot water system in the Unit is repaired or replaced to ensure it operates efficiently.
2. Accommodation and facilities are provided for female clients that ensure their need for privacy and safety are met.

**Te Whare Hohou Roko comments:**

*Accepted all recommendations.*

*1. Accepted. A business case for several repairs to the building, including the hot water system has been put forward for consideration. Water temperature is regularly checked and is within an acceptable range.*

*2. Accepted. The Forensic Service agrees that this is a significant shortcoming. All consumers have individual bedrooms with ensuites and are able to lock the bedroom door from the inside. There is a female only lounge. When female consumer numbers are sufficiently high a wing is designated female only*.

# Activities

## Outdoor exercise

Clients had open access throughout the day to a spacious, well-maintained garden with adequate seating and shade.

*Figure 3: Garden*

*Figure 4: Courtyard*

## Leisure activities/programmes

A full-time Occupational Therapist provided a wide range of programmes and leisure activities, either individually or in groups, to those clients well enough to access them, including community outings and an emotions group.

Clients could access education classes off the Unit.

Clients had access to a selection of gym equipment (in the Unit) and a large sports hall (shared across the Hillmorton site).

A well-presented sensory modulation / comfort facility was available and clients regularly accessed this area.

A moderate sized activities room also doubled as a drop in centre/meeting room where clients could meet and discuss issues with staff or meet with other clients and undertake art and craft activities.

A pool table was also available to clients in the Unit.

Inspectors had no concerns with clients' access to programmes and leisure activities.

## Recommendations – Activities

I have no recommendations to make.

# Communications

## Access to visitors/external communication

Clients could receive visitors if they choose. Visits took place in one of two private rooms leading off the main foyer. There was flexibility around visiting times depending on the visitors' personal circumstances. Visitor rooms were clean and tidy.

There was practical proactive support in place for families in terms of funding for facilitating travel to the Unit. The Unit's Social Worker ensured that family connections were maintained. Strong family collaboration in client care was encouraged and evident.

A telephone was available for clients in the Unit. A cordless phone was available, which would receive incoming calls only, so clients could have telephone conversations in private.

Clients had access to computers in the Unit; a policy had been developed to support client's computer use.

Inspectors had no concerns with clients' access to family and friends, and acknowledge the pro-active approach to maintaining family and whānau contact with the Unit.

## Recommendations – Communications

I have no recommendations to make.

# Health care

A GP worked one day a week in the Unit and was familiar with the client's physical health needs. There was evidence that clients received regular health reviews, and health promotion education. Inspectors had no concerns in relation to the provision of healthcare to clients.

## Recommendations—Health care

I have no recommendations to make.

## Acknowledgement

I appreciate the full co-operation extended by the Acting Charge Nurse Manager and staff to my Inspectors and Advisor during their visit to 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 1: List of people who spoke with Inspectors**

| Management and other service providers | Unit and other |
|---|---|
| Acting Charge Nurse Manager and Charge Nurse Manager | Clients |
| 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 | Family/whānau |
| Nursing Director - Forensics and Intellectually Disabled Persons Health Service | Psychiatrist |
| Clinical Director – Canterbury Regional Forensic Services | Pukenga Atawhai |
| Customer Services Coordinator– Complaints | NZ Nursing Organisation local delegate |
| Chaplin | NZ Nursing Organisation Regional Officer |
| Quality and Patient Safety Team | Visiting General Practitioner |
| Learning and Development | Email contact with District Inspectors |
| Coordinating Consumer Advisor | Coordinating Family Advisor |

# 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:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
    a. for improving the conditions of detention applying to detainees;
    b. for improving the treatment of detainees;
    c. 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:

3. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
4. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
5. interview any person, without witnesses, either personally or through an interpreter; and
6. choose the places they want to visit and the persons they want to interview.

Ombudsman

Fairness for all

OPCAT Report

# Report on an unannounced inspection to Te Whare Manaaki Unit (Hillmorton Hospital) Under the Crimes of Torture Act 1989

30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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# 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 Senior Inspectors and a Specialist Advisor (to whom I have given authority to carry out visits on my behalf) visited Te Whare Manaaki 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 or degrading treatment or punishment.
- All patients had the necessary legal documentation to be detained and treated in the Unit.
- Members of the multi-disciplinary team (MDT) appeared to work collaboratively and effectively.
- Interactions between staff and patients were respectful, constructive and appropriate.
- Accommodation was clean and tidy.
- There were adequate bathrooms and laundry facilities for the number of patients.
- There was a broad range of activities and programmes for both individuals and groups.
- Patients were able to communicate freely with family and friends, either during a visit or through the telephone/mail.

