
OPCAT Report

Report on an unannounced inspection of Puna Awhi-rua Forensic Inpatient Ward, Waikato Hospital, under the Crimes of Torture Act 1989

March 2020

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



Report on an unannounced inspection of Puna Awhi-rua Forensic Inpatient Ward, Waikato Hospital, under the Crimes of Torture Act 1989

ISBN: 978-0-473-51678-9 (PDF)

Published March 2020

Office of the Ombudsman | Wellington, New Zealand | www.ombudsman.parliament.nz

Contents

Executive Summary	1
Background	1
Summary of findings	1
Recommendations	3
Feedback meeting	4
Consultation	4
District Health Board response	4
Facility Facts	6
Puna Awhi-rua Forensic Inpatient Ward	6
Region	6
District Health Board	6
Operating capacity	6
Last inspection	6
The Inspection	7
Inspection methodology	7
Inspection focus	8
Treatment	8
Protective measures	8
Material conditions	8
Activities and programmes	8
Communications	9
Health care	9
Staff	9
Evidence	9
Recommendations from previous report	9
Treatment	10
Torture or other cruel, inhuman or degrading treatment or punishment	10
Seclusion/High Care Secure Lounge	12
Seclusion policies and events	13
Restraint	14
Restraint training for staff	16
Electro-convulsive therapy	16
Sensory modulation	16
Service users' and whānau views on treatment	17
Recommendations – treatment	18
Puna Awhi-rua comments	18
Protective measures	20
Complaints process	20

Records	21
Recommendations – protective measures	22
Puna Awhi-rua comments	22
Material conditions	23
Accommodation and sanitary conditions	23
Access to bedrooms	24
Recommendations – material conditions	26
Puna Awhi-rua comments	26
Activities and programmes	28
Outdoor exercise and leisure activities	28
Programmes	29
Social Worker and Alcohol and Drug Clinician	30
Cultural and spiritual support	30
Recommendations – activities and programmes	31
Puna Awhi-rua comments	31
Communications	31
Access to visitors	31
Access to external communications	32
Recommendations – communications	33
Puna Awhi-rua comments	33
Health care	34
Primary health care services	34
Recommendations – health care	35
Puna Awhi-rua comments	35
Staff	35
Staffing levels and staff retention	35
Recommendations – staff	36
Puna Awhi-rua comments	36
Acknowledgements	37
Appendix 1. List of people who spoke with Inspectors	38
Appendix 2. Legislative framework	39
Tables	
Table 1: Seclusion events 1 March to 31 August 2019	13
Table 2: Restraint data (exclusive of seclusion data) from 1 March to 31 August 2019	14
Table 3: List of people who spoke with Inspectors	38

Figures

Figure 1: High care secure lounge	13
Figure 2: High care secure lounge en-suite	13
Figure 3: Former sensory room	17
Figure 4: Former sensory room	17
Figure 5: Typical bedroom	23
Figure 6: Men's bathroom	23
Figure 7: Women's lounge	24
Figure 8: Women's en-suite toilet	24
Figure 9: Main courtyard	29
Figure 10: Poolroom	29

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 conditions and treatment of service users detained in secure units within New Zealand hospitals.

Between 16 September and 20 September 2019, Inspectors¹ — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Puna Awhi-rua Forensic Inpatient Ward (the Ward), which is located in the grounds of Waiaora Waikato Hospital campus, Hamilton.

Summary of findings

My findings are:

- There was no evidence that any service user had been subject to torture or other cruel, or inhuman treatment or punishment. However, my Inspectors found evidence of a service user subject to degrading treatment.
- All service users had the necessary legal documentation to be detained in the Ward.
- Consent to treatment forms were on file for all service users.
- All service users' paperwork was up to date and well maintained.
- The multi-disciplinary team (MDT) reviews and START² meetings for service users were thorough and the service users were included in the MDT review and offered a copy of their review documentation.
- Interactions between staff and service users were respectful, constructive and appropriate.
- Staff who spoke with Inspectors were positive about the leadership on the Ward and felt supported.
- Service users who spoke with Inspectors were positive about their experiences on the Ward.

¹ When the term Inspectors is used, this refers to the inspection team comprising of an Inspector and two Specialist Advisors.

² The Short-Term Assessment of Risk and Treatability (START) is a concise clinical guide for the dynamic assessment of short-term (i.e., weeks to months) risk for violence (to self and others) and treatability. START guides the assessor toward an integrated, balanced opinion to evaluate the client's risk across seven domains: violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use, and risk of being victimized. <http://criminal-justice.iresearchnet.com/forensic-psychology/short-term-assessment-of-risk-and-treatability-start/>

- The Ward was clean, tidy and well maintained.
- Service users had their own bedroom that they could lock.
- The Ward had a separate accommodation area for women service users.
- There were adequate bathroom, shower and laundry facilities for the number of service users.
- Cultural and spiritual support was provided on the Ward.
- Staff retention had improved.

The issues that needed addressing are:

- The accommodation of service users in rooms other than designated bedrooms amounted to degrading treatment and a breach of Article 16³ of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Convention against Torture').
- Some staff reported they did not have the necessary knowledge and skills to deal with the diverse service user group.
- A prolonged seclusion that did not adhere to *Seclusion Procedure*.
- Lack of privacy blinds in the seclusion/high care secure lounge.
- The inability for service users in seclusion to maintain orientation to day and time.
- Discrepancies in the collection and reporting of seclusion data.
- Relevant restraint policies were out-of-date at the time of the inspection.
- Discrepancies in the collection and reporting of restraint data, including service users' ethnicity.
- No induction/information packs were given to service users or whānau.
- Complaint forms were not available on the Ward on the first day of inspection.
- Contact details for District Inspectors were not displayed on the Ward.
- Service users' recovery plans were not signed.
- Service users' bedroom door observation panels afforded little privacy.
- Service users were subject to a restrictive bedroom access regime.

³ UN Convention against Torture, Article 16(1): *"Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment."*

- Service users were unable to access hot drinks and personal food items independent of staff.
- Service users had limited access to leisure activities.
- Service users were unable to access the telephone independent of staff and generally only between 6pm and 9pm.
- Admission checklists were not in place.
- Staff vacancies in key positions

Recommendations

I recommend that:

1. Rooms such as the sensory modulation room, high care secure lounge, day rooms or offices never be used as bedrooms.
2. Staff receive training to enhance knowledge and skills for dealing with service users designated as having an intellectual disability or high and complex needs.
3. All seclusions adhere to the *Service's Seclusion Procedure*.
4. Privacy blinds be fitted to the external seclusion room windows and door.
5. Improvements are made to the seclusion room to enable service users to maintain orientation to date and time.
6. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of seclusion data.
7. Policies and procedures are up-to-date.
8. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of restraint data, including by service users' ethnicity.
9. Service user induction packs and whānau information packs are provided as a matter of routine.
10. Complaint forms are available in the Ward.
11. District Inspectors contact details are displayed on the Ward.
12. Recovery plans are routinely signed by service users and refusal to sign is recorded in their files.
13. Observation panels in bedroom doors provide privacy from other service users.
14. Service users have increased access to their bedrooms during the day.

15. Service users are able to freely access hot drinks, unless deemed unsafe based on individual risk assessment, and have their own food on the Ward at any time.
16. Service users have increased access to activities and programmes, both on and off the Ward.
17. Service users have access to a telephone, independent of staff, at any time, unless deemed unsafe based on individual risk assessment.
18. A checklist be in place to ensure the admissions process is completed for new admissions to the Ward. **This is an amended repeat recommendation.**
19. The Ward provides more Occupational Therapy and Psychological services on the Ward.

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 Ward's leadership team, to outline their initial observations.

