

**MENTAL HEALTH SERVICES**  
**OF A PUBLIC HOSPITAL**

**A REPORT BY THE  
HEALTH AND DISABILITY COMMISSIONER  
7 FEBRUARY 2001**

# **TABLE OF CONTENTS**

## **1.0 SUMMARY AND DECISION**

## **2.0 SUBJECT MATTER OF COMMISSIONER'S INVESTIGATION**

## **3.0 INVESTIGATION PROCESS**

### **3.1 Interviews and Information**

## **4.0 BACKGROUND TO THE INVESTIGATION**

### **4.1 Ms A, patient at the hospital**

### **4.2 Mr B, patient at the hospital**

## **5.0 REPORTS INTO THE SUICIDES**

### **5.1 Mr C's Report**

### **5.2 Mr D's Report**

### **5.3 Coroner's Reports**

## **6.0 DR E's REPORT INTO THE MENTAL HEALTH SERVICES**

### **6.1 Background Information**

### **6.2 Subject Matter of the Investigation**

### **6.3 Summary**

### **6.4 Conclusions**

## **7.0 RESPONSE TO REPORTS**

### **7.1 The hospital**

### **7.2 Consumers and their families**

## **8.0 COMMISSIONER'S COMMENTS**

## **1.0 SUMMARY AND DECISION**

On 23 June 1998 the former Health and Disability Commissioner, Ms Robyn Stent, initiated an investigation into the provision of mental health services at a public hospital. The investigation resulted from concerns the Commissioner was alerted to following the suicides of Ms A and Mr B in 1997. After the commencement of the investigation, the hospital became the subject of further complaints. On 16 July 1999 the Commissioner extended the investigation to consider these allegations. A large amount of material was submitted and obtained as part of the investigation. Two independent reviewers engaged by the provider and the Coroner investigated and reported on the circumstances surrounding the suicides at the hospital.

On 4 March 2000 Mr Ron Paterson became the Health and Disability Commissioner. Shortly after the appointment, the Commissioner reviewed the investigation to decide what further steps needed to be taken to conclude it. The Commissioner engaged Dr E, psychiatrist, to independently review the mental health services provided by the hospital and report on whether they were of an acceptable standard. Interested parties were invited to comment on the report.

As a result of the investigation to date the Commissioner has decided, in accordance with his discretion under s 37 of the Health and Disability Commissioner Act 1994, to take no further action and conclude this investigation. In the Commissioner's opinion, the independent reviews have been thorough and uncovered the relevant issues. Any further investigation by the Commissioner is unlikely to shed further light on the matter. While there is no doubt that the services to mental health consumers at the hospital required significant development to meet appropriate standards, the Commissioner is satisfied that the mental health services are advancing at a reasonable pace to meet current standards. In the Commissioner's opinion, no benefit can flow from any further action.

However, it would be inappropriate for the Commissioner to conclude this investigation without reporting on the matters affecting the rights of mental health consumers arising from this investigation to ensure such events do not recur. A copy of this report has been forwarded to the Minister of Health, the Ministry of Health, the Director of Mental Health and the Mental Health Commission.

## **2.0 SUBJECT MATTER OF THE COMMISSIONER'S INVESTIGATION**

On 23 June 1998, the former Commissioner, Ms Robyn Stent, decided on her own initiative, under the Health and Disability Commissioner Act 1994, to investigate the mental health services provided at the hospital by the hospital and health service. The hospital and health service merged with another during the period under investigation and, on 1 January 2001, the hospital and health service became a district health board.

The investigation initially covered the circumstances surrounding the suicides of Ms A and Mr B and generic systems issues in respect of the mental health services. The purpose of the investigation was as follows:

*To investigate matters relating to the standard of mental health services being provided by [the hospital and health service] and in particular those being provided by [the hospital].*

After the commencement of the investigation, the mental health services at the hospital became the subject of further complaints. The complaints raised concerns about the premises and facilities being inadequate, policies and procedures in relation to the management of suicidal patients, “specialling” and observation, absence from care without leave (AWOL), family and carer participation, complaints procedures, and staff training. On 16 July 1999 the former Commissioner extended the investigation to consider the matters raised by these complaints.

### 3.0 INVESTIGATION PROCESS

#### 3.1 Interviews and Information

A large amount of material was submitted and/or obtained from interested parties as part of the investigation. The hospital provided the Commissioner with a large amount of written material including copies of relevant policies and procedures. The medical records of Ms A and Mr B were obtained and viewed. The hospital also provided the Commissioner with copies of independent reports undertaken by Mr D, Clinical Manager, and Mr C, Consultant Psychiatrist. A copy of the findings of Mr F, Coroner for the inquest into Ms A's and Mr B's deaths, was obtained and reviewed.

The Commissioner engaged Dr E, psychiatrist, to independently review and report on the mental health services provided by the hospital. Dr E interviewed staff at the hospital and visited the ward. Interviews occurred with:

Mr G	Chief Executive Officer of the hospital and health service following the merger.
Mr H	Regional Business Manager, Mental Health Services, of the hospital and health service following the merger.
Dr I	Acting Clinical Director of the hospital and health service following the merger.
Ms J	Clinical Co-ordinator, Community Mental Health, of the hospital and health service following the merger.
Ms K	Standards Manager of the hospital and health service following the merger.
Ms L	Consumer Advisor, Mental Health Services, of the hospital and health service following the merger.
Ms M	Consumer Advisor, Mental Health Services, of the hospital and health service following the merger.
Mr N	Clinical Co-ordinator, Inpatient Unit, of the hospital and health service following the merger.
Mr O	Level 5 (CCP) nurse at the hospital
Ms P	Level 5 (CCP) nurse at the hospital

*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

Dr E's report on the mental health services was sent to interested parties for their consideration and comment. The Commissioner considered all comments on the report.

#### **4.0 BACKGROUND TO THE INVESTIGATION**

##### **4.1 Ms A**

[Information withheld to protect the privacy of the person involved]

##### **4.2 Mr B**

[Information withheld to protect the privacy of the person involved]

#### **5.0 REPORTS INTO THE SUICIDES**

##### **5.1 Dr C's Report**

On 3 December 1997 Dr C, Consultant Psychiatrist, provided a report into the two suicides at the request of the management of the hospital and health service. Dr C's report was limited to the treatment plans and the provision of psychiatric services to Ms A and Mr B on the days that they committed suicide.