Issues that need addressing were as follows:

- The inappropriate placement of patients with an intellectual disability in the Unit.
- The complaints process and the contact details of District Inspectors was not readily available in the Unit.
- The lack of a designated area on the Unit for female patients.
- Not all patients could access fresh air daily.
- Patient's privacy was compromised when using the patient telephone.
- Not all staff were up-to-date with mandatory training.
- Staff retention was problematic.

## Recommendations

**I recommend that:**

1. Patients with an intellectual disability should be accommodated in facilities which meet their needs.
2. Details of the complaints process and the contact details of District Inspectors are displayed in the Unit.
3. Accommodation and facilities are provided for female patients that ensure their need for privacy and safety are met.
4. All patients are able to access the outdoor area for at least one hour per day.
5. Arrangements be made to ensure greater privacy for patients when using the telephone.
6. All staff complete the Unit's appropriate mandatory training and the required refresher sessions.
7. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

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

## Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection to the Charge Nurse Manager (CNM), Clinical Nurse Specialist, Nurse Consultant and Occupational Therapist (OT) 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 Services), Director of Nursing and the Quality Manager.

## Consultation

A draft copy of this report was forwarded to Te Whare Manaaki 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.

# Facility Facts

## Te Whare Manaaki (the Unit)

Built in 1991, Te Whare Manaaki is a 15-bed medium secure unit. It is part of the Canterbury Regional Forensic Psychiatric Service and is one of two secure forensic units on the Hillmorton Hospital grounds. The Unit receives referrals from the Courts, Prisons and other Forensic Services. Occasionally, patients are admitted from the community on the advice of the Forensic Community Team.

The Unit provides inpatient assessment and treatment in a secure environment for people experiencing acute episodes of mental illness.

## Region

Canterbury

## District Health Board (DHB)

Canterbury District Health Board

## Operating capacity

15 (plus three seclusion rooms)

## Last inspection

Announced visit – July 2014

Announced inspection – May 2010

# The Inspection

The inspection of Te Whare Manaaki Unit (the Unit) took place on 23 to 27 July 2018 and was conducted by two Senior Inspectors and a Specialist Advisor (the Team).

## Inspection methodology

At the commencement of the visit the Team met with the Charge Nurse Manager before being shown around the Unit. During the inspection, there were 14 patients in the Unit comprising 12 males and two females.

Inspectors were provided with the following information during the inspection:

- a list of patients and the legislative reference under which they were being detained (at the time of the visit);
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in use of restraint and reasons for those not up-to-date;
- the number and a sample of complaints for the previous six months and the complaints policy;
- information for patients on admission;
- the activities programme;
- visits policy;
- staff sickness and retention data;
- staff orientation information (in the Unit);
- workforce development framework – mandatory courses 2017/2018; and
- community (patient) meeting minutes for the past three months.

## Inspection focus

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

[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.

## Treatment

Torture, or cruel, inhuman or degrading treatment or punishment

Seclusion/de-escalation

Restraint

Restraint training for staff

Electro-convulsive therapy (ECT)

Sensory modulation

Clients and relatives' views on treatment

## Protective measures

Complaints process

Records

## Material conditions

Accommodation/sanitary conditions

Food

## Activities and programmes

Outdoor exercise/leisure activities

Programmes

Cultural/spiritual support

## Communications

Access to visitors/external communications

## Health care

Primary health care services

## Staff

Staffing levels/ staff retention

### Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to a number of managers, staff and 12 patients. Family and whānau were also spoken with.[2]

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

### Recommendations from previous report

Inspectors followed up on the sole recommendation made following a visit in 2014, namely:

*The seclusion rooms should not be used as long-term accommodation (bedrooms) for those difficult to manage, or difficult to place patients. The DHB, in conjunction with the Ministry needs to find alternative accommodation for the highly complex individual currently accommodated in seclusion.*

This recommendation will be addressed in the body of the report.

## Treatment

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

There was no evidence that any patients had been subject to torture, or other cruel, inhuman or degrading treatment or punishment. However, I have serious concerns about the location on the Unit of two patients with intellectual disability (ID).

Patient A was admitted in June 2004 and as at 27 July 2018 had spent 5,152 days at Hillmorton Hospital. Patient A is the patient referred to in the recommendation from my 2014 inspection report and is now located in the general area of the Unit rather than in seclusion. Patient A was observed by Inspectors to spend most of his day in his bedroom and nursed on a 1:1 basis when in the communal areas of the Unit. At times, his behaviour can be volatile; on one evening during the inspection he became disturbed and threw dining chairs around the room. The situation was de-escalated by staff, who escorted him back to his bedroom.

