

Southern District Health Board

**A Report by the
Mental Health Commissioner**

(Case 17HDC00410)

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Executive summary

1. Ms A, then aged in her late teens, was transferred from a psychiatric unit at a public hospital to a clinic on 16 September 2013. Ms A was under a compulsory in-patient treatment order pursuant to section 30 of the Mental Health (Compulsory Treatment and Assessment) Act 1992 (the MHA).
2. Over the previous year, Ms A had presented with a significantly depressed and anxious mood associated with repeated self-harm behaviours, suicidal thoughts, and suicide attempts.
3. On 10 November 2013, Ms A left the clinic. She was found by the Police and taken to a locked unit at a psychiatric hospital. Clinic psychiatrist Dr C attended to assess Ms A. There was no bed available on the locked unit, so Ms A was transferred to a secure unit under Police restraint, as she continued to struggle.
4. When she arrived at the secure unit her clothing was removed. She was not given a tear-resistant gown to wear. She was also not provided with a mattress or a pillow. She was left with only a tear-resistant blanket and a cardboard bedpan.
5. The lights were left on overnight.
6. A “seclusion recording form” details that two-hourly assessments and 10-minute observations occurred.
7. At 4.30am two nurses recorded an 8-hourly assessment of Ms A.
8. The room was entered at 8.00am on 11 November 2013 to provide food and fluids and to assess Ms A, and again at 9.35am to provide fluids.
9. At 11.05am, the room was entered again, and Ms A was provided with a gown. A mattress was placed in the room, and Ms A was told that they were working towards moving her to the locked unit.
10. At 1pm, the room was entered to allow the clinic staff to assess Ms A’s mood and mental state. At 1.10pm, the seclusion was suspended, and at 2.00pm it was terminated and Ms A was returned to the clinic.

Findings

11. A number of Southern DHB staff failed to comply with the Southern DHB seclusion guideline and the Ministry of Health seclusion requirements, and with the accepted standard of care for nursing staff. DHBs are responsible for ensuring that staff comply with its policies and provide care of an acceptable standard. Southern DHB failed to ensure that staff complied with its policies and provided care of an acceptable standard.
12. I am not able to make a finding that the denial of clothing and bedding was a punitive action or intended to humiliate Ms A; however, I consider that these actions were unacceptable and unkind.

13. The manner of seclusion, over a period of approximately 18 hours, including removing Ms A's clothes, not providing her with a mattress, pillow or gown, and not dimming the lights overnight, meant that Southern DHB failed to respect Ms A's dignity and independence and, accordingly, breached Right 3 of the Code.

Recommendations

14. Southern DHB agreed to provide a written apology to Ms A.
15. Southern DHB agreed to undertake the following steps, with input from a consumer advisor:
 - a) Provide training to the psychiatric hospital's mental health staff on restraint, seclusion, and the Code of Rights.
 - b) Review its restraint minimisation and seclusion guidelines to ensure that they provide sufficient guidance on seclusion practices in line with the current Ministry of Health guidelines and any guidance from the Health Quality & Safety Commission.
 - c) Review the seclusion policy to provide specific guidance on the provisions consumers should be provided with when placed in seclusion, including clothing and bedding.

Complaint and investigation

16. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by Southern District Health Board (DHB) in 2013. The following issue was identified for investigation:

- *Whether Southern DHB provided Ms A with an appropriate standard of care.*

17. This report is the opinion of Mental Health Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

18. The parties directly involved in the investigation were:

Ms A	Complainant/consumer
Dr B	Psychiatrist/provider
The clinic	Provider
Southern DHB	Provider

19. Also mentioned in this report:

Dr C	Psychiatrist
RN D	Registered nurse

20. Independent expert advice was obtained from a registered nurse, Dr Anthony O'Brien, and is included as **Appendix A**.