Consultation

A provisional report was forwarded to the District Health Board for comment as to fact, finding or omission prior to finalisation and distribution.

District Health Board response

The Waikato District Health Board (the DHB) provided a response to my provisional report on the Ward on 15 January 2020. I have carefully considered the comments made before finalising my report. Where the DHB has provided a specific response to my recommendations, this is recorded below each recommendation. Where necessary, I have responded with further comment.

The DHB's report responded to a number of common themes from my inspections of this Ward and three other wards in the DHB which were conducted at the same time⁴, including over occupancy, high and increasing use of seclusion and restraint, and the normalisation of restrictive practices.

The DHB emphasised planned changes or changes that had been made between the inspection in September 2019 and the DHB's comments in January 2020. While I am pleased to hear that

⁴ The wards inspected at the same time were Wards 34, 35, and 36, Puna Poipoi, and Puna Maatai.

the DHB is taking steps to address a number of identified issues, my role as an NPM is to report on the conditions and treatment for people who are being detained, as they are at the time of the inspection. As such, while I acknowledge the further information provided by the DHB, my recommendations relate to the conditions and evidence my Inspectors found during the time of inspection.

I intend to conduct follow up inspections of all the wards, at which point I will be able to assess whether the actions highlighted by the DHB have been successful in addressing my concerns.

Facility Facts

Puna Awhi-rua Forensic Inpatient Ward

Puna Awhi-rua (the Ward) is a 12-bed sub-acute forensic mental health ward in the Henry Rongomau Bennett Centre (HRBC), which is located in the grounds of Waiora Waikato Hospital, Hamilton.

The Ward primarily cares for people from the courts and prisons and receives transfers/referrals from other forensic and adult mental health wards.⁵ It provides these services for male and female service users. The Puawai Midland Regional Forensic Service (the Service) at the HRBC⁶ is also funded for four designated beds for service users with intellectual disabilities.

Region

Puawai Midland Regional Forensic Service – Waikato, Lakes, Taranaki and Bay of Plenty

District Health Board

Waikato District Health Board

Operating capacity

12 plus one high care secure lounge. Ten bedrooms were located in the main accommodation wing and two bedrooms in a separate pod area.⁷

Last inspection

Unannounced inspection – August 2014

Announced inspection – December 2009

⁵ *Student Nurse Welcome Pack* Puna Awhi-rua.

⁶ The forensic service includes Puna Awhi-rua as well as Puna Maatai and Puna Poipoi.

⁷ The separate pod area could be designated for specific service users groups such as those with an intellectual disability or female service users.

The Inspection

Three Inspectors conducted the inspection of the Ward between 16 and 20 September 2019.

On the first day of the inspection, there were 13 service users in the Ward, comprising two females and 11 males. The Ward was over capacity by one service user at the time of the inspection. There were three people on the waiting list for forensic beds with individual wait times ranging from one week to four months. The average length of stay for the preceding six months was 119 days.⁸

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (CNM) and Associate Charge Nurse Manager (ACNM), before being shown around the Ward.

Inspectors were provided with the following information during and after the inspection:

- a list of service users and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data from 1 March to 31 August 2019, and the seclusion and restraint policies;
- any meetings/reports relating to restraint, seclusion minimisation, and adverse events;
- records of staff mandatory training, including Safe Practice Effective Communication (SPEC);
- service users absent without leave (AWOL) events from 1 March to 31 August 2019;
- details of all sentinel events⁹ from 1 March to 31 August 2019;
- complaints received from 1 March to 31 August 2019, a sample of responses and associated timeframes, and a copy of the complaints policy;
- activities programme;
- information provided to service users and their whānau on admission;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number); and
- data on staff, categorised by profession.

⁸ This is based on 'average length of stay' data provided by the Service, which recorded 'zero' days as the average length of stay in Puna Awhi-rua for the months March, April and August 2019.

⁹ Sentinel events are unanticipated events in the healthcare setting which have generally resulted in serious harm to service users.

Inspection focus

The following areas were examined to determine whether there had been torture or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on service users.¹⁰

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Seclusion/High Care Secure Lounge
- Seclusion policies and events
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Service users' and whānau views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Access to bedrooms
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes
- Social worker and Alcohol and drug clinician
- Cultural and spiritual support

¹⁰ 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.appt.ch.

Communications

- Access to visitors
- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of managers, staff and service users. Whānau were also spoken with.¹¹

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

Recommendations from previous report

The Inspectors followed up on two recommendations made by my predecessor, following an inspection of the Ward in August 2014,¹² which were:

- a. Service users should be able to use the telephone in private.
- b. A checklist needs to be put in place to ensure the admissions process is fully completed (including physical examinations) and arrangements put in place to ensure appropriate screening for long-term service users.

The extent to which the DHB has implemented these prior recommendations is referred to in the relevant sections of this report.

¹¹ For a list of people spoken with by the Inspectors, see Appendix 1.

¹² *OPCAT report on an unannounced visit to Puna Awhi-rua Forensic Inpatient Ward under the Crimes of Torture Act 1989*, August 2014

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

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

Over occupancy and a lack of resources were creating significant pressure for staff and service users in the Ward. Staff advised my Inspectors that ‘sleepovers’¹³, the practice of service users being temporarily transferred into the Ward to spend the night to relieve pressure on other wards in the Henry Rongomau Bennett Centre, had become a regular occurrence.

At the time of inspection, sleepovers were occurring in the Sensory Modulation Room, a non-designated bedroom with a hospital bed and no bathroom facilities. The room’s location was in the middle of a thoroughfare with high levels of foot traffic and compromised service users’ privacy.

I consider the accommodation of service users in rooms other than designated bedrooms amounted to degrading treatment and a breach of Article 16 of the Convention against Torture.

The placement of service users in the Ward with high and complex needs¹⁴, and intellectual disabilities that were not forensic service users¹⁵ compromised service users care and limited opportunities for recovery.

Staff made a significant effort to ensure that all service users in the Ward were cared for effectively and treated respectfully. However, my Inspectors were told that not all staff had the necessary knowledge and skills to deal with such a diverse service user group.

Following the inspection, a review of the Ward seclusion data identified one such service user had been secluded¹⁶ in the high care secure lounge (HCSL) between 18 March and 14 June 2019. The seclusion event commenced following an assault on a staff member. After almost three months in the HCSL, the service user was transferred to Puna Maatai Ward.

¹³ ‘Sleepovers’ is the term used by staff at the HRBC. Sleepovers involve service users having to move to other wards to sleep. Inspectors observed service users on sleepovers in the Ward over a number of days.

¹⁴ Information provided by the Service indicates that high and complex needs service users are people presenting with a number of bio-psycho-social-occupational and cultural complexities that cause barriers to their transition and reintegration from the Ward back into the community. These barriers may include factors such as: no identified funding stream available, exited from residential providers due to their behaviour, having a number of medical comorbidities, exhibiting a high risk for residential providers, such as excessive illicit drug and alcohol use, and/or having personality traits and/or disorders that interfere with treatment. *Waikato DHB Inpatient Coordination Team. Operating Manual.*

¹⁵ Non-forensic service users were all under a compulsory detention order.

¹⁶ Seclusion is where a person is ‘placed alone in a room or area, at any time and for any duration, from which they cannot freely exit’. New Zealand Standards. Health and Disability Services Standards. Ministry of Health. 2008.