Inspectors who knew Patient A from previous inspections to the Unit were pleased to note the progress made in managing his integration in to the Unit. Various sensory modulation techniques are used by staff to ameliorate his unsettled behaviour and he is able to enjoy a weekly visit to the local swimming pool.

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

Patient B was admitted to the Unit on 11 July 2018 and at the time of the inspection was being nursed in the de-escalation/admissions area. He slept in the de-escalation lounge and had access to a shower in one of the seclusion rooms, none of which were occupied at the time of the inspection. Patient B was considered a '*…high risk of violence and sexual violence*. *He is a large gender safety risk and is a risk to those he believes are vulnerable'*.[3] Because of the risk to female staff, Patient B was nursed by male staff only. Staff visited him periodically during the day and he was observed via a CCTV monitor in the nurses' station. Patient B could contact staff through an intercom system.

Patient B spent most of the time alone in the de-escalation area watching television and DVDs. He informed Inspectors that staff were helpful to him and, despite being offered some activities, he preferred to watch television. He said that he had enjoyed a visit from the Ngā Pūkenga Atawhai, who had shared lunch with him.

Patient B informed Inspectors that he would like to move into the Unit; the MDT had implemented an incremental progression system by which he is introduced to the Unit gradually. During the inspection, he had begun to use the gym.

Whilst commending staff for their work in attempting to improve the lives of Patients A and B, Inspectors consider that the Unit is not a suitable facility for patients with an ID. Such patients often have complex needs, which require the attention of staff with the necessary experience and expertise to ensure that they are able to live as full a life as possible while in hospital.

Patients with an ID sometimes display unsettled and disruptive behaviour, which can have an adverse impact on the wellbeing of other patients. Staff informed Inspectors that this was often the case on the Unit.

The circumstances of Patient B highlight the demand on staff resources that are sometimes made by patients with ID, particularly if they are a potential risk to others and have to be nursed by same sex staff.

The CNM summed up the situation when he explained to Inspectors *'Manaaki is a forensic mental health unit and it is detrimental to ID patients and other patients because of the staff resource required for ID patients. It can cause tensions between patients because of the ID patients' behaviour'.*

In its 2007 Strategic Plan,[4] the South Island Regional Forensic Working Group identified as one of its High Level Principles: *'Consumers should be accommodated in facilities that match their*

[3] Safety First restraint notes, 22 July 2018.

[4] South Island Regional Forensic Working Group (2007). South Island Regional Forensic Strategic Plan and responses to the Ministry of Health's Future Directions document.

*need*'. Inspectors consider that this principle is not being met currently for those patients with an ID resident on the Unit.

Inspectors observed staff interacting with patients in an engaging, respectful and caring manner. Discussions about patients between MDT members were constructive and sought to identify positive treatment journeys and outcomes for patients. Inspectors were impressed by the compassionate attitudes of some staff towards the patients. For example, two staff who spoke with Inspectors explained that many patients who enter the Unit lack a sense of hope and that it was the responsibility of staff to assist them to regain hope in order to enter a journey of recovery.

Inspectors attended a MDT meeting in which staff discussed the clinical progress of patients' and reviewed and updated care plans. All members of the team were actively involved in the discussion. The patients' input to the MDT process involved a discussion with their case manager prior to the meeting to discuss the clinical review to be presented to the MDT. Whilst patients can request to attend the MDT, staff informed Inspectors that few do so.

Inspectors observed two effective shift handovers, which discussed patients' behaviour, risks and care.

## Seclusion

### Seclusion facilities

The Unit has three seclusion rooms located within the low-stimulus/admissions area. All rooms were clean, tidy and well maintained. Although basic, each room had en-suite toilet and shower facilities, natural light, access to drinking water and a small clock to enable patients to maintain orientation to time. Two of the rooms contained an intercom to enable patients to access staff. The CNM informed Inspectors that he is currently obtaining quotes for the installation of an intercom in the third room.

Since the last inspection in 2014, the environment directly outside the seclusion rooms had been enhanced. In particular, the Occupational Therapist (OT) facilitated a project, Whakapaipai,[5] which, following consultation with patients, resulted in new furnishings and artwork for the area. The OT has also created sensory kits for the area comprising items such as lavender, herbal tea, soft balls and laminated cards of soothing images. Inspectors commend the environmental improvements to this area.

[5] To decorate, adorn, tidy up, beautify, enhance. Māori Dictionary. Downloaded from http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=whakapapai

A de-escalation lounge, with en-suite toilet, leads from the low-stimulus area and can also be accessed through the main unit.