Dr C concluded in his review of services that the staff involved in both admissions were senior nurses, well trained for their role on the ward. He felt that both nurses followed an admission process with their patient that was competent and flexible to the apparent needs of the patient at that time. Despite the ward being very busy, both staff members took time to try to help the patients settle into the ward. Dr C noted the stress and pressure that staff on the ward were under:

*“all staff interviewed commented on the overcrowded ward situation with patient numbers usually above the ward's official capacity and patients at times being required to sleep in offices on mattresses on the floor”.*

Thus any patient in danger of harming themselves or others required constant observation. This situation meant many nurses were called upon to work double shifts.

It was felt by Dr C that *“liaison between community mental health staff, the [community psychiatric] crisis team and the staff on the ward seemed to be efficient with good communication on both occasions”*. Dr C did note two key omissions. These were:

1. There was no clear procedure to designate the nurse in charge of the ward for each shift. It was understood that it would be the senior nurse on duty but this

was not clearly established at handover meetings. Dr C did not consider that this contributed to the deaths of Ms A or Mr B.

2. There was no clear protocol for searching a person such as Mr B on return from AWOL. He was known to be an ongoing drug abuser and whilst the requirement to search him on return needed to be weighed against his needs for privacy and dignity, some clear protocol or guideline would be of use.

Dr C reported that it was the structure of the ward that gave the greatest cause for concern. He stated:

*“The ward consists of a bedroom wing with almost all double rooms. The bedroom wing corridor is clearly visible from the nursing office. Bathroom and toilet facilities in the wing are combined for both the male and female facilities. Thus it is necessary to leave all shower facilities open at night to allow patients free access to toilet facilities. The shower and toilet facilities are unsuitable for the unsupervised use of patients at risk of self harm. As demonstrated tragically, both shower fittings and sprinkler systems are firmly enough fixed to bear the weight of a body. Additionally there are other projections, beams etc. in these facilities which could easily be used in self strangulation attempts.*

*Whilst the ward contains a low stimulation area for disturbed patients with two bedrooms and a common area under good observation from the nursing office, this area is not considered safe and thus patients in this area require constant observation from staff present in the area with them. Time out or seclusion can never be utilised. This considerably increases the need for staff to be constantly observing patients and as described above this necessary proximity can often intensify or prolong someone’s disturbance.*

*The ward itself is relatively small for the complement of patients it is required to accommodate. Corridors, bedrooms etc. seem cramped and with the normal complement of staff this leads to an environment that is overcrowded. To this is added the fact that for most of the time the unit is overbedded and that as a result of this and the absence of seclusion facilities there are additional staff present over and above the normal complement. Overcrowding in an environment automatically increases the tension and pressures of the occupants and this is an important factor in the ward.”*

Dr C concluded that his review did not demonstrate any deficiencies in the assessment and management of Ms A and Mr B. In terms of the systems in place Dr C noted two key omissions set out above but did not consider that the absence of these contributed to the deaths. In terms of the structure of the ward, Dr C felt that *“the structure of the ward is considerably less than ideal for a general psychiatric unit required to cater for disturbed, aggressive or self harming patients. Such a facility should have a secure area for time out and if necessary seclusion.”*

## 5.2 Mr D's Report

Mr D also reviewed the two suicides at the request of the management of the hospital and health service. Mr D is a Registered Psychiatric and Comprehensive Nurse who has worked in the mental health field for over 25 years. He interviewed staff involved in the treatment of Ms A and Mr B, and reviewed the clinical files of both patients.

Mr D concluded that, given the benefit of hindsight, Ms A had strong suicidal ideation and had enunciated suicidal thoughts to Ms Q, members of the community psychiatric team and Ms R. Ms A had been "specialled" previously for suicidal ideation. Ms R did not receive all the information about Ms A that had been gathered and no treatment plan had been completed. Despite this Ms R completed a thorough assessment and spent almost an hour with Ms A.

It was noted by Mr D that the ward was over its patient capacity and the general atmosphere was one of high acuity. Mr D noted:

*"The ward was never designed as a modern acute psychiatric unit. Its initial use as a psychiatric unit was to provide a service to those people who did not require intensive psychiatric care as [another public hospital] provided this service to the [hospital and health service]. In recent times the area has experienced a rapid population growth with an accompanying increase in demand for mental health services. At the same time there was an expectation that the [hospital and health service] would be less reliant on [other hospitals] to provide acute services. As a consequence of this the ward is poorly equipped to fulfil the role expected of it. It is not set out to provide a good quality of observation of patients, there is no safe care area and areas such as the bathrooms are unsafe to say the least."*

Mr D also commented that Ms A had lived with suicidal ideation since the age of 13 and that she had signed a contract to remain safe as part of her admission and agreed verbally to remain safe. She was not the only patient on the ward that night with suicidal ideation and the nurse, Ms R, carried out her duties in a professional and competent manner.

In relation to the suicide of Mr B, Mr D concluded:

*"I believe that there were no errors or omissions by the staff of the ward in relation to the treatment of [Mr B] that contributed to his suicide. I do not think that he gave any indication that he was feeling suicidal. He was facing a court case on the 5<sup>th</sup> of November and this could have been playing on his mind. Young men who have schizophrenia and accompanying drug and alcohol abuse problems have a high suicide rate in NZ. As [the Psychiatric Registrar at an Intensive Psychiatric Care Unit of another public hospital] observed, [Mr B] was a concern because of "his insight which might put him at risk of suicide". This was written in a referral letter to [Dr I] at the hospital on the 16<sup>th</sup> of October."*



*Despite this I do not believe that [Mr B's] suicide could have been predicted or prevented and the nursing staff who worked with [Mr B] on the night of his death carried out their duties in a caring and professional manner.”*

Mr D made the following recommendations:

1. *That a formal policy, process and standards for the transfer of information between [the community psychiatric team] members, the responsible clinician and the admitting nurse be set up.*
2. *That the [hospital and health service] make every effort to fit the bathroom areas in the ward with suicide proof fittings, to identify other areas of the building that staff consider are unsafe and to remedy those problems.*
3. *That [hospital and health service] management meet with [Mr B's] family to listen to their concerns around the treatment of [Mr B].*
4. *That a policy be formulated around the manner in which the family of suicide victims is informed of their family members death. Refer to [Mr B's] family.*
5. *That a policy is formulated for 15 minute observations. No staff I spoke to are aware of such a policy.*
6. *That all registered nursing staff working on the ward are evaluated on their ability to carry out a mental status examination and those who have deficits in this area be given training.*
7. *That a policy and job description be formulated that identifies the role and responsibility for the nurse in charge of each shift on the ward.*

### 5.3 Coroner's Reports

The Coroner, Mr F, carried out an inquest into the suicides of Ms A and Mr B on 5 December 1997 and 3 April 1998 respectively. In relation to the death of Ms A, the Coroner found that:

*“The deceased’s admission to the hospital was made on appropriate grounds. Medical and Nursing Staff at the hospital acted professionally and appropriately. The facilities at the hospital are inadequate to deal with patients of the acuity that are being dealt with there.”*

In relation to the death of Mr B, the Coroner was satisfied that at the time that Mr B was returned to the hospital he gave no indication to the staff that he was suicidal. The Coroner was also satisfied that the care Mr B was given immediately prior to his death was properly and professionally given. However, the Coroner found that:

*“Mr B was ill-treated by the system that prevailed at the hospital.”*

The Coroner noted that:

*“In December I dealt with another death which arose in very similar circumstances in the hospital and at that time I expressed the concern as to the inadequacies of the facilities at the hospital. Those inadequacies were documented by an independent report which was commissioned by the hospital itself. We have a situation where I think everybody concedes that the facilities at the hospital for dealing with psychiatric patients are less than perfect and require urgent upgrade.”*

The Coroner also commented that he was to some extent reassured by the explanation of the Customer Services Manager that the hospital recognised the difficulties with the facility and that it is taking urgent steps to replace the facility. He commented that it is incumbent on everyone involved to ensure the facility is put in place as soon as possible.

## **6.0 DR E's REPORT INTO THE MENTAL HEALTH SERVICES**

In July 2000 the Commissioner, Mr Ron Paterson, engaged Dr E, psychiatrist, to independently review the mental health services provided by the hospital and report on whether they were of an acceptable standard. Dr E reviewed written material provided by the Commissioner including the letters of complaint and further material provided by the hospital. On 9, 10 and 11 August 2000 Dr E visited the mental health services and interviewed persons involved with the services. On 30 August 2000 Dr E reported:

### **6.1 BACKGROUND INFORMATION**

1. *This report has been prepared at the request of the Health and Disability Commissioner, as part of an investigation into the deaths of two patients at [the hospital] in October and November 1997, and in response to complaints received in July 1998 and in January 1999 about the services provided by [the hospital and health service].*
2. *[The hospital and health service] has subsequently been incorporated into the new organisation [another hospital and health service] formed by the merger of [ ]. New structures have been implemented since that merger, including the appointment of a new Regional Business Manager for the Mental Health Service.*
3. *The purpose of this report is not to address the circumstances of the deaths or the details of the specific complaints. Rather, this report is to comment upon the mental health services currently provided by [the hospital and health service] and whether these services are of an acceptable standard.*
4. *To prepare this report a number of sources of information have been utilised. These are outlined in Appendix 1.*

### **6.2 SUBJECT MATTER OF THE INVESTIGATION**

5. *I shall not repeat the details of the events and complaints leading to the investigation. These matters are outlined in the document "Background to the Investigation of Mental Health Services provided by [the hospital and health service]" which accompanied the letter from the Commissioner (27 July 2000).*
6. *In brief however these matters can be summarised in to a number of categories of concern, as follows:*

*Matters arising from investigations into the suicides*

- *procedures to designate nurse in charge of shift*
- *systems for appraising competence of nursing staff and for developing performance*
- *protocols for searching patients*
- *physical structure of the ward*

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- *observation policies*
- *transfer of information between community and inpatient services*
- *adequacy of process for sharing of information with families*

*Matters arising from complaints in relation to the hospital*

- *attitudes of staff and responsiveness to patient needs or requests*
- *adequacy of physical facility*
- *responsiveness to complaints*
- *adequacy of treatment programmes*

7. *I shall address these matters within these broad categories of concern.*

### ***Procedures to designate nurse in charge of each shift***

8. *The Regional Business Manager has instituted a new structure for oversight of the inpatient unit, developing a position of Clinical Co-ordinator of the inpatient service. This position requires the incumbent to have a professional clinical background. This role carries the responsibility of ensuring overall co-ordination of the inpatient service, including the nursing structure within the unit. Within the ward there are 2 main teams of staff, each with a senior nurse co-ordinating the clinical practices within the nursing team and overseeing the care planning and implementation as well as the practice of junior members of the nursing team. On day shifts during Monday to Friday there is a senior nurse overseeing each team. These shifts are the busiest with respect to ward reviews, clinical planning, meetings and other clinical activities. On other shifts one nurse oversees the activity of the whole unit.*
9. *Designated individuals are in charge of each shift, taking this co-ordinating role. These people are identified in advance, covering afternoon and night shifts and weekends. These roles are less clearly defined than the role of clinical co-ordinator, but are expected to fit within the top levels of competency (levels 4 and 5) of the Clinical Care Pathways processes for nursing staff.*
10. *It appears that this process works satisfactorily. It is clear who the senior nurse on duty is, and the role of this person seems to be clearly understood.*

### ***Systems for appraising competence of nursing staff and for developing performance***

11. *The Inpatient Clinical Co-ordinator position description clearly notes the responsibility of this role in ensuring that clinical practice skills and competencies are current and meet client and service requirements. In conjunction with the Clinical Manager (now operational manager), Clinical Director and Professional Advisors, the Co-ordinator ensures that team members are appropriately qualified. Staff performance appraisals are to be completed annually and the Co-ordinator is to ensure that staff receive appropriate supervision. The Co-ordinator is to ensure that team members are assisted to achieve their potential through education programmes, coaching and performance management processes.*

12. *The Regional Business Manager notes that the Clinical Care Pathway (CCP) process addresses performance and competencies. The Professional Nurse Advisor has recently established new competencies following a review of the CCP process, which are to be rolled out for all nursing staff. This individual assessment will lead on to identification of the development needs of these staff.*
13. *In addition, in the next phase of development planning for the new inpatient unit, attention will be given to developing the competence of nursing staff in the area of assessment and mental status examination, as part of an approach to risk assessment and enhanced acute care capacity.*

### **Protocols for searching patients**

14. *Routine practice upon admission of a patient is for property to be itemised. This stops short of search of a person, but will usually include working with the patient to identify their personal possessions. There are not any well documented agreed protocols for searches of patients, except with respect to searches for drugs within the ward. Where possible this avoids a search of an individual patient. The summary table of policy development provided by [the hospital and health service] to the reviewer (with the package of documentation provided on August 4) notes that a draft policy on Personal Searches is in development, as is a draft policy on Illegal Drugs and Alcohol.*
15. *Where there is cause to suspect that a patient may be hiding objects with a view to harm him/her-self, the matter of search is addressed on an individual basis. For example where a person is regarded as at higher risk and requiring entry to the safe care area, personal property remaining in their possession will be examined. Where possible however the preference is to manage risk by close observation rather than by personal search.*
16. *This is an area of practice in which there is some variation across services and where there is a mix of views about the most appropriate approach. There are tensions between legal risks of conducting searches, and clinical risks of not doing so in some situations. It is clear that this is an area of some uncertainty, and at the national meeting of Directors of Area Mental Health Services and [the public hospital] Mental Health Service Managers (30 August 2000) there was considerable interest in this matter. There is a lack of clarity about the best approach. The approach being taken by [the hospital] appears to be a pragmatic middle line, avoiding searches where possible (and managing by close observation), but with preparedness to search in some situations. Clearly however, completion and distribution of local policies in accord with national guidelines (based upon facilitative legal opinion) will be useful in limiting any variations in practice in this area, at least in this service.*