Approximately one month into the seclusion event, the service user consented to being placed on a 'Night Safety Procedure' (NSP). The NSP, in place between the hours of 8pm and 8am, negated the need for the same level of observation and assessment required for a service user in seclusion – for example, the requirement for two hourly room entries, and eight hourly reviews by a psychiatrist.¹⁷

The multi-disciplinary team (MDT) rationale for using the NSP stated:

MDT rationale: to attempt to develop more trust/rapport with this service user and therefore a way forward to terminate this seclusion episode by:

- *Allow less intrusive observations (from constant to 10 minutes/thereabout check)*
- *More privacy for the use of toilet, to meet personal needs etc.*
- *More opportunity to sleep better, less disruptive lighting from the HCSL office.*

The service user withdrew their consent to the NSP on 14 May 2019, and returned to 24 hour seclusion monitoring.

The service user had a number of periods out of the seclusion room with staff, for example to eat their lunch in the poolroom. Furthermore, seclusion documentation detailed consecutive weeks of room entries and interactions with the service user, without incident.

Inspectors noted a number of seclusion reviews by doctors were conducted over the phone in breach of the Service's *Seclusion Procedure*, which states: '*The responsible clinician or delegate completes an 8 hourly, face to face assessment of all service uses/tāngata whaiora in seclusion*'.

Clinical review meeting minutes¹⁸ for the service user stated: '*Please capture risk as stated by (service user) on any occasion that it's admitted – does not meet the DASA¹⁹ criteria for risk*'. Seclusion documentation showed DASA scores of zero, one and two at various times throughout the seclusion period.

I consider the justification for continuing seclusion over a period of over 16 weeks was not established. The seclusion documentation regularly described a service user who did not demonstrate an imminent risk to the safety of others. The service user had numerous transition periods out of the seclusion room without incident. Additionally, as documented in clinical review meeting minutes they did not meet the Ward's DASA criteria for risk, nor did the seclusion adhere to the Service's *Seclusion Procedure*.

¹⁷ The Ministry of Health seclusion guidelines state '*it is mandatory that a suitably qualified clinician shall psychiatrically assess the review of a person in seclusion occur at least once every eight hours*'. Eight hourly reviews assess, among other things, the need for a patient to remain in seclusion. Ministry of Health. 2010. Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992: Ministry of Health.

¹⁸ Meeting minute action points of 10 May 2019 and 24 May 2019.

¹⁹ DHB's Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA: IV). DASA score 0 or 1 level of risk low, 2 or 3 moderate, over three3 high.

I consider prolonged seclusion in these circumstances was degrading treatment and a breach of Article 16 of the Convention against Torture.

Seclusion/High Care Secure Lounge

Seclusion/High care secure lounge facilities (HCSL)

The Ward had one HCSL with en-suite bathroom facilities. This area was used as a seclusion room when required. The room was of a reasonable size, clean and bright and opened into the Ward's main courtyard area. However, there were no integral blinds on the external windows or door in the HCSL room to afford privacy or to alter the amount of light entering the room.

The positioning of the toilet provided privacy for service users. A television (situated behind toughened glass) was available for service users but controlled by staff. A clock situated in the staff area of the HCSL enabled service users to orientate to time; however, there was no ability for service users to maintain orientation to the date. I consider that a more permanent fixture is required in the seclusion area to ensure service users' ability to orientate to day and time.

Service users in the HCSL were able to access fresh air in the internal courtyard; however, there were no facilities for service users when in seclusion in the HCSL to access a low stimulus area. Neither was there a de-escalation²⁰ lounge to transition from seclusion to the main Ward.²¹ Staff advised Inspectors that the 'poolroom'²² was used to assist the gradual reintegration of service users' back into the Ward. It is concerning that there is no de-escalation area on the Ward to assist in both the de-escalating and reintegration of service users.

Staff told Inspectors that finger food was provided to service users in seclusion; however, this was on a case-by-case basis assessed on risk. For prolonged periods in seclusion (over 24 hours), I have concerns about the quality and variety of food provided.

There were no service users in the HCSL during the inspection.

²⁰ De-escalation is 'A complex process in which the highly aroused [service user] is re-directed from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely, appropriate, and effective interventions and is achieved by service providers using skills and practical alternatives'. New Zealand Standards. *Health and Disability Services (General) Standards*. Ministry of Health. 2008.

²¹ The Ministry of Health seclusion guidelines state that 'a planned and graduated process of reintegration into the ward may be required, particularly after a prolonged period in seclusion'. Ministry of Health. 2010. Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.

²² A smaller room (poolroom) off the main lounge that had an air hockey table, table soccer, TV and gaming console.



Figure 1: High care secure lounge



Figure 2: High care secure lounge en-suite

Seclusion policies and events

A copy of the Service's *Seclusion Procedure 1860* (dated 28 August 2017) was provided to Inspectors. The procedure had a review date of 28 August 2020.

Data provided by the Service indicated that for the period 1 March to 31 August 2019 there were 35 seclusion events involving nine service users. The total seclusion time was 2090.89 hours. This is broken down as follows:²³

Table 1: Seclusion events 1 March to 31 August 2019²⁴

Month	Events	Service user numbers	Hours	Average hours
March	3	2	734.59	244.90
April	13	1	173.40	12.38
May	15	2	893.28	59.55
June	1	1	67.50	67.50
July	2	2	197.29	98.64
August	1	1	24.83	24.83
Total:	35	9	2090.89	59.73

²³ The figures in the table are those provided by the Service. Additional analysis of raw data by Inspectors resulted in some differences for the total and average hours.

²⁴ As reported by the Service.

My Inspectors found a number of discrepancies in the data for the period 1 March to 31 August 2019. For example, within the aggregated data provided above, the average seclusion hours appear to be incorrectly calculated. Further, analysis of the underlying data provided by the Service suggests that there was also a single seclusion event that crossed over the end of March, April, and May and up until mid-June, which appears to have been recorded incorrectly.

I therefore do not have full confidence in the accuracy of the information. However, the data available is sufficient to reach some conclusions around the use of seclusion in the Ward.

The data provided indicates a significant increase in seclusion events from the inspection in 2014. Comparable information for 1 January to 30 June 2014 showed only three seclusion events in the Ward.

I acknowledge that work is underway to reduce the use of seclusion across the Service. Further information provided by the Service shows that a Seclusion Elimination Steering Group has been established and meets regularly. The information provided demonstrates a commitment to reducing seclusion, including for Māori. However, the progress of this work is slow and the data indicate that the work is yet to have an impact on the rate of seclusion in the Ward.

I therefore consider that action is required to reduce the use of seclusion.

Restraint

A copy of the Service's *Restraint Policy 2162* (dated 10 March 2017) was provided to Inspectors. The policy was due for review on 1 July 2019 and was out-of-date.

Data supplied by the Service showed that for the period 1 March to 31 August 2019 there were 10 episodes of restraint involving nine service users. This is broken down as follows:

Table 2: Restraint data (exclusive of seclusion data) from 1 March to 31 August 2019²⁵

	March	April	May	June	July	August
Total restraint episodes	2	0	3	0	1	4
Total service users restrained	1	0	3	0	1	4
Personal restraint ²⁶	0	0	2	1		1

²⁵ As reported by the Service.

²⁶ Personal restraint is when a service provider(s) uses their own body to limit a service user's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

	March	April	May	June	July	August
Mechanical/physical ²⁷	0	0	0	0	0	2
Environmental (door locking) ²⁸	2	0	0	0	0	0
Police restraint	N/A	N/A	N/A	N/A	N/A	N/A
Number of males restrained	2	0	3	0	1	3
Number of females restrained	0	0	0	0	0	1
Youngest person restrained	70	N/A	24	N/A	23	23
Oldest person restrained	70	N/A	59	N/A	23	59

My Inspectors identified several discrepancies with the data provided. The Service reported ‘ongoing issues’ with the recording of restraint on the *Restraint Event Notification* form resulting in inaccurate data capture.

Consequently, I do not have confidence in the data that has been provided.

