Ombudsman

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OPCAT Report

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

February 2022

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Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report of an unannounced inspection of Ward 6C Dunedin Hospital under the Crimes of Torture Act 1989

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Executive summary

Background

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

Between 4 and 7 May 2021, Inspectors[1] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Ward 6C, which is located in the grounds of Dunedin Hospital in the Southern District Health Board region.

Summary of findings

My findings are:

- staff engaged respectfully with patients;
- whānau[2] of patients were warmly received and provided with updates on any change in their whānau member's treatment; and
- the detention status of each patient was recorded.

The issues that need addressing are:

- whānau were unable to '*take in*'[3] information during their whānau member's admission process, reducing their ability to remember what services their whānau member had been offered;
- provision of an admission pack about the Ward to whānau was inconsistent – some whānau had been provided with a pack, while others had not;
- whānau were unsure what 'voluntary status' meant; and
- access to fresh air and sunlight for patients was restricted.

[1] When the term Inspectors is used, it refers to the inspection team that included the OPCAT Manager, Senior Inspectors, and Inspectors.

[2] This document refers to whānau rather than family. In Te Ao Māori, whānau encompasses family in the fullest meaning. Whānau may include immediate and extended family, whakapapa (genealogy), as well as all persons connected by emotional or spiritual bonds. Any person who has been involved in the care or welfare of a patient may also be considered whānau (kaupapa whānau).

[3] When asked, whānau spoken to said they could not always recall the information they had been provided with on admission.

Recommendations

I recommend that:

1. On admission to the Ward, patients and their whānau are welcomed appropriately, and provided with relevant information in various forms (electronic, physical, and verbal) at appropriate times to support their understanding.
2. The Ward ensures its complaints system is accessible and well communicated, includes the centralised recording of complaints, the corrective action taken, and a clear pathway of escalation.
3. The Ward installs a permanent, clearly identifiable suggestions box that is easily accessible to patients and their whānau.
4. The Ward puts in place processes to enable voluntary patients to leave the Ward freely and safely, and informs patients of the processes.
5. Each day patients are provided with the opportunity to leave the Ward, escorted where necessary, including to access an outdoor area that provides space for social interaction, engaging with the natural environment, exercise, and relaxation.
6. The Ward ensures it has sufficient staff to enable patients to spend time outdoors daily.

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

Feedback meeting

On completion of the inspection, my Inspectors met with representatives of the Southern District Health Board and the Ward's leadership team, to summarise their initial observations.

Facility facts

Ward 6C, Dunedin Hospital

Ward 6C (the Ward) is a 12-bed secure mental health/psychogeriatric ward for older persons.[4] Voluntary patients could be accommodated at the Ward. Voluntary patients' informed consent formed the basis for their placement in the Ward. However, informed consent did not change the fact that there were considerable restrictions which meant voluntary patients were not free to leave the Ward at will. I discuss these issues further on pages 9 – 10.

The Ward is located on the sixth floor of Dunedin Hospital. The Southern District Health Board (Southern DHB) has provided the following *'entry criteria for all admissions'*.

- *Live within the Southern DHB district*
- *Are referred to the Mental Health Service for Older People (MHSOP) on the Internal Referral Form (internal document 15093) or GP letter*
- *Are 65 years and over and have a mental illness with an associated level of disability and/or risk, and have not received treatment by any other local Mental Health service in the past two years*
- *Require assessment and specialised treatment for an age-related mental health condition*
- *Adults of any age with an established diagnosis of dementia complicated by complex behavioural and psychological symptoms (BPSD).*

Previous inspections

Visit – 21 March 2013

Visit – 31 January 2019

[4] This information, and the points that follow, were provided by the Chief Executive Officer of the Southern DHB.

The inspection

Inspectors conducted the inspection of the Ward between 4 and 7 May 2021. On the first day of the inspection, there were six patients in the Ward, five females and one male. The average length of time those patients had been in the Ward was 19 days. Another male patient was admitted to the Ward on day two, and a further female patient on day three, bringing the total to eight patients.[5]

Inspection methodology

The physical inspection[6] spanned four days – Tuesday 4 May to Friday 7 May 2021 (inclusive),[7] and included formal interviews with the Service Manager, Specialist Mental Health and Intellectual Disability Services; and the Facility Manager. My Inspectors interviewed staff involved with patient care and whānau, and spoke with patients themselves. The physical inspection included a tour of the Facility and reviewing six patient clinical records, and observing interactions between staff and patients.