A small, vehicle access area doubles as an exercise yard for patients located in the seclusion rooms. While the surroundings are blank concrete walls, there is shelter and seating available.

*Figure 1: Seclusion room*

*Figure 2: De-escalation with art work*

### Seclusion incidents and policies

A copy of the DHB's *Seclusion Policy* (dated 28 April 2017) was provided to Inspectors. The policy did not include a review date.

Data provided by the DHB indicated that between 1 January 2018 and 30 June 2018 there were 74 episodes of seclusion involving 14 patients. The total seclusion time for this period was 918.94 hours. This is broken down as follows:

**Table 1: Seclusion episodes 1 January - 30 June 2018**

| Month | Events | Patient numbers | Hours | Average hours |
|---|---|---|---|---|
| January | 18 | 8 | 211.03 | 11.72 |
| February | 18 | 4 | 215.32 | 12.00 |
| March | 12 | 3 | 75.92 | 6.33 |
| April | 3 | 2 | 4.16 | 1.40 |
| May | 10 | 5 | 124.16 | 12.42 |
| June | 13 | 3 | 288.35 | 22.18 |
| Total | 74 | Actual = 14 | 918.94 | 12.42 |

The data indicates a significant reduction in the use of seclusion since the inspection in 2014. Comparable data for the period 1 January to 30 June 2014 shows 299 episodes of seclusion, totalling 4,153 hours. Inspectors commend this reduction in the use of seclusion.

Inspectors spoke to three patients who had previously been placed in seclusion, all of whom reported that their personal needs had been met.

No patients were in seclusion at the time of the inspection.

## Restraints

The DHB provided Inspectors with a copy of its *Restraint Minimisation and Safe Practice Policy* (dated 19 June 2018). The policy did not indicate a review date.

Data supplied by the DHB showed that for the period 1 January 2018 to 30 June 2018, there were 123 episodes of restraint involving 14 patients. Three patients accounted for 80 of these episodes (65 percent).

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

**Table 2: Restraint incidents 1 January - 30 June 2018[6]**

| Patients | Total restraint numbers | Locked doors | Full restraint | Partial restraint | Seclusion |
|---|---|---|---|---|---|
| Patient 1 | 7 | 00 | 00 | 2 | 5 |
| Patient 2 | 3 | 00 | 00 | 00 | 3 |
| Patient 3 | 9 | 00 | 1 | 00 | 8 |
| Patient 4 | 4 | 00 | 00 | 4 | 00 |
| Patient 5 | 29 | 1 | 11 | 9 | 8 |
| Patient 6 | 3 | 00 | 00 | 00 | 3 |
| Patient 7 | 33 | 00 | 3 | 11 | 19 |
| Patient 8 | 1 | 00 | 00 | 00 | 1 |
| Patient 9 | 1 | 00 | 00 | 00 | 1 |
| Patient 10 | 4 | 00 | 00 | 3 | 1 |
| Patient 11 | 6 | 00 | 00 | 2 | 4 |

[6] 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.

| Patients | Total restraint numbers | Locked doors | Full restraint | Partial restraint | Seclusion |
|---|---|---|---|---|---|
| Patient 12 | 2 | 00 | 00 | 00 | 2 |
| Patient 13 | 3 | 00 | 00 | 00 | 3 |
| Patient 14 | 18 | 00 | 00 | 5 | 13 |

This data indicates a significant reduction in the use of restraint since the inspection in 2014. Comparable data for the period 1 January to 30 June 2014 showed 333 restraint episodes involving 14 patients, although one patient accounted for 228 of the episodes during this period.

A note on the door to the low-stimulus/admissions area read '*if patient is NOT secluded……write: "Patient nursed in the admission area, unsecluded in S1/2/3" DO NOT WRITE nursed in open seclusion!'* The CNM explained to Inspectors that this instruction related to those instances when a patient is located in the de-escalation lounge/admissions area and the door to the main Unit remains open. However, were the patient to attempt to enter the Unit staff would attempt to persuade them not to. In such circumstances, if the patient is prevented from entering the Unit, by whatever means, Inspectors consider this environmental restraint and should be recorded as such.

## Restraint training for staff

All Unit staff were up-to-date with Safe Practice Effective Communication (SPEC) training, with the exception of five staff for whom the training was scheduled for August 2018.

## Electro-convulsive therapy (ECT)

There were no clients undergoing a course of ECT in the Unit at the time of the inspection.