Inspectors made an additional post-inspection request for restraint data. The amended additional data provided to Inspectors showed two episodes of physical restraint for the purpose of dental visits.

The Service also confirmed that they do not record information on the ethnicity of service users who have been restrained. Understanding how restraint is applied to different populations is important to understanding whether it is used equitably. The need to collect this information in relation to Māori arises from the principles of te Tiriti o Waitangi²⁹

²⁷ As per the Service’s *Restraint – Wrist and/or Ankle Procedure 2158*: Universal wrist and/ or Ankle Restraint are the only items authorised.

²⁸ ‘Where a service provider intentionally restricts a consumer’s normal access to their environment, for example where a consumer’s normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied’. Ministry of Health’s clarification of NZS 8134.2.2008 *Health and Disability Services (Restraint minimisation and Safe Practice) Standards environmental restraint*.

²⁹ Specifically the principles of equity and active protection, which include a requirement to be fully informed of how Māori are treated. See, for example, Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wellington, Legislation Direct, 2019) p 138.³⁰ SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies,

I therefore recommend that the Ward take all necessary steps to enable the collection and reporting of restraint data by service users' ethnicity.

Restraint training for staff

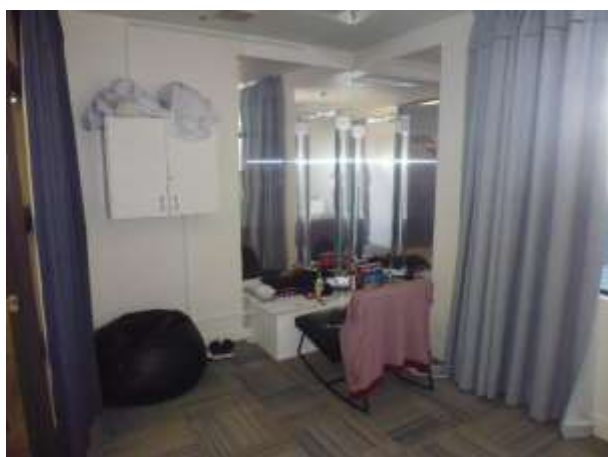
Inspectors were informed that refresher Safe Practice Effective Communication (SPEC) training was provided every two years. Information provided by the Service showed that 36 of the 38 Ward staff were up-to-date with SPEC training.³⁰ The Service informed Inspectors that refresher training was to occur, however no dates were provided.

Electro-convulsive therapy

There were no service users undergoing electro-convulsive therapy (ECT)³¹ in the Ward at the time of the inspection.

Sensory modulation

At the time of Inspection, the Sensory Modulation Room³² was not available to service users for its intended purpose. It was being used as an additional bedroom and had been for approximately 12 months. The use of this room as a bedroom had become normalised.



alongside the provision of training in safe, and pain free personal restraint techniques.

<https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149>.

³⁰ SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. <https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149>.

³¹ Electroconvulsive therapy is used mainly in the treatment of severe depressive episodes. It involves the passage of an electric current across the head of a person to produce a convulsion. <https://www.health.govt.nz/publication/electroconvulsive-therapy-ect>

³² The Service's *Sensory Modulation Procedure 3248* (dated 28 Jan 2019): 'A therapeutic environment specifically designed to promote self-organisation and positive change. Sensory modulation rooms can be used for de-escalation and for identifying new skills and preferences that can be transferred to other environments.'

Figure 3: Former sensory room

Figure 4: Former sensory room

This area was not a designated bedroom and it was inappropriate for it to be used in this way. At the time of inspection, the Ward's only Occupational Therapist (OT) was on leave and all sensory modulation equipment was stored in the OT office area. Individualised sensory modulation was not available to service users at the time of inspection.

Service users' and whānau views on treatment

Service users informed Inspectors that they generally felt safe in the Ward, and with the standard of care in the Ward. Inspectors observed respectful and positive interactions between service users and staff.

Service users spoken with by Inspectors were complimentary about the staff and the management of the Ward. They understood their programmes, medications, leave entitlements and visiting arrangements for friends and whānau. Service users reported that staff were very respectful and helpful, that their confidentiality was maintained and that there was always a staff member to talk to.

Service users reported they were given the opportunity to be fully involved in their recovery plan. Both service users and their whānau stated they were regularly encouraged to attend Multi-Disciplinary Team Meetings (MDT), as well as whānau hui on Fridays respectively.

A weekly community meeting was held on the ward. Staff and service users confirmed that the Consumer Advocate attended. Service users could contact the Consumer Advocate by issuing a request to nursing staff.

Inductions into the Ward appeared inconsistent. Service users commented that much information about Ward routines and rules was learnt from other service users. Service users stated that they did not receive an information pack on admission to the Ward.

Service users spoken to expressed frustration at being unable to access their bedrooms freely from 7.30am to 2.30pm during the week and from 10am to 2.30pm on weekends.

Whānau spoken with advised Inspectors that they felt their whānau members were treated well on the Ward. However, some stated that the duration of visits was short, and that there was a lack of activities for their whānau at the weekend.

Whānau raised concerns that they did not receive any information booklet in regards to support available to them, or information on how to access advice.

Recommendations – treatment

I recommend that:

1. Rooms such as the sensory modulation room, high care secure lounge, day rooms or offices never be used as bedrooms.
2. Staff receive training to enhance knowledge and skills for dealing with service users designated as having an intellectual disability or high and complex needs.
3. All seclusions adhere to the Service's *Seclusion Procedure*.
4. Privacy blinds be fitted to the external seclusion room windows and door.
5. Improvements are made to the seclusion room to enable service users to maintain orientation to date and time.
6. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of seclusion data.
7. Policies and procedures are up-to-date.
8. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of restraint data, including by service users' ethnicity.
9. Service user induction packs and whānau information packs are provided as a matter of routine.

Puna Awhi-rua comments

The DHB accepted recommendations 5, 7 and 8.

The DHB partially accepted recommendations 1, 2 and 9.

The DHB rejected recommendations 3, 4, 6.

Recommendation 1 response:

The DHB did not provide a specific response to recommendation 1. However, the DHB's overall response to this report and the inspections of a further three wards³³ contained information concerning the theme of over occupancy highlighted in all reports. The DHB commented in its general response that the inspection team may not have been provided full detail of the work underway to address the issues of high occupancy. It stated that an Acute Sustainability Response Plan was implemented in June 2019 to address the significant pressures on inpatient services, and that associated risks had been noted as diminishing.

³³ Wards 34,35, and 36, Puna Maatai, and Puna PoiPoi.

The DHB also commented in its general response that data relating to occupancy levels was showing a downward trend.

Ombudsman response:

I acknowledge that work is currently underway to address the issue of over occupancy on the Wards and I support the Service's development of the Acute Sustainability Response Plan. I reiterate that recommendations relate to the conditions and evidence my Inspectors found during the time of inspection. The inspection teams' findings, based on Inspectors' observations and information provided by the Service, were that high occupancy levels were an ongoing issue at the time of inspection.

I emphasise my expectation that rooms such as day rooms, offices or seclusion rooms should never be used as bedrooms.

Recommendation 2 response:

The ability to provide care to service users with high and complex needs is a component of ongoing development of staff skills and knowledge in a mental health and addictions service. All staff are able and skilled to work with individuals with complex needs, owing to the nature of the complexities which are present in the forensic population.

There is currently a national process in place looking at MH workforce development on secure intellectual disability care.

The mental health and addictions service provided training by Altogether Autism in 2019. Additional training will be looked into during the first quarter of 2020.

Recommendation 3:

The DHB made the general comment that efforts are underway to reduce seclusion by a dedicated group with initiatives including data and reporting.