The inspection also included remote inspection activity including reviewing operating policies, plans, and incident data; and conducting interviews with staff and whānau. A full list of the documents reviewed is attached as Appendix 1.[8] The Southern DHB has responded to my provisional report, advising me of steps they are taking or intend to take in response to my provisional report. I appreciate the efforts and engagement of the DHB, and look forward to seeing the improvements discussed when I follow up in future.

Inspection focus

Four main areas were examined to determine whether there had been torture or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on the treatment of and conditions for patients.[9] These areas were:

- **Safety**, including detention status, advocacy and support, admissions, complaints, restrictions, and restraint;
- **Healthcare and treatment**, including therapeutic interventions;

[5] One of the patients was on leave from the Ward at the time of the inspection.

[6] The physical inspection was conducted onsite at the Ward.

[7] Between 3 and 7 May 2021, OPCAT Inspectors also conducted an inspection of Ward 10a and Helensburgh Cottage, which are located in the ground of Wakari Hospital, Dunedin.

[8] For a list of people Inspectors spoke with, see Appendix 2.

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

- **Decency, dignity and respect**, including whānau involvement, and the facility environment;
- **Leadership and culture**, including staffing.

Safety

I expect patients in the Ward to be kept safe, and that the Ward's practices promote patient independence. My Inspectors reviewed areas of interest including each patient's detention status, their access to advocacy and support services, and the Ward's admission and complaints processes. Any restrictions placed on the voluntary patients in the Ward were of particular interest.

Detention status

Management of the Ward told Inspectors all eight patients in the Ward were admitted to the Ward on a voluntary basis, which meant they were under no legal compulsion to remain in the Ward and receive treatment. Voluntary patient files Inspectors reviewed showed that the patients concerned had given their consent to be in a locked ward. However, I am concerned that some patients were transferred to the Ward and then asked to sign paperwork indicating they were willing to be there on a voluntary basis. I consider this consent process should occur prior to a patient's arrival in the Ward.

The Southern DHB responded to my provisional report and has advised, *'This issue has been addressed with the Emergency Psychiatric Service for acute admissions and the senior medical officers who wish to transfer from other Dunedin Hospital wards or directly from outpatient appointments. There is an expectation that the consent form is discussed and completed prior to admission.'* I am pleased to hear that this matter has been raised, and look forward to seeing voluntary patient consent forms completed prior to admission in future.

Inspectors reviewed a patient's file which showed the patient's status had changed while they were on the Ward, from being a voluntary patient to being detained under section 29(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).[10] The file notes showed the patient concerned had been consulted about the change to their status.

Inspectors were informed there were patients on the Ward who had an enacted enduring power of attorney (EPOA), and one patient was in the process of gaining an EPOA.[11]

[10] Section 29(3) of the Mental Health Act provides that a responsible clinician may direct that a patient who is under a community treatment order be treated as an inpatient for a period of up to 14 days.

[11] An enduring power of attorney (EPOA) is a legal document which sets out who can take care of your personal or financial matters if you can't. That person is called your attorney. See: https://superseniors.msd.govt.nz/finance-planning/enduring-power-of-attorney/ [accessed on 27 July 2021]

Advocacy and support

There did not appear to be an advocacy service that consistently and proactively engaged with patients on the Ward. The Consumer Advisor was initially identified as an advocate for patients, but Inspectors were told the role did not allow that person to provide advocacy for patients. Instead, the Consumer Advisor's role was to consider patient *'patterns and systems'*. Staff told Inspectors that the Southern DHB's Consumer Advisor *'had not been seen in the Ward for four months'*. I would expect staff to be aware of what the Consumer Advisor's role involves, so they can accurately advise patients and their whānau about the advocacy and support available to them. I also consider the Consumer Advisor may find it beneficial for their work, to maintain a closer connection with the patients and staff on the Ward.

In response to my provisional report, the Southern DHB noted that it recognises the need for independent consumer advocacy for patients and their whānau and advised that, *'The Southern DHB Consumer Advocate will visit the service on a regular basis and respond to requests for support from patients.'* This is a positive development for the patients and their whānau.

Advocacy and support services available to patients

Staff mentioned other advocacy services to Inspectors, including Alzheimer's New Zealand, Support Families (SF) Otago, and the District Inspector.[12] Inspectors observed posters about the Health and Disability Commissioner displayed in the Ward, along with brochures about Alzheimer's Otago, and posters advertising interpretation services. However, they did not see the District Inspector's contact details publicly displayed. Inspectors understand that because voluntary patients do not receive treatment under the Mental Health Act those patients do not have access to District Inspectors. However, the Ward also accommodated patients under the Mental Health Act, and the District Inspector also said they sometimes advised voluntary patients, *'especially when it appears they will eventually come under the Mental Health Act'.* I would like to see information about the District Inspector, including their contact details, displayed on the Ward. The Southern DHB has advised that contact details for the District Inspectors are now displayed in the Ward, and pamphlets about advocacy and support services are on the Ward's family information board. I am pleased to learn this.