### **Physical structure of the ward**

17. *There has been no fundamental change to the structure of the ward over the time since the suicides. Improvements have been made to some elements of the ward to reduce risks of harm (shower fittings, drop-away curtain rails) but there remain many fixtures that would readily provide an anchor for an attempt*

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*at strangulation or hanging, for example. The layout of the ward remains inadequate.*

18. *Planning for a new ward is well developed and at the time of my visit it was understood that decisions in regard tenders were imminent. The plan for the new unit demonstrates a facility that will be superior to the current unit, and in accord with standards of modern psychiatric care.*
19. *The Regional Business Manager and Inpatient Clinical Co-ordinator clearly recognise the need for the next phase of planning to prepare for changes in staff practice in staffing a unit with a clinical caseload that includes patients previously (and currently) transferred to [other neighbouring facilities].*

### ***Observation policies***

20. *The complaints being addressed by this investigation included several in respect of observation.*
21. *It was of concern to one complainant that “There is a need for increased use of specialling to avoid incidents of self-harm”. This is so, but appears a reasonable response by staff to the poor physical structure of the ward. The layout of the ward is inadequate for good observation of people about whom there is increased concern, and there is inadequate space for safe unobtrusive observation short of the patient being placed in seclusion. The use of special observations in such poor physical facilities is a reasonable compromise between risks to safety and undue restriction of seclusion.*
22. *A recommendation from one review of the suicides noted that a policy be formulated for 15-minute observations. There are now several documents that address safe observation of patients. None of those provided to the reviewer specifically address 15-minute observations, although one does address the more general matter of specialling a patient, which appears to refer to constant observation. The Co-ordinator notes that his review of this policy finds it requiring work to assist differentiation of forms of observation and the procedures associated with these. I agree this is necessary and will be helpful.*
23. *15-minute observations are a feature of many psychiatric inpatient facilities, and it is helpful to have clear understandings regarding this level of observation, addressing such matters as whose responsibility such observation is, how the observation is initiated and terminated, how matters such as meal breaks or shift changes are incorporated, and how and what documentation should occur. It must be realised though that this level of observation is insufficient to prevent episodes of self-harm or violence, or absences from care, by people who are serious in this intent.*

### ***Transfer of information between community and inpatient services***

24. *Each of four community mental health teams provides service to one of four geographical areas of the catchment area of the ward. Each team may admit patients to ward, involving the team psychiatrist in that decision. Once a patient is admitted, there is some variation in practice in regard the patient's usual community case-manager continuing involvement in care planning. The four community team psychiatrists however all have responsibility for their patients in hospital, thus maintaining some continuity of oversight and in the treatment plan.*
25. *Each community team participates in a weekly 'sector meeting', a combined inpatient and community team review of inpatients of that team (as well as providing a forum for discussion of other clinical matters relating to outpatients, referrals and other matters).*
26. *Pressure on acute beds may occasionally precipitate a discharge without the usual planning process. This has the potential to compromise co-ordination of care.*
27. *Policies exist in respect of admission to the acute inpatient unit (draft version December 1999) and transfer of care (draft version December 1999). Each policy identifies the importance of ongoing assessment and care, with appropriate documentation and provision of information (including information to family or other supports). Risk assessments are to be completed within four hours of admission.*
28. *In general the sector meetings appear to be a good forum for discussion between inpatient and community staff, to assist co-ordination of care. This is a useful mechanism. This co-ordination and continuity of oversight is further enhanced by the outpatient psychiatrists having responsibility for their patients during admission.*
29. *Whilst the sector meeting provides good opportunity for co-ordinated review of inpatients, it appears that there is a less reliable mechanism to ensure that all patients under the care of community teams are reviewed regularly and comprehensively. I am advised these arrangements are more informal. Although review of community teams in that respect may be beyond the terms of reference of this review, that does appear to be an area for improvement.*
30. *In the same way, an area for improvement is in relation to risk assessment. There is a format for risk assessment for inpatients, as noted already, with the requirement regarding timing of this documentation. Optimal practice however would involve all patients having a risk assessment completed soon after entry to service, with regular review and update (as more information becomes available, or as condition changes, or at sentinel points of care such as transfer between teams or upon admission).*

31. *There appears to be no formal requirement or structure for community teams to complete such activity. Ideally risk assessments would be available for all patients prior to admission, and this information would be transferred to the inpatient unit and modified in the context of events leading to admission, rather than starting 'from now', as appears currently the situation, on admission.*
32. *It must be recognised that the marked attention nationally to more systematic assessment and management of risk has been most pronounced in the last 2 years. In July 1998 the Ministry of Health produced the document "Guidelines for Clinical Risk Assessment and Management in Mental Health Services", and expectations have been more clear regarding the standards for such processes. In 1997 at the time of the suicides the standards would have been less evident, although there would still be expectation of a reasonable level of attention to risk factors, especially in inpatients. The previous reviews into the suicides do suggest that reasonable assessments were carried out for these inpatients.*

### ***Adequacy of process for sharing information with families***

33. *There is little evidence available in respect of this area of concern. An undated document "[the hospital] Mental Health Service Policy regarding Family and Carer Participation" notes that families and carers are involved in planning, implementation and evaluation of the mental health service. This document outlines a number of aspects of care to which families may contribute and in which they may participate.*
34. *This policy does in some form appear to have survived into the era of [the hospital and health service], as a policy "Family and Carer Participation" is noted in the summary table of policy development in Mental Health Services (dated 26 July 2000). This table notes this policy to have reached a stage of a completed draft, not yet signed off by the Clinical Director and Business Manager.*
35. *As noted already, staff note that there is now much more routine involvement of families in a process of treatment (particularly discharge) planning.*
36. *The consumer advisors note that the feedback loop to consumers in regard complaints and incidents is not yet complete, although feedback to complainants is now identified in the policy for dealing with complaints. The Regional Business Manager also notes that this is an area for attention in the recently initiated review of monitoring and review processes (outlined in his memorandum to [Ms S, the Service Development Co-ordinator], 7 August 2000).*
37. *One of the original concerns to be addressed by the investigation was in relation to advice to families regarding the death of a family member. [A family member] noted that this was a matter for careful attention and that a policy was not needed (memo to CEO, 26 February 1998). The intention was for information to be provided to clients and families in a caring and compassionate manner. A draft of a policy in regard to family and consumer*