Ombudsman response

As noted above, my Inspectors identified an instance of a service user in seclusion where the relevant procedures were not adhered to.

Recommendation 4 response:

Privacy is facilitated through frosting of the glass windows for the seclusion room and restriction of courtyard use outside the seclusion room when in use, this allows for the individual to both have adequate natural light and to look out onto the courtyard gardens. This is monitored by the CNM.

Ombudsman response:

I have reviewed the information provided and consider that frosting of the glass window and door does not fully address privacy issues, as it was only a partially frosted pattern. Integral blinds would address this issue and would also allow the service user to regulate the amount of light entering the room.

Recommendation 5 response:

Staff currently put a means of orientation to time in place when a service user is in the seclusion room. A permanent fixture providing orientation to date and time will be sourced.

Recommendation 6 response:

The DHB made the general comment that 'The use of Seclusion is monitored and reported clearly to the highest levels of clinical and operational leadership in the service'.

Ombudsman response:

My concerns regarding the accuracy of data remain.

Recommendation 9 response:

Service user and whānau information will be a component of the service user and whānau orientation to the ward environment. Work on this process is already under way.

Protective measures

Complaints process

A copy of the Service's *Consumer Feedback and Complaints Policy 0101* (dated 28 January 2019) was provided to Inspectors. The procedure had a review date of 18 January 2022.

Complaint forms were not available on the Ward on the first day of the inspection. Inspectors brought this to the attention of staff and the issue was remedied.

The complaints process was displayed in the communal areas of the Ward. Copies of the Service's feedback form '*Your feedback*' were located alongside the complaints box and easily accessible by service users.

Service users said they knew how to make a complaint and felt supported by staff if they needed assistance. Inspectors spoke to a number of staff in relation to service users' complaints and all were familiar with the process.

Information provided to Inspectors recorded no complaints for the period 1 March to 31 August 2019.

Posters for the Health and Disability Commissioner's '*Code of Rights*' were also displayed in the Ward.

Contact details for District Inspectors (DI), while on display in the staff office, were not displayed in the Ward. Service users instead had to request staff contact the DI on their behalf. Staff informed Inspectors they regularly facilitated these phone calls. Various explanations provided for the restriction on access to DI's contact details.

It is the statutory role of District Inspectors to hear service users' complaints and of the facility to ensure that service users are informed of this.³⁴

I therefore consider that it is insufficient for District Inspectors' details to be accessible only on request; these details should be clearly visible on the Ward.

Records

There were 13 service users in the Ward on the first day of the inspection. Inspectors reviewed all service users detaining paperwork. All files contained the necessary documentation authorising the detention (and treatment) of the service users' in the Ward.

Seven service users were detained under the Criminal Procedure (Mentally Impaired Persons) Act 2003 and six service users' were detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

My Inspectors also reviewed service users' files for evidence of completed consent to treatment forms. While service users in the Ward are not there voluntarily, it is standard to seek consent to treatment wherever possible. Staff confirmed this expectation with Inspectors.

Consent to treatment forms were available for 12 service users. The remaining service user, who had declined to sign the consent to treatment form, had this noted on their file. Service users were given a copy of their detaining paperwork. If service users declined the paperwork, staff documented the reasons on their file. Whānau contacts and associated levels of disclosure³⁵ were comprehensive and clearly documented on file.

At the time of the inspection, eight service users had approved Ward leave of various levels.³⁶ Five service users did not have approved leave.

The Ward had one absent without leave (AWOL) event for the period 1 March to 31 August 2019. Inspectors reviewed the paperwork for this event. Documentation and process was in order.

Inspectors reviewed copies of service users' recovery plans, approved leave forms, clinical review meeting minutes, and recovery review meeting minutes. All documentation was thorough, although service users had not signed their recovery plans. Inspectors found service users' electronic files comprehensive and easy to navigate.

Inspectors observed two effective shift handovers, during which staff discussed service users' behaviour, risks and care.

³⁴ Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 64 (2)(g). The functions and powers of District Inspectors is located in sections 94 to 98 of the Act.

³⁵ Waikato District Health Board – *Consent treatment/Consent to sharing information* (A3114MHF)

³⁶ There are six types of patient leave available: escorted ground leave, unescorted ground leave, escorted community leave, unescorted community leave, overnight leave up to three nights and overnight leave up to six nights.

Recommendations – protective measures

I recommend that:

10. Complaint forms are readily available in the Ward.
11. District Inspectors contact details are displayed on the Ward.
12. Recovery plans are routinely signed by service users and refusal to sign is recorded in their files.

Puna Awhi-rua comments

The DHB accepted recommendation 10.

The DHB rejected recommendation 11.

The DHB partially accepted recommendation 12.

Recommendation 10 response:

CNM's will ensure complaint forms are readily available for service users.

Recommendation 11 response:

Providing the contact details on the wards would result in the following:

- *It would not be clear as to which District Inspector is on duty*
- *The District Inspectors would receive calls about matters that are unrelated to the role of the District Inspector*
- *The District Inspectors are always accessible by staff and will speak to service users put through by a staff member at any time.*

Ombudsman response:

I acknowledge the DHB's comments. However, I do not consider the reasons provided justify the restriction on access to District Inspectors' contact information. Service users should be able to contact District Inspectors at any time, independent of staff.

There should be practical ways of mitigating the issues raised while also improving accessibility and visibility of the District Inspectors' contact information. My Inspectors have observed several facilities where this information is displayed prominently without this proving to be problematic.

Recommendation 12 response:

Recovery plans are electronic. There is now a box included to indicate that the recovery plan has been sighted and agreed to by the service user.

Material conditions

Accommodation and sanitary conditions

The Ward was clean and tidy, and walls and floor coverings were in good condition.

The main communal area of the Ward was comfortably furnished with large leather armchairs and beanbags. There were high levels of natural light from large windows overlooking an open courtyard. Inspectors noted that there was a lack of ancillary space for service users, the poolroom being the only separate area generally available to service users.

Windows in the Ward lounge opened with a safety latch to provide ventilation.



Figure 5: Typical bedroom



Figure 6: Men's bathroom

The 10 bedrooms in the male accommodation wing were spacious and had good natural light. Rooms had curtains for privacy and a small freestanding wardrobe unit with shelves and a lockable cupboard, although keys were not issued for the cupboards. All rooms had a means of raising the alarm. There were four bedrooms with en-suite toilet facilities and all other rooms had easy access to toilets and showers.

Two toilets, directly off the main communal area, were available for male service users to use during the day. Female service users accessed their pod area to use the bathroom.

The large bathroom had signage indicating it was accessible for disabled people; however, there were no fittings to aid accessibility. Staff advised that a seat was available for service users who needed support to use the shower. There were a sufficient number of showers in the Ward for the number of service users. Toiletries were provided to service users.

Laundry facilities were available for those wanting to launder their own clothes. Service users were encouraged to use these facilities to maintain personal hygiene and were provided with clean bedding each week.

At the time of inspection, a separate pod area had two allocated women's bedrooms. Both rooms had en-suite toilet facilities and a shared shower; storage for personal possessions, curtains for privacy and a means of raising the alarm. During the inspection, both bedrooms were in use by female service users.



Figure 7: Women's lounge



Figure 8: Women's en-suite toilet

There was a small lounge in the separate pod area for female service users if they wanted to use it. The lounge contained comfortable seating and a television and stereo.

Service users were permitted to decorate their rooms with photos and posters, however, few had done so. Bedroom doors could be locked from the inside but were not able to be locked by service users when leaving their rooms.

Bedroom observation panels had Velcro curtains on the outside. These could easily be lifted or moved to one side by other service users which could compromise service users' privacy.

Bedroom windows could not be opened for ventilation.