The admission pack provided to my Inspectors (discussed in the 'Admissions' section below) did not contain information about Dunedin Hospital's inpatient advocacy services. It was also not clear to Inspectors whether patients and their whānau were provided with information about support services on their discharge. I expect the Ward to provide patients and their whānau with information about support services when the patient is discharged.

[12] District Inspectors are lawyers appointed by the Minister to protect the rights of people receiving treatment under the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. See: https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-district-inspectors. [accessed on 17 June 2021]

Ability for patients to contact advocacy and support services

Inspectors observed there was a phone at the nurses' station, which patients could use. However, a patient who had been admitted that day informed Inspectors they were unaware of the phone. Another patient told Inspectors they had a cell phone but no data to make calls. I encourage staff to check whether patients are aware of how they can contact friends, whānau, and the wider outside world, including by accessing the Hospital's Wi-Fi, and to assist patients to do so should they need it. This would also enable patients to contact an advocacy service, if required.

I consider having advocacy services proactively engage with voluntary patients who are in the Ward would be beneficial, particularly as these patients do not have the safeguards available to them that those admitted under the Mental Health Act do.[13] I would like to see information about the advocacy services available at Dunedin Hospital included in any admission pack for patients and their whānau. I would also like to see patients and their whānau provided with information about support services on their discharge. I consider that increasing patients' access to advocacy services would help patients to understand their rights and the options available to them.

Admissions

Inspectors observed the admissions room to be private but not very welcoming. The room had no natural light and the furnishings were dated, with mismatched tables and chairs and faded artwork on the walls.

When interviewed, whānau told Inspectors that when first entering the Ward with their whānau member it could be difficult to *'take things in'*. One whānau member said, *'It was all a bit of a blur.'* The way whānau said they had received information on entering the Ward could be described as 'ad hoc'. Some people said they had received an admission pack and been given a tour of the Ward, while others reportedly had not. Staff members' understanding of the admission process varied. On request, my Inspectors were provided with a hard copy of a pack entitled, *'Mental Health for Older Persons Information for Consumers, Family and Support Networks'.* The pack contained a guide to Ward 6C; pamphlets on privacy, Alzheimers NZ, and EPOAs; and information about how to keep safe, give feedback, and make a complaint. I would like the Ward to provide patients and their whānau with electronic copies of these documents, and separate information packs for voluntary patients and those admitted under the Mental Health Act. These should reflect the differences between voluntary patients and patients admitted under the Mental Health Act. For example, the pack for voluntary patients should include information about how to leave the ward.

In responding to my provisional report, the Southern DHB has acknowledged that there should be separate information provided for voluntary patients and those under the Mental Health Act and their whānau, and *'this will be addressed by the end of October 2021.'* I commend the

[13] This includes access to District Inspectors.

DHB on taking action to provide this information for patients, and look forward to seeing the updated information in future.

The Southern DHB also acknowledged that at various times throughout the patient's stay they could seek patient and whānau understanding of information provided to them. They advised they will '*look into a process of gaining email addresses to be able to provide information electronically where possible, in addition to written and verbal information.'* I am pleased to learn this and will review the effectiveness of this when I follow up in the future.

Inspectors observed information for patients, whānau, and staff displayed in the Ward on three different noticeboards. The information for all three audiences was mixed up together, making it hard to determine what information was for which audience. Inspectors saw that most of the information appeared to be directed at whānau. I encourage the Ward to organise the information on its noticeboards so that it is clear who the information is for, especially the information for patients.

Patients and their whānau should be well informed about what to expect in the Ward. I am pleased that, in response to my provisional report, the DHB has advised that the Ward has replaced its information board for whānau with a '*bigger, more visual section with increased capacity for pamphlets'*. I consider these actions will contribute to a more positive experience in the Ward for patients and their whānau, and look forward to seeing this when I follow up on this inspection.

Complaints

Management of the Ward informed Inspectors there had been no recorded complaints in the previous 12 months (May 2020 to May 2021). I note that while having no recorded complaints could indicate that no one had made a complaint, it could also reflect that patients and whānau did not know how to make a complaint, were unable to do so, or felt uncomfortable making a complaint.