*participation is apparently now in a process of development, but was not seen by this reviewer.*

38. *The original complaints also were of a lack of communication with carers and that there was little if any feedback in response to expressed concerns. The steps identified above appear directed to remedies that are appropriate.*
39. *Overall it does not appear that [the hospital and health service] is markedly different to some other services in respect of these matters. Policy development is under way. Increasing routine involvement of families and caregivers is appropriate, but is an area for development in many services, as in [the hospital and health service]. Completion and promulgation of the policy on carer/family and consumer participation in treatment planning, accompanied by systematic training and support for this practice, will be important in [the hospital and health service], as it is in other services.*

#### ***Attitudes of staff and responsiveness to patient needs or requests***

40. *I met with several staff who made comments relevant to this area of concern and with the consumer advisors.*
41. *Mr H notes that one of the underpinning philosophies in the development of the new acute inpatient facility is provision for individual needs and the varying clinical presentations of individuals attending the unit.*
42. *Senior staff of the ward note that there is now much more frequent occurrence of family meetings in the process of planning of care, and in discharge planning in particular. They note also that there have been recent improvements in the programme running within the ward, since the employment of an occupational therapist. This creates opportunities for more meaningful and therapeutic use of time, rather than patients experiencing the boredom that has been a prominent feature prior to that appointment.*
43. *These staff noted that there have been marked improvements in the attitude of staff toward patients with certain personality disorders, although there remains some variation in this. These comments were in response to questions about human elements of care for patients, and to perceptions of patients as individuals. There did not seem to be an understanding that this had been a concern of some patients.*
44. *The consumer advisors noted that a recovery focus, now recognised as an important orientation for planning and delivery of care, is somewhat limited within the ward. They do not feel that staff have a strongly developed “customer focus” or respect for clients, although comment that this probably is no different to that found in other services. They note use of expressions such as “taking down” people (as a term for using restraint) as indicative of some attitudes amongst some staff. They note some rudeness from staff to patients at times.*

45. *These advisors however are heartened by attention to gaps in services and to increased co-ordination. They feel as advisors that they are well received by the senior staff and feel their input into services is valued. These advisors convey a sense of hope and some optimism that the service is increasingly responsive to consumer needs and that attitudes are changing in a positive manner.*
46. *Overall this view of the consumer advisors seems realistic. There does appear to be a commitment to change evident in attitudes of the Regional Business Manager, Inpatient Unit Clinical Co-ordinator and some senior nurses in the unit. In discussion with staff I do not get a strong sense that a strongly client/patient focussed approach is universally evident, but this does not appear markedly at variance with the range of attitudes that are still found in other acute inpatient services. Attention is being directed to this matter.*
47. *There does not appear to be a systematic and structured approach to identifying needs and planning care. The well developed mechanism for co-ordination of approaches between the community and inpatient teams (the sector meetings) assists in ensuring that inpatient care is in accord with community-based plans, but there is a lack of comprehensive structured need-based or goal-based orientation that is applied consistently for all patients. This risks a haphazard approach to care and missed opportunities for optimal contribution of all staff disciplines. This too however is not atypical of many services, although there is not yet an indication that [the hospital and health service] has identified this as an area for development.*

### ***Responsiveness to complaints***

48. *The consumer advisors note that there seems to have been less attention given to this area than there ought to be, and that there has been no real policy to date. They also comment that the feedback loop to consumers following complaints is not complete.*
49. *The Regional Business Manager has given attention to developing a policy in regard dealing with and responding to complaints. This policy within the Mental Health Service places much greater emphasis than the organisation-wide policy on the service's own role in addressing complaints. The process outlined in the policy includes formulation of a letter of response to the complainant.*
50. *Summary information in regard complaints is collected and reported with the Standards Manager and Chief Executive receiving monthly reports. Copies also go to the Clinical Board and the [the public hospital] Board.*
51. *Further to these processes, the Regional Business Manager has requested that the Service Development Co-ordinator develop processes to facilitate the monitoring of complaints (as well as incidents, and episodes of restraint and seclusion).*

52. *There is evidence therefore of a commitment to attending properly to complaints, and to using summary information and more detailed reports as part of an ongoing process of quality improvement. Such mechanisms do not appear to have been in place previously.*

### ***Adequacy of treatment programmes***

53. *As noted already, there does not appear to be a structured assessment of needs or approach to treatment planning that is based upon a systematic review of domains of need or goals. The relatively recent inclusion of an occupational therapist in the inpatient team has allowed this additional perspective to be represented in treatment plans, and has assisted the development of a more comprehensive day programme within the ward.*
54. *Within the inpatient service there has been the development of a structure for documentation of risks of violent and suicidal behaviour and for planning clinical management to address these risks. The risk assessment does not address other areas of potential clinical risk, such as absence from the ward, non-compliance with treatment, vulnerability to harm from other people, or neglect. There does appear to be reasonable development of plans to address the identified risks of violence of suicide or self-harm.*
55. *A policy of specialising a client in the acute inpatient unit has been developed and is due for review in February 2001. This policy looks satisfactory and appears to be understood by staff and reasonably applied in practice.*

### **6.3 SUMMARY**

56. *There have been a number of changes in the mental health services previously provided by [the hospital and health service] from the hospital. The merger has allowed a new structure of management to be implemented, which has resulted in considerable attention to policy development and to aspects of standards of care.*
57. *New nursing structures within the ward are contributing to enhanced processes for co-ordination of care and for the quality of this care. There is some room for greater clarity of documentation regarding some levels of observation, notably 15-minute checks.*
58. *The continuity provided by community team psychiatrists maintaining responsibility for their inpatients is helpful. Sector meetings provide a useful forum for co-ordination of planning and for transfer of information. It would be helpful for a more systematic approach to risk assessment and documentation to be evident in community teams, and for this information also to be transferred to the inpatient service upon admission of a client.*
59. *The appointment of consumer advisors seems to be contributing to an enhanced focus on the needs of patients, and to systems that have a greater focus on consumer involvement.*