Access to bedrooms

A copy of the Service's *Bedroom Access for service users – Puna Awhi-rua and Puna Maatai Procedure*³⁷ 0512 (30 July 2018) was provided to Inspectors. The procedure had a review date of 30 July 2021.

³⁷ The Service's *Bedroom Access for service users – Puna Awhi-rua and Puna Maatai Procedure* states: Bedroom access is provided for the following reasons:

- To enable attention to ADLs (activities of daily living) at various times of the day, introducing some flexibility into the structured/secure environment.
- To provide period of 'quiet time' enabling service users/tāngata whaiora to have time to self/privacy/rest and assist in maintaining the therapeutic milieu.

Service users' access to their bedroom throughout the day was restricted. Service users were not permitted to access their bedrooms during the stated locked periods.³⁸ Those wishing to access the bedroom area outside of stated times to get something from their bedroom, or to shower, were locked in the corridor area (male accommodation wing). Service users were not able to stay for any length of time in these instances.

Staff told Inspectors that the restriction placed on service users' access to their bedrooms was to both encourage better sleep hygiene³⁹ and support service users' engagement in the therapeutic programme. However, staff also told Inspectors that attendance at therapeutic programmes was not compulsory.

The Services *Bedroom Access for service users – Puna Awhi-rua and Puna Maatai Procedure* states that bedroom access is to be provided for a number of reasons, including periods of 'quiet time' enabling service users to have time to themselves, for privacy and rest. Inspectors observed service users sleeping on couches and beanbags in the communal area throughout the inspection. Service users stated to Inspectors that they were not happy with the restricted access to their bedrooms. The same level of restriction to bedrooms was not reflected in Puna Maatai, which was an acute forensic ward.

While I acknowledge the Ward's efforts to encourage engagement in therapeutic programmes, I consider the current arrangements for service user access to their bedrooms unduly restrictive. Further, this practice does not adhere to the Service's *Bedroom Access for service users – Puna Awhi-rua and Puna Maatai Procedure*.

Food

Service users could choose their meals from a daily menu and dietary requirements were provided for. Staff and service users could order small, medium or large portions. Menu choices changed every two weeks. Service users were able to choose from a "chef's special" six times per fortnight, three at lunch and three at dinner. Staff in the small servery area attached to the dining room prepared breakfast. Lunch, dinner and supper were prepared in the hospital kitchen and transported to the Ward in a trolley.

Inspectors observed the lunch meal and the quality and quantity of the food appeared satisfactory. Service users spoken to advised that the quality and volume of food provided was very good.

All meals were taken in the dining area. On weekdays, breakfast was between 7.30am and 8am and from 8am and 8.30am on weekends and public holidays. Lunch was served at midday,

-
- Sleeping purposes.
 - To provide service users/ tāngata whaiora a structured/safe/therapeutic environment at promoting recovery.

³⁸ Puna Awhi-rua House Rules restricts free access to bedrooms from 7.30am to 2.30pm and again at 5pm during dining hours on weekdays. Lock times for bedrooms on weekends and the school holiday period are from 10am to 2.30pm.

³⁹ 'Sleep hygiene' is a term that health professionals use to describe good sleep habits. Source: www.healthinfo.org.nz/patientinfo/46895.pdf

dinner at 5pm and supper at 7pm. Morning and afternoon tea, including a selection of fruit was made available at 10am and 2pm respectively.

Outside of meal times, the dining area was locked. Service users were unable to access the kitchen area to make their own hot drinks during the day. The Ward provided a water cooler for service users to access cold drinks throughout the day.

My Inspectors were advised staff conduct a weekly shop on Saturday for service users who wish to purchase snacks. Snacks are stored in the dining room, and accessible to service users at 7pm. Snacks were eaten in the dining room to avoid tension on the Ward as not all service users had the funds available to make purchases. Service users were able to have takeaways on Friday evening.

I am concerned that the blanket restriction on access to the kitchen adversely affects service users' ability to access hot water and other personal food items as and when they wish.

Recommendations – material conditions

I recommend that:

13. Observation panels in bedroom doors provide privacy from other service users.
14. Service users have increased access to their bedrooms during the day.
15. Service users are able to freely access hot drinks, unless deemed unsafe based on individual risk assessment, and have their own food on the Ward at any time.

Puna Awhi-rua comments

The DHB rejected recommendations 13 and 14, and an earlier iteration of recommendation 15.⁴⁰

Recommendation 13 response:

The curtains on the bedroom windows are consistent across the service to enable privacy and a means of observation for safety purposes by staff. The service has no record of service user complaints about their privacy not being maintained through the use of these curtains.

Ombudsman response:

I remain of the view that action is required to address the issue of other service users being able to lift the curtains.

⁴⁰ Service users are able to freely access hot drinks and have their own food on the Ward at any time.

I consider that there will be other practical ways of ensuring a means for staff observations while also safeguarding the privacy of service users. For example a lockable shutter with staff only access.

Recommendation 14 response:

Increased access to bedrooms during the day has in the past impacted on the ability to facilitate the rehabilitation programme on the ward. Service users are more motivated to participate in programmes when they do not have ready access to their bedrooms. The bedrooms are opened during the day for rest times after lunch. There is open access to bedrooms in the weekend and during the break in the formal therapeutic programme which coincides with school holidays.

Ombudsman response:

As noted above, while I acknowledge the Ward's efforts to encourage engagement in therapeutic programmes, I consider the current arrangements for service user access to their bedrooms unduly restrictive. Further, this practice does not adhere to the Service's *Bedroom Access for service users – Puna Awhi-rua and Puna Maatai Procedure*.

The DHB has also raised an issue of the clinical risk presented by some individuals at times. However, the current blanket policy disadvantages all service users irrespective of safety risk. I consider that access to bedrooms should be facilitated based on individual risk and subject to regular review.

Recommendation 15 response:

There is a safety aspect of care for both service users and staff. The potential for injury through hot drinks being thrown is a risk within the forensic area of practice. They are however regularly provided and can be made when requested.

Ombudsman response:

I acknowledge the safety concerns. However, it is not clear to me why a hot drink made by a staff member is less likely to cause injury than one made by the service user. My Inspectors' observations are that there is not a consistent approach to this issue across all facilities. The current policy on the Ward disadvantaged all service users as it applied to everyone irrespective of safety risk. I consider that free access to hot drinks should be available for all service users unless deemed unsafe based on an individual risk assessment. I have adjusted my recommendation accordingly.

Activities and programmes

Outdoor exercise and leisure activities

The Service provided Inspectors with a copy of the *Courtyards Procedure 0516* (dated 22 February 2019). The procedure had a review date of 22 February 2020.

There were two outside areas available to service users; a large courtyard shared with Puna Maatai and a smaller internal courtyard. The large courtyard had a volleyball court as well as a basketball hoop, and tables and chairs. Access to the large courtyard was through a door at the end of the Ward.

Access to the second smaller internal courtyard was through a door directly opposite the nurse's station and had large windows along the side of the Ward giving good vision into the area. There were raised planter boxes containing both flowers and vegetables that service users could tend. There was ample seating available and the area was bright and colourful with a large mural completed by service users on a wall. Service users when placed in the HCSL also used this courtyard. When the HCSL was in use, other service users used the internal courtyard at the discretion of the CNM.

Access to both courtyards was with direct supervision of staff. During the inspection the smaller courtyard was open and in use for long periods and was well utilised by service users. Staff told Inspectors the only time the courtyards were not utilised was when there were staff shortages.

During medication rounds and meal times, service users were not able to access the courtyard.

The Ward lounge had a TV, a well-stocked library cupboard, pool table, table tennis table, craft cupboard and a variety games and puzzles. A smaller room (poolroom) off the main lounge had an air hockey table, table soccer, and TV and gaming consoles.