Inspectors were told *'community meetings'* held in the Ward, which patients were actively encouraged to attend, were used to resolve concerns as they arose. I am pleased the Ward provides patients with the opportunity to have their say through community meetings. However, I consider complaints raised at that forum, and the actions taken in response, should be recorded and tracked. Failure to do so creates the risk that patients may experience inconsistent or delayed responses.

In responding to my provisional report, the Southern DHB has advised that, *'The complaints process is discussed with the patients and whānau if any issues are raised at meetings, and the information pamphlet is given.'* I am pleased to learn this, as I consider providing information about the complaints process in multiple ways and on multiple occasions supports patients and whānau understanding and use of the process.

I consider having a formal process for receiving and responding to complaints assists a facility, such as the Ward, to identify patterns of issues arising, address what is causing them, and provide consistent, equitable and fair resolution of complaints. I expect the Ward to inform

patients and their whānau about how they can make a complaint and how their complaint will be responded to.

The Southern DHB has briefly outlined its complaints process, and noted that complaints are recorded in patients' files. '*If a family makes a verbal complaint, it will be documented, and the usual process followed. The complaint is logged and investigated by the Charge Nurse Manager (CNM) and a formal response provided.'* While I am pleased to learn that records of complaints are kept, I consider having complaints recorded in individual patient files may reduce the opportunity to identify patterns of issues being raised, and to make sure issues are addressed in a consistent way. Therefore, I would like the Ward to ensure its complaints system includes the centralised recording of complaints and the corrective action taken to address each complaint.

My Inspectors observed a suggestions box in the Ward, but it had been designed to look like a book and was not immediately identifiable as a suggestions box. I expect the Ward's suggestions box to be easily recognisable as such, easily accessible to patients and their whānau, and located in a permanent fixed place. The Southern DHB has agreed that the suggestions box is not easily identifiable as such. They have informed me that, *'A replacement is currently being built by our Building & Property Services team.'* I am pleased this action is being taken. I consider having an easily accessible suggestions box will make it easier for patients and their whānau to make suggestions and raise issues. I look forward to seeing this at a follow up visit.

Restrictions

I expect that patients are not subject to greater restrictions than are individually necessary for their safety. Inspectors observed the main door to the Ward was locked at all times. As noted above, all eight patients in the Ward were admitted to the Ward on a voluntary basis. Therefore, Inspectors were particularly interested in how any restrictions affected them.

Inspectors reviewed the policy document, *'Leave from Inpatient Facilities – MHAID [Mental Health, Addictions and Intellectual Disability] Service (District)'*. The document outlined the types and conditions of leave for patients, and stated, *'The MHAID Service cannot restrict the movement of voluntary patients.'* It then went on to list the patients the document applied to and included, *'Voluntary patients with their informed consent following a full explanation of their rights (as a voluntary patient), including their right to withdraw consent at any time.'*

Despite the policy noting that voluntary patients cannot be restricted, inspectors were told that no patients at the Unit were on 'unescorted leave', therefore all patients, including voluntary patients, were on 'escorted leave'. The document defined 'escorted leave' as being, *'leave off the ward when a consumer is escorted by staff. Leave with others (e.g. family and friends is not escorted leave. It is unescorted leave and will follow the considerations in the section on unescorted leave'.* Escorted leave included leave within the hospital grounds and leave in the community. The document provided that unescorted leave within the hospital grounds had to be authorised by the clinical team and negotiated on a shift-by-shift

assessment with the registered nurse assigned for the duty. Staff told my inspectors that the rationale behind escorted leave was *'safety, many patients are a falls risk'.*

In responding to my provisional report, the Southern DHB has informed me, *'Ward 6c class escorted leave as being able to occur with staff or whānau, so when staff spoke of nobody on unescorted leave, they meant patients being able to go out on their own without staff or whānau. This is also documented on the patient board – escorted staff only or escorted with whānau.'*

My key concern remains the limited ability of patients, particularly voluntary patients, to leave the facility. I appreciate that the Ward is trying to keep its patients safe, and is therefore understandably concerned about falls. However, my expectation is that the environment in the Ward protects and nurtures the independence and autonomy of the voluntary patients, including their ability to leave the Ward at will. I expect evidence is available to show that patients have been taken outside the Ward on a regular basis. In my view voluntary patients have a fundamentally different legal status to people detained under an order and should not be treated the same. I encourage the Ward to consider how it can work with patients and their whānau to enable patients to leave the Ward freely and safely.