60. *Greater attention is being paid to involvement of families and other caregivers, and development of policies and standards of practice in this area are under way.*
61. *A planning process has been underway for some time to develop a new physical facility to replace the current ward. That phase of planning is now ending. There is recognition that the orientation of planning must now shift to prepare for the changes in internal systems and skills necessary to manage a ward with a higher capacity to provide for greater degrees of disturbance in patients.*
62. *Comprehensive structured assessment instruments are not evident as a basis for planning of care, although the assessments that are conducted appear to be of a reasonable standard and comparable to those found in other services. The capacity of the ward to respond to a greater range of needs has been enhanced by the appointment of an occupational therapist to the unit. A focus on staff capacity to respond to people with certain types of personality disturbance appears to be having a positive effect upon nature of interventions provided.*
63. *Responsiveness to complaints has been enhanced through development of systems and standards for investigation and reviewing complaints, and further attention is being given to systematic monitoring and review of complaints (and other key matters, such as incidents and episodes of restraint and seclusion).*

#### **6.4 CONCLUSIONS**

64. *A strong sense is obtained from this review of some of the mental health services of [the hospital and health service] that the service is advancing at a reasonable pace to meet current standards of practice that would be found in comparable settings.*
65. *The greatest deficit in current provision remains the inadequate physical facility of the ward. The plans for the replacement ward however appear quite adequate, and there is a plan in place to begin the next phase of preparation for enhancing the systems and standards of care that will need to be applied in the new environment.*
66. *[The hospital and health service] does not routinely use structured instruments to assist in assessment of care and planning of care. This is not unusual however in similar services.*
67. *[The hospital and health service] does systematically structure the documentation of risks of violence and of suicide amongst inpatients, although does not appear to do so for outpatients. This is an area for attention, in both the comprehensiveness of range of risks identified and in the coverage of this practice.*
68. *The Guidelines for Clinical Risk Assessment and Management in Mental Health Services (Ministry of Health 1998) outline a number of other domains of risk that are usefully addressed systematically in assessing risk. The guidelines note too that risk assessment should be an integral part of every clinical assessment.*

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*There should therefore be structures to support documentation of risk at stages of care other than solely inpatient treatment.*

69. *Although the inpatient risk assessment format within [the hospital and health service] does address context and triggers of risk (which some assessments in other services fail to address), and although standards of compliance with these Ministry of Health Guidelines do vary across services nationally, in my view this is an area in which there is a need for improvement still.*
70. *Work is still needed in clarification of some policies and procedures to assist reduction of ambiguity or personal and idiosyncratic practice. In particular this is in the areas of observation level, and search. The former is generally reasonably well structured in most services, but the latter is an area in which there is little consensus and some variation in approach nationally. Practices in [the hospital and health service] in response to complaints seem reasonable, and seem likely to continue to improve.*
71. *In some respects therefore it seems that this review has occurred at a time when some matters requiring attention have been identified and have progressed satisfactorily (complaints policy and responsiveness; plans for replacement physical facility; some aspects of risk assessment and documentation; attitudes of staff; nursing performance and oversight; transfer of information between services) to a standard comparable with similar services, whereas some matters have been identified and are in a stage of planning for further development (systems of care in new unit; clarification of observation policy; draft policies in development for searches of patients and for family/carer participation).*
72. *An area of relevance to this review apparently not noted as needing attention until brought to the notice of the service by the reviewer is that of standard approaches to documentation of risk within the outpatient population. There is still however marked variation in comprehensiveness of risk assessment nationally, and [the hospital and health service] is not clearly lagging behind other comparable services in that regard.*
73. *Overall, as noted above, it appears that good progress is being made in development of standards in the mental health services of [the hospital and health service]. The current practices and standards do not appear dissimilar to those that would be found in a range of other services and in some aspects are superior. The ongoing work in development of the processes of care within the new acute inpatient facility will continue the process of improvement already evident.*
74. *[The hospital and health service] is aware that there is more work to do. This review captures a snapshot of current state that is not fully satisfactory but which is not regarded as such by the service. Another snapshot after a further period of time seems likely to capture a service that has continued to develop. The current picture though is not generally out of kilter with similar services, at least in regard the areas of concern leading to the investigation.”*

## 7.0 RESPONSE TO REPORTS

### 7.1 The Hospital's Response

The hospital advised the Commissioner that following the suicides it took immediate steps to improve the safety of the mental health service. The hospital engaged two independent experts to review and report on the two suicides and implemented the report recommendations (which are summarised in section 5 of this report) and made further improvements to the service. It also identified its ongoing development needs and plans.

#### *Physical Environment*

The hospital advised the Commissioner of the following changes to the physical environment of the ward:

- shower roses have been changed on all showers to be non weight bearing;
- fire sprinklers have been altered to ceiling flush type in all bedrooms, toilets, bathrooms and some ancillary rooms which cannot be locked off;
- screws have been loosened on all curtain rails so that these will “fall down” if weight is put on them;
- locks on external doors have been changed to magnetic;
- window glass has been replaced with safety non break glass throughout the unit; and
- low stimulus area has been modified to allow for two seclusion rooms.

The hospital advised that it has also identified potential physical hazards which cannot be altered and developed guidelines or protocols regarding their safety and use. Ward safety checks by management and staff have also been introduced.

#### *Policies and procedures*

The hospital advised the Commissioner that it has developed and implemented mental health policies which are relevant to the prevention of suicide by patients, as well as a complaints policy and recruitment policies. A plan to implement the National Mental Health Standards is also in place through an audit process which builds on previously completed work.

In response to the number of patients going AWOL, the hospital advised that 15-minute observations were being initiated more quickly. To achieve this, it is the practice to “*initiate assessment and care plan re AWOL risk and management*”. Also, the leave status of all patients is clearly identified on the patient management board.

In order to ensure compliance by staff with policies and procedures, the hospital advised that copies of all related mental health policies have been photocopied and issued to Customer Services and to relevant medical staff. In addition, certain policies have been displayed in the ward area for staff to note. Education sessions are also

held to introduce new policies and procedures. Staff have formed working parties to discuss and develop policies and procedures that need implementing or changing.

The hospital noted that its systems and processes still require ongoing monitoring and review, particularly *“the need to ensure documentation and continuity of care reflects ongoing care planning following assessment on admission or prior to admission particularly regarding assessment of risk. Monitoring and review processes need to be firmly in place over the next year in order to pick up key indicators such as incidents, personal restraints, use of seclusion and complaints .... A working group will be set up from the ‘user group’ members who will now focus on service development for the inpatient unit, and will achieve improved practice in service delivery in this environment. Education of current inpatient unit staff is ongoing, and will assist with the development of improved practice.”*

#### *Replacement of the facility*

The ward is a converted isolation ward and mental health services have been provided from there since 1975. The hospital advised that up until the changes to the Mental Health Act 1992 the existing facility had been adequate for its purpose. However, the changes to the Mental Health Act and the closure of the nearest public hospital meant that the ward had to care for an increasing number of higher acuity patients which it was not designed to cope with. The hospital advised that the closure of the neighbouring public hospital was not accompanied by plans to care safely for patients who required intensive patient care (IPC) and who would typically have gone to the neighbouring public hospital. In its opinion, the risks to patients and staff during the transition from the neighbouring public hospital to a mental health centre could have been managed better.