A well-equipped gym located outside of the Ward was available two days a week for a structured gym programme delivered by an external contractor. Outside of the structured programme, trained Ward staff supervised service users in the gym when sufficient staff were available. The gym, which was also used by service users from Puna Maatai and Puna Poipoi, had recently been refurbished, was well equipped and in good condition. Service users received a physical examination before using the gym.

A woodwork room was available for craft and woodwork activities. This area was clean and tidy and held many examples of work by service users. Staff supervision was required in this area. Staff reported that this area was used infrequently often due to health and safety concerns.

A structured programme of daily activities including art, kapa haka and Māorioko⁴¹ was available to service users. The Ward's Occupational Therapist Assistant (OTA) provided encouragement and engagement in activities on the Ward.

⁴¹ Karaoke sessions conducted in the whare.

Women in Secure Environments (WISE)⁴² women's group was available for female service users. Inspectors noted one female service user from the Ward attending the group during the inspection.

At the time of the inspection, eight service users had approved Ward leave ranging from escorted hospital ground leave to family supported leave.

The Ward held an annual whānau day that both service users and whānau reported as enjoyable.

However, service users reported boredom due to the lack of structured activities to occupy them. Staff also reported that service users had a significant amount of unoccupied time, particularly at weekends.



Figure 9: Main courtyard



Figure 10: Poolroom

Programmes

A cross-service therapeutic programme was in place across the three forensic wards, with a mix of open and closed groups divided into four terms per year. Courses were between eight and 10 weeks in duration. Service users could not join closed groups part way through a term, but were able to join them in subsequent terms.

There were six closed group therapeutic programmes operating during the period of the inspection.

Clinical assessments informed participation in therapeutic programmes. Inspectors attended Short-Term Assessment of Risk and Treatability (START) and clinical meetings. These meetings were multi-disciplinary and staff showed a good understanding of service users' health needs.

⁴² Puawai Midlands Regional Forensic Psychiatric Services – *Welcome to our service - Women in Secure Environments* – Service User Information Pamphlet. WISE is a multi-region initiative “to ensure women service users accommodated in secure environments that their individual needs for emotional and physical safety” are met.

Inspectors were advised by staff that attendance at programmes was not compulsory; however, staff encourage service users to attend. At the time of inspection, seven service users were attending four of the six closed therapeutic groups. Information provided by the Service confirmed that seven service users in the Ward had participated in closed groups across the current term.⁴³

Inspectors reviewed a recently refreshed forensic service therapeutic programme that had several new treatment groups added or planned for future terms, including a violence prevention programme in 2020.

The majority of programmes and activities took place in the whare, which is located outside of the Ward.

The lack of provision of structured programmes and activities was a concern for service users who advised they had long periods each day where they had nothing to do. When asked what was available to do at weekends, one service user said that they 'sit around and eat'.

Social Worker and Alcohol and Drug Clinician

The Ward had a full-time equivalent (FTE) Social Worker who provided social support to service users and their whānau. They were the main point of contact for whānau throughout the inpatient admission; and the lead co-ordinator for organising whānau hui. Whānau hui generated from the MDT were conducted on Fridays as required. Inspectors were advised Whānau information packs used to be distributed, but this no longer occurred.

A FTE Alcohol and Drug (AoD) clinician was available to support service users with identified AoD needs. One-to-one AoD counselling was provided to service users along with the delivery of group sessions as part of the core therapeutic programme.

Cultural and spiritual support

The Kaitakawaenga visited the Ward daily and were active in providing cultural support to service users, including input into the therapeutic programmes and multidisciplinary meetings. As noted above, the Kaitakawaenga led the daily whakamoemiti involving karakia and waiata at the beginning and end of each session.

Inspectors also attended one of the open 'Māorioko' sessions in the whare, led by the Kaitakawaenga, where service users were able to sing karaoke along with staff. Engagement with staff during these sessions was positive.

The Kaitakawaenga had the role to provide support to new arrivals with a whakatau and then make contact with the service users after they had settled into the Ward.

The head chaplain advised he led a team of five chaplains that provided service across Waikato Hospital. Church services were facilitated each Sunday in the Ward's dining room.

⁴³ Term Three, 22 July – 27 September 2019.

Chaplains visit service users in the Ward following a request from staff.

The chaplain visited service users in seclusion (on request) provided the risk was not high. Inspectors reviewed seclusion documentation that indicated the chaplains attending to service user's spiritual needs when in seclusion.

Recommendations – activities and programmes

I recommend that:

16. Service users have increased access to activities and programmes, both on and off the Ward.

Puna Awhi-rua comments

The DHB rejected recommendation 16.

Recommendation 16 response:

The Forensic service has a therapeutic programme in place which is developed by the therapeutic coordinator...

In addition there are activities provided on the wards for clients to participate in if they choose, and group activities / challenges are organised by staff periodically throughout the year.

Ombudsman response:

I acknowledge that a therapeutic programme is in place and that activities are provided for. My Inspectors were provided with the therapeutic programme during the inspection and its contents had been taken into account in making my recommendation. I remain of the view that service users should have increased access to activities and programmes.

Communications

Access to visitors

The Service provided Inspectors with a copy of its guideline *Visiting Patients at Waikato Facilities 0125* (dated 1 July 2017). The guideline had a review date of 1 July 2020.

Supervised visits were able to take place between 4pm and 5pm and 6pm and 7.45pm on weekdays.⁴⁴

⁴⁴ For weekends and public holidays, visiting hours are 10am to 11.30am, 3pm to 4.45pm and 6.15pm to 7.45pm. (Waikato DHB – *Visiting Puawai inpatient forensic services – a visitor's guide*).

Visits took place off the Ward in a meeting room shared with Puna Maatai. The use of a meeting room for visits in the absence of a dedicated visits area was understandable, but the environment was not ideal. Visits were pre-booked 24 hours beforehand to suit the day-to-day operation of the Ward, however, visiting times could be flexible.

The number of visitors for a service use was restricted to four at any one visit; however, there was provision for more visitors on special occasions such as birthdays. Visits were generally 30 minutes for local visitors and one hour for out-of-area visitors. A member of staff was present during the visit.

Whānau could access petrol vouchers through the social worker to assist visits.

Whānau raised concerns with Inspectors about the strict time limit for visits. They felt this was not sufficient time to visit whānau members.

No service users reported any complaints about access to visitors.

Access to external communications

My predecessor made the following recommendation, following the 2014 inspection:

- a. Service users should be able to use the telephone in private.

My Inspectors were pleased to see that service users could conduct telephone calls in the poolroom with a staff member supervising. This afforded privacy from other service users on the Ward.

Service users were only able to access a telephone on request between 6pm and 9pm. Calls for legal purposes and to the District Inspector were able to be made at any time of day, again on request. Phone calls were restricted to 15 minutes. There was provision to accept incoming calls; however, these calls were limited to five minutes.

Staff reported to Inspectors that services users' restricted access to the phone during the day was in place to encourage service users' engagement with their programmes. Three service users had a signed phone plan that allowed alternative arrangements outside of the 6pm to 9pm regime. Service users could negotiate telephone calls outside of these times with a staff member or the wider treating team.

While internet access was not permitted for service users, there was a laptop available to assist service users with internet banking.

Service users could send and receive mail without censorship. However, staff screen incoming and outgoing mail on occasions.⁴⁵ Service users did not raise any concerns with Inspectors about the ability to send and receive mail.

I consider the regime for telephone access and length of call time to be unduly restrictive. It is necessary to have protocols in place to safeguard against prohibited or unsafe communication,

⁴⁵ As provided for under sections 123 and 124 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

such as where a protection or non-association order is in place. However, I am unaware of a compelling rationale for limiting personal calls to between 6pm and 9pm, particularly given the generally long periods of inactivity for service users during the day.