Information gathered during investigation

Background

21. Ms A, then aged in her late teens, was transferred to a clinic in the hope that it would be of assistance in addressing her mental health difficulties.
22. Over the previous year, Ms A had presented with a significantly depressed and anxious mood associated with repeated self-harm behaviours, suicidal thoughts, and suicide attempts.
23. At the time of these events, Ms A was under a compulsory in-patient treatment order pursuant to section 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).
24. Clinic psychiatrist Dr B stated:

“One of the major concerns we had with [Ms A] was to do with the safety of being able to contain her in the relatively open environment at [the clinic]. There were occasions when [Ms A] experienced an increase in the intensity and frequency of suicidal thoughts and was not able to co-operate with staff to a sufficient degree that we felt she could be safely contained in our unit.”

The psychiatric hospital

25. The psychiatric hospital is operated by Southern DHB and has a locked unit for patients who are experiencing an acute phase of a mental health disorder and are unable to be managed in an open ward.
26. The secure unit is for consumers who are involved with the justice system and require assessment, treatment, and rehabilitation. Clients have either been charged with a criminal offence, or alleged to have offended, and are known or suspected to have a mental illness, or require assessment and treatment whilst serving a prison sentence, or are unable to be managed safely in general mental health services.
27. Both units have facilities for the seclusion¹ of patients.

Memorandum of Understanding

28. As stated, the clinic has a relatively open environment and does not have seclusion facilities. As it sometimes needs to place patients in a more secure environment, it has a Memorandum of Understanding with Southern DHB that governs the processes and procedures by which in-patients at the clinic are transferred to the psychiatric hospital.
29. The clinic provided HDC with the Memorandum of Understanding it entered into with the then Otago District Health Board (subsequently Southern DHB) in June 2008. The Memorandum of Understanding states that except in exceptional circumstances, patients

¹ The New Zealand Health and Disability Services Standards define seclusion as “where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit”.

who require intensive care will be admitted to the locked unit. It states that the clinic consultant will contact the consultant at the psychiatric hospital who will be caring for the patient, via the nurse in charge of the locked unit, and discuss the admission. Clinic staff then transport the patient to the psychiatric hospital. If a patient is required to be admitted to an Otago District Health Board (now Southern DHB) hospital, all relevant documentation should accompany the in-patient, including all recent assessment and care planning documentation. All transfers must be notified to the Clinical Director/Clinical Leader Mental Health Services at Southern DHB.

30. The clinic said:

“[W]hilst we often can manage patients who are at some risk of engaging in self-harm or suicidal behaviours, when these escalate to a certain level and are accompanied by a lack of willingness or capacity on the part of the patient to work cooperatively with [clinic] staff, the consideration is given to transferring them to a more secure locked facility. For the most part our patients only require the added containment of a locked ward, rather than seclusion, but on occasion, seclusion has been considered necessary.”

31. The clinic stated that the arrangement was that if a patient was transferred to the psychiatric hospital, the patient would be assessed by his or her regular clinic psychiatrist at least daily until the patient was transferred back to the clinic. Dr B told HDC that if there were any major management difficulties while the patient was in the psychiatric hospital, the staff would contact clinic staff. He stated that this would usually be the situation should a clinic patient need to be secluded, “which is a relatively rare event for [clinic] patients who have been transferred there”.

10/11 November 2013

32. Ms A was transferred to the psychiatric hospital on 10 November 2013. The clinic’s nursing notes state that Ms A was on half-hourly observations, and at approximately 7.10pm she was seen to leave the premises after having had a verbal disagreement with another patient. She was followed by nursing staff, but refused to return. The records state that staff followed Ms A in the unit car and saw her leave the road and enter some bushes.
33. Clinic staff called the Police, who arrived with a police dog and located Ms A sitting in a tree. She had harmed herself.

Transfer to the psychiatric hospital

34. Clinic records state:

“Police forcibly assisted [Ms A] out of the tree and into restraint, escorted by police out of bushes. Partial restraint by [Registered Nurse (RN)] and attending police officer, whilst the officer retrieved police dog. Restraint on [the road] approximately 5 [minutes] whilst waiting for confirmation of admission to [the locked unit]. Transported to [the locked unit] in police car.”