The Southern DHB has advised, *'Ward processes have been reviewed to see if changes to current processes can be made. A decision has been made to retain the current process – voluntary patients are informed that they can ask staff to open the door once their leave status has been confirmed (patients are reviewed by the team on admission and a risk assessment is undertaken to ascertain if a patient can leave the ward escorted or unescorted). We are unable to provide uncontrolled egress to individuals (e.g. by providing them with a swipe card or PIN number to open the locked door) as this would present significant risk of patients who are not able to leave the ward unescorted leaving the ward at the same time as a patient who can.'*

I consider maintaining a patient's independence and autonomy to the fullest extent possible is central to their care. Each patient's independence should be protected and nurtured by the Ward environment and culture, with leave seen to facilitate recovery.

Restraint

Restraint involves using personal, physical, or environmental methods to restrain a person who is at risk of harming themselves or others.[14] My Inspectors did not observe restraint information – including any restraint practice – in patient files, although they did observe restraint equipment stored in a room on the Ward.

Inspectors asked staff whether restraint was used in the Ward. They were informed that least restrictive interventions were attempted, such as de-escalation and distraction, before physical restraint was used. The use of these interventions would be documented on the patient's file. Staff said the type of physical restraint used in the Ward involved a staff member using a

[14] See the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2 at https://www.standards.govt.nz/shop/nzs-8134-22008/.

physical arm hold on a patient. Staff also told Inspectors the mechanical restraint mechanisms used in the Ward included a floating chair, table and chair restraints, bed rails, and mitt gloves.[15] Staff told Inspectors any use of restraint was recorded in a patient's restraint plan.

I am pleased to hear that least restrictive interventions are attempted by staff before restraint is considered. I expect any use of restraint to be authorised, practiced, and documented appropriately, and only used as a last resort. I encourage the Ward to continue to work towards minimising restraint.

Restraint training for staff

Inspectors were informed that 15 of the 36 staff members had not yet received the required Safe Practice Effective Communication (SPEC) training or refresher training.[16] There was a plan in place that meant all staff would be up to date with their SPEC training by November 2021. Staff told Inspectors that if a staff member was required to assist in a physical restraint situation, that person would be expected to intervene, even if they were not up to date with their SPEC training. Having staff who are not fully trained intervening in restraint situations is not acceptable. I expect only staff with up to date SPEC training are involved in restraint practice.

[15] These are all mechanical restraint devices applied to a person's body or a person's limb to restrict their movement.

[16] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraint. SPEC training has a focus on therapeutic interventions that reduce the incidence of restraint and seclusion. See: https://www.tepou.co.nz/news/safe-practice-effective-communication-launch/911#:~:text=SPEC%20is%20a%20training%20programme,and%20implementation%20of%20the%20programme.&text=There%20are%20a%20number%20of%20outcomes%20sought%20from%20SPEC%20National%20Training. [accessed 25 June 2021]

Recommendations – safety

I recommend that:

1. On admission to the Ward, patients and their whānau are welcomed appropriately, and provided with relevant information in various forms (electronic, physical, and verbal) at appropriate times to support their understanding.
2. The Ward ensures its complaints system is accessible and well communicated, includes the centralised recording of complaints, the corrective action taken, and a clear pathway of escalation.
3. The Ward installs a permanent, clearly identifiable suggestions box that is easily accessible to patients and their whānau.
4. The Ward puts in place processes to enable voluntary patients to leave the Ward freely and safely, and informs patients of the processes.

Healthcare and treatment

Inspectors observed that staff engaged respectfully with patients. Whānau of patients were warmly received in the Ward, and they were provided with updates on any change in their whānau member's treatment.

There was no evidence that any patient had been subjected to torture or cruel, inhuman or degrading treatment or punishment. There was also no evidence that seclusion was used in the Ward.

Therapeutic interventions

Inspectors observed the Ward had a dedicated sensory room with a range of sensory resources for patients to use, including tactile items, games, a rocking chair, and a foot spa. Staff told Inspectors the sensory room was used to provide therapy for patients, and patients could also use the room independently when they wanted some quiet time. While Inspectors did not observe any patients using the sensory room during the inspection, patients were observed using sensory items from the room.

Activities for patients

A whiteboard at reception displayed the patient activities for the day. On arriving at the Ward my Inspectors observed the whiteboard had not been updated for a day or two. However, as the inspection got underway, Inspectors observed it was updated on a daily basis.

Staff told Inspectors they went around the Ward inviting patients to come to the group activities. Activities offered included housie, bowls, quizzes, cooking, walks around the block, colouring, and craft. Inspectors observed patients reading the newspaper, knitting, and

watching television. Whānau told Inspectors the Occupational Therapy Team (OT Team) were '*great'*, as they brought things for their family member to do.