Recommendations – communications

I recommend that:

17. Service users have access to a telephone, independent of staff, at any time, unless deemed unsafe based on individual risk assessment.

Puna Awhi-rua comments

The DHB rejected an earlier iteration of recommendation 17.⁴⁶

Recommendation 17 response:

Access to telephone use is a security issue and is based on conditions of protection orders, and short stay provision of hospital level care for individuals from prison.

As service users progress through the forensic rehabilitation pathway access to phones is implemented as part of their recovery pathway and includes full use of personal cellphones.

Ombudsman response:

I acknowledge the concerns regarding security. However, my Inspectors' observations are that there is not a consistent approach to this issue across all facilities. The current policy on the Ward disadvantaged all service users as it applied to everyone irrespective of safety risk. I consider that independent access to a telephone should be available for all service users unless deemed unsafe based on an individual risk assessment. I have adjusted my recommendation accordingly.

⁴⁶ Service users have access to a telephone, independent of staff, at any time.

Health care

Primary health care services

My predecessor made the following recommendation, following the 2014 inspection:

- b. A check list needs to be put in place to ensure the admissions process is fully completed (including physical examinations) and arrangements put in place to ensure appropriate screening for long term service users.

Staff advised Inspectors that the Ward was not an admitting ward and therefore not required to have an admission checklist. In general, service users' come into the Ward via a transfer of care form from another ward. Admission information was stored electronically and staff said that nurses on the Ward check to ensure all necessary documentation has been completed, including the physical examination. Inspectors reviewed a number of service users' electronic records that confirmed the completion of physical examinations.

Inspectors were aware of a service user admitted directly to the Ward from prison. The service user advised Inspectors that they received a comprehensive induction to the Ward inclusive of physical examination. They further stated that they had regular health checks conducted on the Ward.

I consider that an admissions checklist should be in place for instances when a service user is admitted directly to the Ward.

Staff were proactive about arranging specialist medical appointments for service users and arranging the necessary leave applications for service users. Service users' electronic records contained details of health interventions and there was evidence of routine health screening and dental checks occurring. Service users' electronic records contained details of physical examinations. The House Doctor visited the Ward regularly.

My Inspectors were pleased to see weekly Hauora education sessions as part of the cross service therapeutic programme. The WISE group met fortnightly with a number of sessions focusing on health education specific to women.

The Pharmacist attended all MDT meetings and clinical review meetings, and completed medication reviews. The Pharmacist was present at the MDT meeting attended by my Inspectors.

A locked treatment room was available on the Ward for physical examinations. A separate locked medication room stored medications, including controlled drugs. Both rooms were tidy and well organised.

The Ward shared an emergency trolley, containing oxygen and a defibrillator, with Puna Maatai. The trolley was located on Puna Maatai.

Recommendations – health care

I recommend that:

18. A checklist be in place to ensure the admissions process is completed for new admissions to the Ward. **This is an amended repeat recommendation.**

Puna Awhi-rua comments

The DHB accepted recommendation 18.

Recommendation 18 response:

All wards will have an admission checklist in place appropriate to their context.

Staff

Staffing levels and staff retention

There was a good mix of age, gender, ethnicity and experience among staff. The Service conducts an annual review of staff gender balance.

Registered Nurses (RN) received an orientation to the Ward, which included the allocation of a preceptor.⁴⁷ Nurses that Inspectors spoke with were positive about the orientation they had received. All staff were encouraged to participate in clinical supervision.

There was an annual mandatory training schedule accessible to all Service staff.

The Ward did not have a Clinical Psychologist at the time of inspection. The position had been vacant since August 2019. Staff told Inspectors a new Clinical Psychologist would be in post at the start of December 2019. The Ward was also holding two vacant positions for one OT and one Occupational Therapist Assistant (OTA). Additional information provided to Inspectors indicated that the Ward was carrying vacancies for a 1.5 full time equivalent (FTE) RN.

Staff worked to a three-shift roster with a designated staffing level on each shift. The weekday morning shift ran from 7am to 4pm with five RNs and three Psychiatric Assistants (PAs), afternoon shift from 3pm to 11.30pm with three RNs and two PAs, and the night shift from 11pm to 7.30am with one RN and three PAs. The weekend morning shift ran from 7am to 4pm with four RNs and three PAs, afternoon shift from 3pm to 11.30pm with three RNs and two PAs, and the night shift from 11pm to 7.30am with one RN and two PAs.

Staff were complimentary of the leadership and management of the Ward. They reported feeling well supported and that they were part of a cohesive team environment. Inspectors'

⁴⁷ A preceptor is an experienced and competent nurse who provides support and learning experiences for a new graduate nurse.

observations during the inspection confirmed this. Staff worked well together and good practice was evident around team support and de-escalation of service users.

Over the course of the inspection, Inspectors observed staff spending the majority of their time actively on the Ward with service users.

Data provided by the Service indicated that during the period 2018/2019, staff turnover on the Ward had decreased considerably from the previous financial years.⁴⁸ Sick leave rates had declined somewhat over the same period.⁴⁹

Recommendations – staff

I recommend that:

19. The Ward provides more Occupational Therapy and Psychological services on the Ward.

Puna Awhi-rua comments

The DHB rejected recommendation 19.

Recommendation 19 response:

There are currently two occupational therapists, an occupational therapy assistant, a senior occupational therapist who runs the therapeutic programme, a psychologist and a visiting exercise and wellness specialist for this area.

Ombudsman response:

At the time of inspection, my Inspectors were unable to evidence adequate provision of both occupational therapy and psychological service for service users on Puna Awhi-rua due to the vacancies identified in the body of this report. While the service was utilising staff from other wards to provide some cover, this was not adequate. It is unclear from the DHB's response as to whether these roles are still being performed by Puna Maatai staff or whether these positions have since been filled.

I remain of the view that a full complement of staff dedicated to Puna Awhi-rua is essential to provide an appropriate service to the service users on this ward.

⁴⁸ The turnover rate in the Ward was 24.1 percent for the 2016/17 year, 19.4 percent for the 2017/18 year and 6.9 percent for the 2018/19 year.

⁴⁹ Staff sick rates in the Ward were 4.2 percent for the 2016/17 year, 3 percent for the 2017/18 year and 2.6 percent for the 2018/19 year.

Acknowledgements

I appreciate the full co-operation extended by the Charge Nurse Manager, Associate Charge Nurse Manager and staff to the Inspectors during their inspection of Puna Awhi-rua. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Managers	Ward staff	Others
	Charge Nurse Manager	Service users
	Associate Charge Nurse Manager	Family/whānau
	Clinical Nurse Specialist	District Inspector
	Registered Nurses	Kaitakawaenga
	Psychiatric Assistants	Chaplain
	Consultant Psychiatrist	Consumer Advocate
	Clinical Psychologist	
	Pharmacist	
	House Officer	
	Therapeutic Programme Coordinator	
	Occupational Therapist Assistant	
	Social Worker	
	Student social worker	
	Drug and Alcohol Clinician	
	Family/whānau Advisor	

Appendix 2. Legislative framework

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

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

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

Places of detention – health and disability facilities

Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

(d) a hospital

(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”

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

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

“...in health and disability places of detention including within privately run aged care facilities; ...”

Carrying out the NPM’s functions

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

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

Under sections 28 - 30 of COTA, NPMs are entitled to:

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

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

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

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

More information

Find out more about the Chief Ombudsman's NPM function, inspection powers, and read his reports online: www.ombudsman.govt.nz under *What we do > Protecting your rights > Monitoring places of detention*.