## Sensory modulation

The CNM informed Inspectors that patients' had used the Unit's sensory modulation room infrequently as, in accordance with the DHB's protocol,[7] they were required to seek permission from staff to use it. Adopting a pragmatic approach, the CNM converted the room to a Comfort Room,[8] which enabled patients' to have open access to the facility. Inspectors observed the Comfort Room in frequent use by patients throughout the inspection period and one patient reported to Inspectors the '*huge benefit'* of having easy access to the room in order to 'calm down'. Inspectors endorse the approach adopted by the CNM, which has provided much benefit to patients.

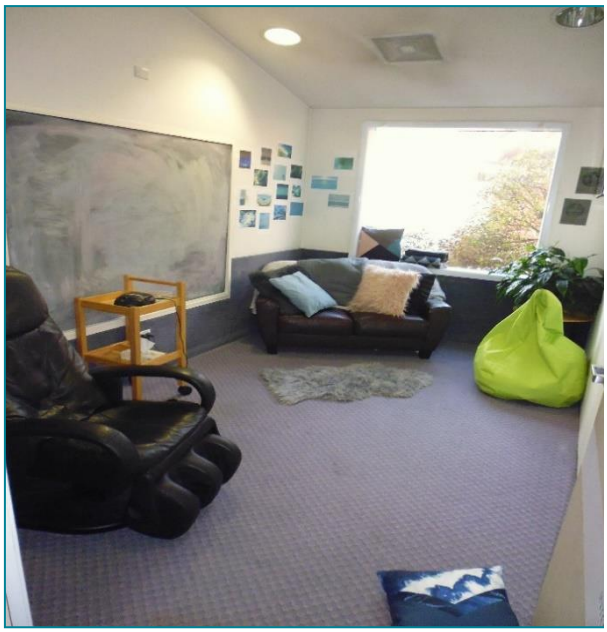

Figure 3: *Comfort room*

## Patients' views on treatment

Patients informed Inspectors that staff treated them with kindness and respect and were interested in their wellbeing. They felt that they could approach staff if they had any concerns. Inspectors observed respectful interactions between patients and staff.

Patients' reported that staff were open and approachable when they wanted to discuss their legal status, and information is provided to them in a way that was easy to understand.

Staff were described by patients' as showing regard for their privacy, and Inspectors observed staff knocking on patients' bedroom doors before entering.

Some patients commented that they would like more to do on the Unit and have easier access to the outdoor area.

Inspectors attended the weekly patients' community meeting, facilitated by the OT. Patients were observed to be actively involved and minutes from previous meetings indicate a broad range of topics discussed, including: menu planning; bedroom maintenance issues; choice of Sky channels to purchase; and, the establishment of new therapeutic groups and activities.

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7 Canterbury DHB. Sensory Modulation Protocol.

8 '*A therapeutic environment equipped with a range of furniture and sensory based resources that can be used with safety by the individual in an unsupervised manner'.* Canterbury DHB. Sensory Modulation Protocol.

### Recommendations – Treatment

**I recommend that:**

1. Patients with an intellectual disability should be accommodated in facilities which meet their needs.

### Te Whare Manaaki comments

Accepted recommendation 1.

Recommendation 1 response:

*The Forensic Service agrees with this recommendation. The inability to access the National Secure Intellectual Disability beds results in consumers with intellectual disability being admitted to the Forensic Service, which is unable to provide their rehabilitation needs.*

## Protective measures

### Complaints process

Information about the complaints process[9] is provided to patients in their admission pack and those patients to whom Inspectors spoke said that they knew how to make a complaint and felt supported by staff when assistance was sought. Inspectors spoke to a number of staff in relation to patient complaints and all were familiar with the process.

A copy of the complaints process was not displayed in the communal areas of the Unit. Inspectors consider that this would be a helpful addition to the general information on display for patients, particularly as some nurses informed Inspectors that the information given to patients on admission is often discarded.

Copies of the consumer response form '*Suggestions, Compliments and Complaints'* were located alongside the complaints box and easily accessible by patients.

There were four recorded complaints, one of which included a compliment, in the six months preceding the inspection. All complaints were responded to in a satisfactory and timely manner. One patient informed Inspectors that she had been happy with the response she received to her complaint and with the process in general.

Contact details for District Inspectors, while on display in the staff office, were not displayed in an area easily accessible for patients. While all patients to whom Inspectors spoke said that

[9] Canterbury District Health Board. Complaints Management Process: Patient and Whānau Information.

they had met with a District Inspector during their stay, Inspectors consider that it would be helpful for patients to have their contact details on display in the Unit.