Staff told Inspectors the Ward's OT Team was made up of an Occupational Therapist and an Assistant Occupational Therapist, who between them worked Monday to Friday. Nurses and the Mental Health Assistant ran the activities on the weekends and in the OT Team's absence. At those times, the health staff could access the resources in the Ward's occupational therapy cupboard. The OT Team was responsible for organising planned group and individual activities for patients throughout the day. Inspectors were told the activities were set up in the dining room adjacent to the communal lounge, which contained a television patients could freely access. Inspectors were informed the activities were dependant on the needs of the patients in the Ward, and they were developed based on *'assessments and in consultation with the Multi-Disciplinary Team'*.[17] The activities were designed to re-balance patients from being in a 'hyper' or 'hypo' state.[18]

I am pleased to learn of the work of the OT Team, as I consider engaging in activities and sensory modulation contributes to a patient's wellbeing.

Recommendations – Healthcare and treatment

I have no recommendations to make.

Decency, dignity and respect

Overall, patients were positive about their experience in the Ward. Patients told Inspectors they liked the meals, and the Ward was warm. Most patients had their own room, and Inspectors also saw patients outside of their room engaging in activities. Staff and patients were observed interacting while doing activities together, including art therapy, and Inspectors saw the patients' artwork displayed in the Ward. Each patient was dressed appropriately for the time of the day, including wearing shoes.

Whānau involvement

Generally, whānau were positive about their involvement in the care and treatment of their whānau member. They told Inspectors they were kept updated about any changes to their whānau member's medication or care plan. They also said they felt welcome in the Ward. A whānau member described the staff as *'fabulous'* and another said they were *'awesome'* and that the Ward felt like *'a big family'.* Whānau said their whānau member felt safe, *'The nurses introduce themselves and actually talk to the patients and engage.'*

[17] All staff involved in the care and treatment of patients were involved in the Multi-Disciplinary Team.

[18] 'Hyper' is used to mean overstimulated, while 'hypo' has the opposite meaning.

Facility environment

Inspectors observed the layout of the Ward resembled that of a typical hospital ward, with linoleum floors (except in the carpeted admissions room) and wide corridors that allowed patients with mobility aids to move around easily. None of the windows in the Facility opened. A whānau member described the Ward as *'stuffy'.* While the Facility was clean and tidy, the décor and furnishings were tired and dull. Inspectors observed an armchair with torn upholstery that needed replacing. The dining table and chairs were mismatched and appeared more suited to an office conference room.

In responding to my provisional report, the Southern DHB acknowledged that the facility and environment are not best suited for the patients. However, they stated, *'There are now 12 new dining chairs that have arms as this is easier for most patients to get themselves up from.'* While I am encouraged to learn this, I consider there is a need to address the Ward's overall décor and furnishings, and to ensure that there is a flow of fresh air.

Entry to the Ward was through a secure, heavy door that required a pin code or swipe card to open. The door was kept locked. If the door was opened it would automatically close after 20 seconds.

There were four designated office areas, including two meeting rooms and a large nurses' station in the middle of the Ward. Staff informed Inspectors the largest meeting room was used for staff meetings, multi-disciplinary meetings, larger whānau gatherings, and admission of patients. Inspectors observed from the nurses' station that staff had oversight of each of the patients' bedrooms that were occupied at the time of the inspection.

Patients' bedrooms

The patients' bedrooms included single rooms with ensuites, and shared rooms with four beds. Inspectors observed the patients' bedrooms had limited personalisation. Inspectors saw patients used a small cupboard and bedside drawer for storing clothing and personal items. Each bedroom had large windows providing natural light, but the windows did not open. I would like to see patients encouraged to personalise their bedrooms, as I consider this would support their wellbeing, dignity, and independence.

The Southern DHB advised that although my Inspectors observed on their inspection that the patients' bedrooms had limited personalisation, *'this is encouraged by the team and does happen frequently. Unfortunately, this had not occurred with the cohort of patients on the ward at that time.'* I look forward to following up on this in the future.

The Ward's lounge areas

The Ward had two lounge areas each with their own kitchenettes and tables at which patients could dine or engage in activities. The lounges had comfortable armchairs and various sensory equipment, games, books, and a daily newspaper for patients to use. One lounge (the quiet lounge) was used for de-escalation and when patients wanted a place to spend some quiet time out of their room. A swipe card was needed to access the quiet lounge from the other

lounge (the communal lounge).The quiet lounge was less inviting than the communal lounge, and the furniture was shabby. It included a television. The Clinical Nurse Specialist's office and a stationary bicycle were also located in the quiet lounge.