A letter from Dr I to the Director of Mental Health, dated 13 May 1998, comments that patients going absent without leave from the hospital is a continuous problem as the ward is not designed to cope with serious levels of mental illness. Although on occasion the front doors of the facility have been locked, patients are still able to leave the ward on a daily basis. Following the closure of the neighbouring public hospital, staff at the hospital have had the option of transferring patients to four beds at a mental health centre. However, this arrangement has been the source of problems. Two of the beds are taken by long term patients and staff are reluctant to fill the other beds with people who go AWOL. There were reported difficulties in accessing Intensive Patient Care (IPC) beds.

The hospital and health service advised the Commissioner that it had commenced construction of a new acute inpatient unit to replace the ward. The unit would include Intensive Patient Care (IPC) beds:

*“A ‘business case’ for the construction of a new facility was developed during the latter half of 1998 and early 1999. An extensive proposal was needed as the new facility was a major capital project and would require additional capital from CCMAU. This business case required an evaluation of alternatives (alternate sites, refurbishing etc) and a commitment from the HFA to purchase the number of inpatient beds identified as needed.*

*In January 1999 the HFA agreed to 22 beds in total which enabled us to produce a 'viable' business case. The business case was sent to CCMAU on 14 May 1999. In addition [the public hospital] used an independent evaluation to compare the proposal with ... clinical and financial standards. This evaluation was conducted by [a management consulting firm]."*

In September 1999 the Minister of Health approved the business case for the construction of a new facility. The hospital reported that:

*"Prior to this, work had already been carried out in reviewing the planning for this project, including the sketch plan developed in anticipation of approval, and a number of deficits were found.*

- *The sketch plan was not functional and would not support appropriate intensive patient care.*
- *The sketch plan represented a focus in the service on the Inpatient Unit as the centre of the service as opposed to a more appropriate emphasis on the community.*
- *Future planning for the Inpatient Unit expansion was not adequate.*
- *Activity space for clients. The range of activity space was not adequate and the range of accessible space for de-escalating was not adequate.*
- *Community services were planned to be placed within the Inpatient Unit new building. There was inadequate space provision for this, but most importantly, the philosophical idea of placing community services in an inpatient setting was flawed.*

*The review of the Inpatient Project established an opportunity to appoint new project management Project architectural input to the Project."*

In September and October 1999 the Project structure was set up.

*"A 'user group' process, co-ordinating a mix of clinical, consumer, medical and family representatives, and Iwi representatives into a 'user group' process, to develop the new design was established. New Project Management, OCTA Associates provided input bringing expertise in Mental Health inpatient unit project management with them. In November 1999 an architectural firm was appointed, bringing design expertise with them in mental health."*

The hospital advised that:

*"The User Group input has established an improved level of confidence in the project on the part of users within the Inpatient Unit. This confidence was not present at the beginning of the project. This confidence has been slowly built up on the basis of opportunities for detailed input to design with an emphasis on basic principles such as achieving a high level of environmental safety.*



*Details in our design include:*

- *Spaces designed within the unit to de-escalate patients prior to using restrictive practices such as seclusion, as an integrated approach to provision of acute and Intensive Care.*
- *The design also includes the ability to separate out those clients who have special needs (for instance adolescents or vulnerable female clients) and other groups through using design features such as of bedroom clusters, with integrated living areas.*
- *This approach is underpinned by ensuring that ensuited individual bedrooms are available that are large enough to have families stay for support if necessary.*

*Further additions to the design included separating out areas to provide intensive patient care and providing a range of areas such as upgraded bedrooms and de-escalation spaces, where individualised intensive patient care may be provided. This also includes appropriate access to seclusion rooms for emergency care.*

*Project completion is expected August 2001 with construction commencing in August 2000.”*

The new purpose built inpatient facility is now under construction and should be open by the end of 2001.

#### *Dr E's Report*

Mr G, Chief Executive Officer of the public hospital advised the Commissioner that Dr E's report has received detailed attention from the mental health services and action was currently being taken to attend to areas identified in the report as needing more immediate attention.

Mr G also commented:

*“The investigation was commenced at a time when there were serious concerns about the Mental Health Service, in what was then [a public hospital]. The investigation and completion of the report is an important milestone as part of the development of our Mental Health Services ... I believe the Service, over the last 18 months, has made excellent progress in both prioritising development and identifying serious issues to respond to through implementation of an appropriate management structure. This has enabled [the hospital and health service] and the Mental Health Services to get on with the business of delivering quality health services and also to engage in very active and substantial development. The most significant part of this development, in some respects, is the commencement of construction of our new purpose built inpatient unit, which is at present, being constructed and will be open in 2001.”*

Mr H, Regional Business Manager of the public hospital, advised the Commissioner that there were issues that surfaced in the report which still require more immediate development:

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*“An example of this is definition of observations within the inpatient unit where I am unhappy to find that the level of specification for observation is not adequately documented. We will immediately address this particular issue and also pick up other issues within the report for action. I have sent through the report for review and action plans to be developed to our Service Development Co-ordinator, [Ms S], for further work.”*

Mr H commented that while the report was appropriate in its comments and recommendations, he wished to clarify and respond to three areas within the report:

#### Adequacy of Process for Sharing Information with Families (paragraph 36)

*“Direct feedback to complainants is part of our overall focus in our complaints policy. However, individual feedback regarding individual complaints may not go to consumer advisors, or for that matter to other staff members or members of our management team outside of the area within which they specifically apply. The feedback loop that is being set up is that consumers participate in monitoring of complaints in an overall monitoring role, as opposed to specifically being advised of each response to a complainant as it is written to them. Therefore, I would like to note that the wording should reflect that the ‘feedback loop’ to consumers in regard to complaints and incident monitoring is being completed through development of monitoring.”*

#### Identifying needs and planning care (paragraph 47)

*“The inpatient service has a developed format for care planning. I enclose a copy of this with this report. I accept the comment in general that there are issues generally about comprehensive needs based, or goal based planning applying consistently for all patients, particularly in our community services. However, I would like to note that the inpatient unit does have a system for assessment and care planning as noted within the format of the care plan report attached to this report.”*