Posters for the Health and Disability Commission's '*Code of Rights'* were displayed in the Unit and contact details for the Health and Disability Advocacy service was provided in the patients' admission pack.

## Records

There were 14 patients in the Unit during the inspection and the Inspectors checked all their files.

Nine patients were detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and five patients were detained 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 have a Case Manager and an Associate Case Manager who developed a treatment plan with the patient. All files contained a signed copy of the patient's treatment plan and a copy was given to the patient.

Copies of patients' weekly clinical reviews written for the MDT were also contained in the files.

## Recommendations – Protective measures

**I recommend that:**

2. Details of the complaints process and the contact details of District Inspectors are displayed in the Unit.

## Te Whare Manaaki comments

Accepted recommendation 2

Recommendation 2 response:

*Contact details of district inspectors are now displayed in the unit.*

NPM further response:

I am pleased that the contact details for District Inspectors are now displayed in the Unit. However, details of the DHB's complaints process should also be displayed in the Unit.

# Material conditions

## Accommodation/sanitary conditions

The Unit was clean and tidy but somewhat tired in appearance. Some parts of the Unit had recently been repainted.

A large, combined lounge and dining room provided comfortable furnishings, a good level of natural light and a television. The Unit also contained two smaller lounges, which provided quiet spaces for patients and each had a computer. Containing a selection of books and board games, one of the small lounges also functioned as a library.

Inspectors had concerns about the lack of specific facilities for female patients and little flexibility in the building for creating any sense of separation from male patients. The two female patients residing in the Unit at the time of the inspection occupied bedrooms in the same corridor as male patients and used one of the general purpose shower rooms, albeit the facility had been set aside for their sole use. One of the small lounges had also been designated a 'Women's only lounge' between 1.00pm and 4.00pm daily.

Staff had identified one of the female patients as being particularly vulnerable and at risk from some of the male patients. The lack of a designated female area in the Unit placed an additional burden on staff because, in order to ensure the patient's safety, her allocated nurse was required to maintain line of sight observation when she was out of her bedroom.

Inspectors consider that the lack of specific accommodation and facilities on the Unit for female patients leaves this group of women with limited privacy and creates a potential risk to their safety.

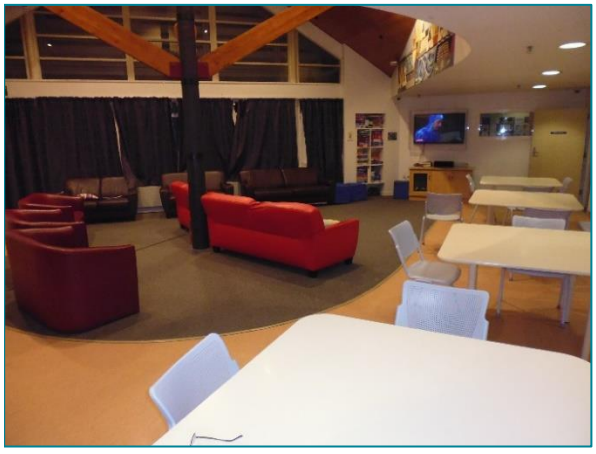

*Figure 4: Patient lounge and dining area*

*Figure 5: Smaller lounge/library with computor*

Patients had their own bedroom with an integral toilet and hand washing facility, privacy screening, and sufficient storage for personal possessions. There was no night seclusion in the

Unit and patients could enter and exit their bedrooms at any time of the day or night. Inspectors commend this practice.

There was a sufficient number of showers in the Unit for the number of patients, and a laundry facility was available for those wanting to launder their own clothes.

## Food

Meals were prepared in the hospital kitchen and transported to the Unit in a trolley. Patients had a choice of meals from a daily menu and special dietary needs were catered for. The quality and quantity of the food over the course of the inspection was satisfactory and patients were generally happy with the standard of the meals. Patients had not submitted any formal complaints about the food in the previous six months.

Breakfast was scheduled for 8.00am, lunch at 12.00pm and dinner was served at 5.30pm. Hot drinks and snacks were prepared for patients on two occasions in both the morning and the afternoon and once again during the evening. Patients did not have access to facilities to make their own hot drinks during the day, but were able to do so in the evenings in the OT room.

## Recommendations – Material conditions

**I recommend that:**

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

## Te Whare Manaaki comments

Accepted recommendation 3.