By comparison, the communal lounge was warm and inviting, decorated with paper butterflies made by patients. Patients were encouraged to dine and take part in group activities in the communal lounge, and it also housed a television. Inspectors observed that when patients spent time out of their room they usually did so in the communal lounge.

Access to the outdoors

Research has found that the environment in which a person lives can be a positive therapeutic intervention on its own, regardless of the type of health care that person receives.[19] Access to gardens and outdoor environments allows patients to experience and enjoy nature, exercise, and recreation.

The Ward was located on the sixth floor of Dunedin Hospital, and it did not have a designated outdoor space for patients. To access fresh air in an outdoor environment, patients had to be escorted to the ground floor in an elevator, along busy hospital corridors, and through the main reception before arriving outside on a busy main street. Inspectors observed there was no enclosed, outdoor green space for patients within the hospital grounds or close by. I consider these circumstances alone made it challenging to access the outdoors.

The Southern DHB have advised this is not something that can be addressed at this time, but planning for the new Dunedin Hospital is taking this into account. I consider it essential that patients have frequent access to fresh air in an outdoor space. Therefore, I expect the Southern DHB and the Ward to prioritise arrangements to provide this access, and I would appreciate being informed of any arrangements being made to address this in future.

In addition, in order to spend time outside the Ward, patients had to seek permission to have escorted or unescorted leave, according to the policy. The DHB's policy definition of escorted leave, requiring that a staff member escort the patient off the grounds, meant that patients had to depend on staff to be able to leave the facility. Staff told Inspectors escorted leave was dependent on staff availability, the patient's level of *'wellness',* and whether it was safe for them to leave the Ward. As noted above, the Southern DHB has informed me, *'Ward 6c class escorted leave as being able to occur with staff or whānau, so when staff spoke of nobody on unescorted leave, they meant patients being able to go out on their own without staff or whānau.* I note that this view differs from that articulated in documentation provided during the inspection.

In interviews with staff and whānau, and discussions with patients, Inspectors were told patients were provided with few opportunities to leave the Ward, on average just two times a week. When asked whether they went outside often, one patient said, *'No, I've been out twice in the five weeks I've been here'*.

[19] See the Ministry of Health's *Secure Dementia Care Home Design* published in 2016. [accessed on 24 June 2021]

Patients should be supported to frequently spend time outside, as part of their care and treatment. I am concerned that this does not appear to be happening on the Ward. I consider the Ward's location on the sixth floor is contributing to the difficulty in enabling patients to have regular time outside, particularly as they are unable to access an enclosed outdoor area themselves. The location is causing the patients to be 'situationally disabled', meaning the patients are unable to access the outdoors. The lack of a suitable outdoor area in the hospital grounds in which to walk is not aiding the patients' mobility.

The Southern DHB has stated, *'The restrictions of the current environment of Ward 6c, on the sixth floor of the Dunedin Hospital Ward Block, is not something that can be addressed at this time.'* However, the DHB informed me the Charge Nurse Manager of Ward 6C has been involved in planning the new inpatient unit (a mental health service for older patients) in the New Dunedin Hospital. In doing so, *'these restrictions have been addressed, with three planned large outdoor areas available for patients and whānau to use.'* I am pleased to learn this.

However, in the meantime I consider the restrictions imposed on the patients to be unacceptable. Access to fresh air, and an outside space, is vital for mental health and wellbeing, and is a basic standard that all persons are entitled to. I expect the Southern DHB, together with management of the Ward, to take action to provide this access for patients in the Ward too. I would appreciate being informed of a plan to achieve this as soon as possible, even if it involves moving the Ward to a more suitable location.

Access to fresh air

The windows in each patient's room do not open. This, in conjunction with the inability to easily access outdoor areas (discussed above), impacts on patients' access to fresh air.

I would like to see patients provided with the opportunity each day to leave the Ward, including having access to an outdoor area that provides space for social interaction, engaging with the natural environment, exercise, and relaxation.