#### Responsiveness to complaints (paragraph 48)

*“The development of a complaints policy was a priority identified by the Regional Business Manager earlier on in the development of the service in June/July of 1999. A comprehensive policy was developed and quickly implemented by October of last year. The policy and process has been in place over the last year, and is now a thorough process with clear policy guidelines attached. The policy, which has now been adapted by [the hospital and health service], as its complaints policy, is attached for your information, as well as samples of complaints log forms which we also use to track progress.”*

*As noted above, the development of monitoring systems which will include monitoring complaints, incidents, events of personal restraint, seclusion, requests for change of responsible clinician, etc is ongoing by the monitoring group. This group has been set up, involving consumers, and will maintain oversight of these key indicators within the Mental Health Service.”*

In summary, Mr H advised:

*“I believe that the report provides an accurate record of the current stage of development within the Mental Health Service and appropriately notes substantial development particularly in implementing a new structure and other changes over the last now 18 months.”*

## **7.2 Consumers and their families’ response**

The Commissioner sought to consult complainants about the report engaged by the Commissioner on the mental health services. The Commissioner regrets that he was unable to contact all interested parties. Most complainants who responded to the report were pleased with the improvements to the mental health services and that a new inpatient unit was finally being built. However, they were still concerned about the level of communication between hospital staff, patients and families. One complainant commented that there was a need for greater consultation with families to help them cope with the expectations placed on them as carers. Another was concerned that the new inpatient unit would not have a secure ward and there would still be no safe place for suicidal patients to go in the hospital.

## **8.0 COMMISSIONER’S COMMENTS**

As a result of the investigation to date the Commissioner has decided, in accordance with his discretion under s 37 of the Health and Disability Commissioner Act 1994, to take no further action and conclude this investigation. The matters under consideration have been subject to a number of reviews. In the Commissioner’s opinion, the reviews have been thorough and uncovered the relevant issues. Any further investigation by the Commissioner is unlikely to shed further light on the matter. During the investigation, the Commissioner received a clear and strong message of mental health services that required urgent development but were now advancing at a reasonable pace to meet current standards of practice. In the Commissioner’s opinion, no further benefit can flow from any further action on his part *in terms of promoting and protecting consumers’ rights.*

There is no doubt that at the time of the deaths of Ms A and Mr B the service to mental health patients at the hospital required urgent development. The inadequate nature of the facility was well known. There was overcrowding, an acutely ill patient population, no seclusion areas and the shower heads and sprinklers were exposed. Several letters prior to and soon after the two suicides in October and November 1997 drew attention to the inadequacy of the facility and the overcrowding that has occurred:

*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.*

1. The District Inspector of Mental Health to Area Director Mental Health Services, dated 16 December 1996;
2. Ward staff to the Chief Executive Officer of the hospital and health service [at the commencement of the Commissioner's investigation], dated 2 October 1997;
3. The community psychiatric team to the Chief Executive Officer of the hospital and health service [at the commencement of the Commissioner's investigation], dated 3 October 1997;
4. Dr I to Ms T of another hospital and health service, dated 4 November 1997; and
5. The Consultant Psychiatrist, to the Chief Executive Officer of the hospital and health service [at the commencement of the Commissioner's investigation], dated 20 November 1997.

It was widely accepted that there was an urgent need to replace the ward with a purpose built unit. The Commissioner acknowledges that the construction of a new facility was constrained by external factors, including the need for a commitment for long term funding. However, the physical improvements to the ward that were recommended in Mr D's report and later implemented would have been relatively inexpensive. These improvements would have minimised the potential harm to patients of the ward and could possibly have averted the deaths of Ms A and Mr B.

It is incumbent on everyone involved in the provision of mental health services to take all reasonable steps to ensure that services are of an adequate standard and provided in a manner that minimises the risk of harm to mental health consumers. It is particularly important for people who receive mental health services that the services on which they depend are of an adequate standard.

The Commissioner accepts Dr E's advice that most areas of the mental health service now meet current standards of practice, and the remaining areas are advancing at a reasonable pace. The complaints policy, plans for replacement of the physical facility, some aspects of risk assessment and documentation, attitudes of staff, nursing performance and oversight and transfer of information between services have progressed satisfactorily to a standard comparable with similar services. While the consumer advisors noted some lack of "customer focus", the Commissioner was encouraged that the advisors conveyed a sense of optimism that the service was increasingly responsive to consumer needs and that attitudes are changing in a positive manner. It was also pleasing to see the developments that have occurred in relation to the complaints policy.

However, as detailed in Dr E's report, further development is required in certain areas, including policies and procedures on searching patients, observation levels, family/carer participation and systems of care in the new unit.

#### *Searching patients*

Dr E found that there were not any well-documented agreed protocols for searches of patients, except with respect to searches for drugs within the ward. The

Commissioner agrees that the completion and distribution of local policies in accordance with national guidelines would be useful in limiting variations in practice in this area.

*Observation policies*

The Commissioner accepts that the use of special observations in such poor physical facilities is a reasonable compromise between risks to safety and undue restriction of seclusion. However, the observation policy requires further development to assist in the differentiation of forms of observation and the procedures associated with these, including specific reference to 15-minute observations.

*Adequacy of process for sharing of information with families*

The policy in regard to family and consumer participation together with the “feedback loop” to consumers in regard to complaints and incidents monitoring should be finalised as a matter of priority, following consultation with consumers and their families and/or carers.

*Adequacy of treatment programmes*

Risk assessments should be available for all patients prior to admission, and this information should be transferred to the in-patient unit and modified in the context of events leading to the admission. The structure for documentation of risks and risk assessment should also address other areas of potential clinical risks such as absence from the ward without leave, non-compliance with treatment, vulnerability to harm from other people, and neglect.

*Systems of care in new unit*

For too long the inpatient services have been provided in inadequate facilities. It is very positive and exciting for patients, their families and staff to know that the new inpatient facility is now under construction and should be open in the very near future. While Dr E was satisfied that the plan for the new unit demonstrates a facility that will accord with standards of modern psychiatric care, systems of care and staff training in relation to the new facility should be addressed. The Commissioner accepts that the construction of the new inpatient unit will significantly improve the safety and quality of the inpatient services.

Dr E concluded:

*“Overall, the current practices and standards of [the hospital and health service] do not appear dissimilar to those that would be found in a range of other services and in some aspects are superior. The current state is not fully satisfactory but is not regarded as such by the Service. [The hospital and health service] is not generally out of kilter with similar services, at least in regard the areas of concern leading to the investigation.”*

The Commissioner would like to commend the hospital for acknowledging the deficiencies of its services and working co-operatively and constructively to develop them in accordance with the recommendations in Dr E’s report. To ensure that the services continue to develop to meet the appropriate standards, a copy of this report has been forwarded to the Minister of Health, the Ministry of Health, the Director of Mental Health and the Mental Health Commission.

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