Recommendation 3 response:

*The Forensic Service agrees that this is a significant shortcoming.*

*If it is deemed that a female consumer is vulnerable or at risk from other consumers, a special 1:1 nurse will be allocated to the female consumer.*

*When the number of female consumers who do not need medium secure level of security are sufficiently high, a wing in Te Whare Hohou Roko is designated female only.*

# Activities and programmes

## Outdoor exercise/leisure activities

A large outdoor area with adequate seating and shade is available for patients but it can only be accessed when two staff are available to supervise. This resulted in patients having restricted access to outdoor exercise and fresh air. With the exception of organised activities such as volleyball, the outdoor area was open only once during the inspection.

A weekly Hīkoi[10] is organised for patients from the Unit and Te Whare Hohou Roko involving going out for a drive, walks and, occasionally, having lunch.

Some patients have leave privileges and are able to leave the Unit to undertake activities (both escorted and unescorted).

Two part-time Occupational Therapist's (OT) provide a structured programme of daily activities, which includes both individual and group work. Activities such as arts and crafts were available in the OT room, which also doubles as a drop-in centre in the evenings where patients and staff can get together. During an evening visit, Inspectors observed the room to be well attended.

A small kitchen is also available for patients in which the OT organises cooking sessions. Patients using the kitchen can do baking and cook meals, which they are able to share with another patient.

*Figure 6: Occupational therapy room*

*Figure 7: Patients' gym*

Exercise equipment, table tennis and pool are available to patients in the Unit's gym.

[10] To step, stride, march, walk. Māori Dictionary. Downloaded from: http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&keywords=hikoi

### Programmes

Several individual and group therapeutic programmes were organised by the Unit's social worker, OT and clinical psychologist. These included Anger Management, Violence Prevention and an Emotion Group.

Patients could attend a weekly adult education group on the Unit, facilitated by a tutor from Hagley College. Activities included scrabble, spelling and number games.

### Cultural/spiritual support

A hospital chaplain attends the Unit weekly.

The Ngā Pūkenga Atawhai visits the Unit regularly to provide Māori cultural and spiritual support to patients and is involved in a number of activities such as orientation of new patients, the Hīkoi and meeting with patients in seclusion.

### Recommendations – Activities and programmes

**I recommend that:**

4. All patients are able to access the outdoor area for at least one hour per day.

### Te Whare Manaaki comments

Accepted recommendation 4.

Recommendation 4 response:

*Staff aim to provide access to outdoor areas. Consumers identified risk and sufficient staff to support adequate safety of each consumer and staff is required for outdoor activity.*

*A proposed rebuild will incorporate an internal courtyard for consumers in high secure areas.*

## Communications

### Access to visitors/external communication

There is a designated room for both domestic and legal visits located at the entrance to the Unit. The room is clean and tidy with adequate seating and good natural light.

Supervised visits take place between 10.00am and 3.00pm; unsupervised visits are from 10.00am to 8.00pm. Patients can have an unlimited number of visits but, owing to the limited availability of space, visits must be prearranged. For patients able to have unsupervised visits, the family room on Te Whare Hohou Roko is sometimes used. Patients told Inspectors that the appointment system worked well and they were able to have visits regularly.

There was a patients' telephone on the Unit. However, its location (just off the main corridor, opposite the nurses' station) offers little privacy for patients.

Patients are generally able to send and receive mail, unless otherwise directed by the MDT for clinical reasons or to protect members of the public.

The DHB has published a procedure[11] for the use of the internet by patients located in the forensic psychiatric service. The OT informed Inspectors that the MDT had approved 11 patients for supervised access to the internet. A computer is available for patients in both the small lounges and they can access the computer in the OT room. Patients use the internet for activities such as checking emails, online shopping, accommodation searches and obtaining song lyrics. Inspectors observed two patients using the internet during the inspection and commend the implementation of this facility for patients.

*Figure 8: Visititors room*


*Figure 9: Patients' phone*

[11] Procedures on Chromebook and Internet use within Secure Forensic Inpatient Units. Canterbury DHB

### Recommendations – Communications

**I recommend that:**

5. Arrangements be made to ensure greater privacy for patients when using the telephone.

### Te Whare Manaaki comments

Accepted recommendation 5.

Recommendation 5 response:

*This is being addressed with the staff. Consumers can be given access to cordless phones and provided with private areas for phone conversations. On a case by case basis, risk management may result in supervised phone calls.*

## Health care

### Primary health care services

On admission, all patients receive a physical examination by a House Surgeon and can access an on call House Surgeon for acute physical health needs at any time. For more long-standing health issues a General Practitioner (GP) attends one-day per week, and patients can obtain an appointment by first notifying the Unit staff. The patients that Inspectors spoke with commented that they were satisfied with the physical health care they received.

Patients' electronic records contained details of health interventions and there was evidence of routine health screening and dental checks occurring.