Recommendations – Decency, dignity and respect

I recommend that:

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

Leadership and culture

Management of the Ward told Inspectors they had worked together as the Ward's leadership team for three or more years. Inspectors observed this consistency in leadership was reflected in the tidy presentation of the Ward and the calm and quiet environment to support patient

rehabilitation. A whānau member told Inspectors, *'The staff are fabulous, they are very good with patients and families.'*

Staffing

A review of the staff roster, occupancy rates, and nurse's board indicated that the Ward was sufficiently staffed to provide treatment for the number of patients in the Ward. However, Inspectors were told staff were regularly re-deployed to other hospital wards, making it difficult for staff on the Ward to provide therapeutic activities for patients. While this was not evident to Inspectors from the staff roster, Inspectors did observe staff other than the Occupational Therapy team (OT team) facilitating patient activities when the OT team was unavailable. I encourage the Ward to ensure the redeployment of staff elsewhere is captured in the roster so staffing needs can be appropriately assessed.

The Southern DHB has responded to my provisional report stating, *'When staff are moved to other areas this is recorded on a sheet in the roster folder, the daily roster sheet, as well as on Trendcare[20] notes. Trendcare can do a report as to how many hours and which category [of staff] have been transferred out. These are discussed at our monthly Local Data Council (part of Care Capacity Demand Management – CCDM) meetings. Safe staffing numbers identified from the Care Capacity Demand Management work are yet to be finalised, but it is anticipated it will result in an increase in FTE for Ward 6C.'* I appreciate this information and would also appreciate an anticipated timeframe for the staffing decision, and to be informed of the decision and its impact on the patients. In particular, I'm interested in how this will affect the availability of staff in the Ward to provide therapeutic activities for the patients, as I consider these activities central to the patients' wellbeing.

Availability of staff to provide escorted leave for patients

Staff and whānau told Inspectors that a lack of staff frequently restricted patients from having access to the outdoors. The Ward's leave policy stated patients could only be escorted outside by staff (not whānau members), and the limited availability of staff to do this meant patients could not go outside daily. Staff told Inspectors that on average patients were escorted outside twice a week. A staff member told Inspectors that when patients went out of the Ward their mood did improve. My expectation is that patients have ready access to the natural environment, and are able to spend time outdoors.

I consider patients should be encouraged and supported to frequently spend time outdoors, as this is important for their wellbeing. I would like to see sufficient staff to support the therapeutic needs of patients to spend time outdoors daily.

The Southern DHB has stated that, *'Ward 6C staff do their very best to get patients outside where possible*' but they are reliant on having sufficient staffing levels to accommodate the patients. *'This is not merely due to being unable to meet core staffing levels, but also due to the*

[20] 'TrendCare' is a workforce planning and workload management system that provides dynamic data for clinicians, department managers, hospital executives and high level healthcare planners. See: https://www.trendcare.com.au/ [accessed 1 November 2021]

acuity of the cohort of patients on the ward at the time. Recruitment to core staffing levels has been a challenge for Ward 6c and this has been the major limiting factor in the availability of staff to escort patients outside. Recruitment is ongoing and the ward is currently finalising CCDM staff staffing numbers which are expected to see an increase in the core staff numbers which will further improve the situation.' I am pleased to learn that staffing needs are being considered, and look forward to seeing an improvement in patients' access to the outdoors.

Recommendations – Leadership and culture

I recommend that:

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

Acknowledgements

I appreciate the full co-operation extended by the Facility Manager and staff to the Inspectors during their inspection of the Ward. I am also grateful to the patients at the time of the inspection and their whānau, in particular those who took the time to speak to my Inspectors. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of documents reviewed by Inspectors

Inspectors reviewed the following information during the inspection:

- Consumer complaints policy
- Developing consumer treatment plan
- Enabler guides
- Family/whānau staying in acute inpatient units
- Giving information and informed consent
- Informed consent for healthcare procedures
- Informed consent form – electronic completion
- Inpatient process checklist
- Kai oranga hauora
- Leave from inpatient facilities
- Locking doors to rehab units
- My safety plan MHAID service
- Occupancy rates for the last 12 months
- Sensory modulation guidelines
- Staff responsibilities under PPPR Act
- Te Ara Hauora

Appendix 2. List of people who spoke with Inspectors

Table 1: List of people who spoke with Inspectors

Managers	Ward staff	Key people
Facility Manager Service Manager	Consumer Advisor Clinical Nurse Manager Clinical Nurse Specialist Director of Area Mental Health Services District Inspector Mental Health Assistant Nurse Practitioner Occupational Therapist Psychiatrist Registered Nurse Social Worker	Patients Whānau

Appendix 3. Legislative framework

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

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

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

Places of detention – health and disability facilities

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

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

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM's functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
  - for improving the conditions of detention applying to detainees;
  - for improving the treatment of detainees; and
  - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

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

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

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on his behalf.

More information

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