The hospital has an onsite dentist, who will review patients on the Unit but all treatment is completed in the dental unit.

A shared emergency trolley, containing oxygen and the defibrillator, is located on Te Whare Hohou Roko.

### Recommendations – Health care

I have no recommendations to make.

# Staff

## Staffing levels/staff retention

Data provided by the DHB showed the Unit to have a multi-disciplinary staff complement (excluding medical staff) of 47.71 full time equivalent (FTE). The CNM informed Inspectors that there were no vacancies at the time of the inspection.

Nursing staff worked to a three-shift roster with a designated staffing level on each shift. However, the CNM informed Inspectors that for the previous two years he had rostered additional staff onto two of the shifts to manage effectively the acuity of the patients on the Unit and to ensure the appropriate balance of male and female staff. The CNM has submitted a business case to the DHB to increase the FTE by one nurse on both the A and the D shifts.

**Table 3: Nursing staff shifts**

| Shift | Hours | Funded staffing (FTE) | Actual (FTE) |
|---|---|---|---|
| A shift | 10.45pm to 7.15am | 3 | 4 or 5 |
| B shift | 7.00am to 3.30pm | 8 | 8 |
| D shift | 3.00pm to 11.00pm | 5 | 6 or 7 |

The CNM informed Inspectors that the Unit does not currently employ Health Care Assistants but he may do so in the future to address the staffing shortage and need for more male staff.

All new nurses received a two-day orientation to the Unit, which included the allocation of a 'buddy'. Nurses Inspectors spoke with were positive about the orientation they had received.

The Clinical Nurse Specialist informed Inspectors that all staff are encouraged to participate in clinical supervision. In the case of new entrant registered nurses, they undertook 20 hours of supervision during their first year of practice.

The DHB has published a list of mandatory training for staff.[12] Training data for the Unit indicated that the majority of staff had undertaken the required mandatory training or have it scheduled in the near future. However, Inspectors observed this was not the case for some staff. In particular, the data indicated that six members of the control room staff were not up-to-date with their fire training. Staff said that this was because they were unable to leave their post for this training.

[12] Workforce Development Framework – Mandatory Courses 2017/2018

During the period 2016/17 to 2017/18, staff turnover on the Unit increased from approximately 22 percent to 40 percent. Whilst the CNM was able to offer some potential causes for this increase such as the loss of some older nurses, no systematic evaluation of the reasons for the increase in turnover had been undertaken.

Coupled with an increase in staff turnover, staff sickness levels had risen from 77.87 hours per FTE in 2015/16 to 111.13 hours per FTE in 2017/18, an increase of 42.71 percent. While casual nurses covered staff shortages, the CNM informed Inspectors that nurses were often required to work overtime or double shifts to ensure full staffing on the Unit. Inspectors observed first-hand the impact of staff sickness on the Unit. On day one of the inspection, three staff were off sick and this, combined with the running of the MDT, resulted in fewer staff on the Unit. Staff, at times, appeared to Inspectors to be under pressure.

## Recommendations – Staff

**I recommend that:**

6. All staff complete the appropriate mandatory training and the required refresher sessions.
7. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

## Te Whare Manaaki comments

Accepted recommendations 6 and 7.

Recommendation 6 response:

*The Forensic Service Leadership team is addressing this recommendation.*

Recommendation 7 response:

*The Forensic Service Leadership team is addressing this recommendation.*

## Acknowledgement

I appreciate the full co-operation extended by the Clinical Nurse Manager and staff to my Inspectors and Advisor 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 4: List of people who spoke with Inspectors**

| Senior Managers | Unit Staff | Others |
|---|---|---|
| General Manager | Patients | Chaplain |
| Director Area Mental Health Services (DAHMS) | Charge Nurse Manager | Ngā Pūkenga Atawhai |
| Clinical Director, Canterbury Regional Forensic Service | Consultant Psychiatrist | General Practitioner |
| Clinical Director, Intellectually Disabled Persons Health Services | Clinical Nurse Specialist | Quality and Patient Safety Team |
| Nursing Director, Forensic and Intellectually Disabled Services | Registered Nurses | Consumer Advisor |
| Director of Allied Health | Enrolled Nurses | NZNO Local representative |
| Quality and Improvement Manager | Housekeeper | NZNO Regional Officer |
| Pou Whirinaki | Occupational Therapists | Customer Services Coordinator - Complaints |
| People and Capability Advisor | Clinical Psychologist | |
| | Social Worker | |

# 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:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
    a. for improving the conditions of detention applying to detainees;
    b. for improving the treatment of detainees;
    c. 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;
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.