35. Southern DHB stated that its mental health services were contacted on the evening of 10 November 2013, probably by clinic psychiatrist Dr C.² There is no record of the contact or of the information conveyed.
36. Southern DHB stated that on 10 November 2013, “Police were required to assist due to [Ms A’s] level of aggression to [clinic] staff and the potential high risk of [Ms A] to self harm”. Southern DHB stated:
- “[Ms A] continued to remain highly aggressive/volatile and the clinic staff (it is likely this was [Dr C]) contacted [the locked unit] to again ask for assistance in the form of using a seclusion room to contain [Ms A] and manage her risk to self and others, given her level of resistance.”
37. The clinic said that the decision was made to transfer [Ms A] to the more secure and locked ward at the psychiatric hospital “due to it being considered that she could not be safely contained in the more open environment at the clinic”.
38. Ms A was taken to the locked unit at the psychiatric hospital for assessment. Dr C attended the locked unit to assess Ms A. A Southern DHB incident form completed by RN D on 10 November 2013 (included in the progress notes) states that there was no bed available on the locked unit, so Ms A was transferred to the secure unit under Police restraint, as she continued to struggle.
39. The incident form states: “Whilst in partial restraint her clothing ... was removed. [She was given first aid].” Southern DHB said that it was necessary to restrain Ms A to provide first aid.

Seclusion

40. Ms A was placed in a seclusion room in the secure unit. Dr C recorded in the Southern DHB progress notes that Ms A had been refusing food, had not had any medication for six days, and had “continued to be uncooperative and [had] been secluded in [the secure unit]”.
41. The Southern DHB incident form states:
- “She had been non compliant with medication for the previous six days and refused to accept any [in the secure unit]. In view of her previous history of severe self harm and her current high risk presentation and inability to work with staff, she was secluded. Full restraint required to exit the room safely.”
42. The seclusion recording form includes the account of events recorded on the incident form. It is signed by Dr C, identified on the form as the Medical Authorising Clinician, and RN D, identified as the Initiating Clinician. The incident form and the seclusion recording form state that the restraint team consisted of three nurses. Dr C and two clinic nurses were also present. The seclusion recording form indicates that the seclusion commenced at 8.25pm.

² Dr C has since retired and was not able to be contacted.

43. The seclusion recording form states that when Ms A was informed of the seclusion, she provided no response and she “continued to struggle [and] try [to] bite staff”.
44. Ms A stated that when she arrived at the secure unit, a number of nurses held her down and forcibly removed all of her clothing, including her underwear. She stated that previously when she had been transferred to the psychiatric hospital she had been given a tear-resistant gown to wear, but on this occasion one was not provided. She said that once she was naked, the staff pushed her onto the floor, left the room, and locked her in. She said that all she had was a tear-resistant blanket and a cardboard bedpan.
45. Southern DHB stated that the removal of the mattress and pillow is not documented, but they may have been removed because of the level of risk. RN D completed a treatment plan/review, which states that Ms A was to be nursed on 10-minute observations and secluded until her level of risk was reduced. It also states: “Encourage to be open about her thoughts [and] feelings to staff.”
46. Southern DHB told HDC: “Given her level of risk and presentation, clothing was also removed and seclusion blankets were provided.” It said that Ms A was not provided with a gown because of her risk of self-harm. In response to the provisional opinion, Ms A stated that the gowns were tear resistant, there were no ligature points in the room, and the gowns were made from similar if not the same material as the blanket she was given. She said that if the absence of a gown was to mitigate risk, she should not have been given a blanket either.

Monitoring

47. The progress notes at 10pm state that Ms A remained in seclusion on 10-minute “checks”, and that there had been no further unsafe behaviour attempted, although she continued to be non-communicative with staff and would not give safety assurances. The progress notes overnight state that Ms A remained on 10-minute observations, and that her room was not entered, to allow her to sleep. The seclusion recording form indicates her room was not entered between 10.15pm and 8am.
48. In response to the provisional opinion, Southern DHB provided HDC with an observation form detailing the 10-minute observations. Southern DHB also provided a “seclusion recording form” that details two-hourly assessment, and that the plan overnight was to promote sleep and not to enter the room and wake her if she was “safely sleeping”. The 10-minute observations on the seclusion recording form state that she was “resting quietly” or “appears asleep” for the majority of observations from 10.50pm until 7.50am.
49. Southern DHB said that it is standard practice to leave the light on to enable observation checks of patients in seclusion; however, the lights are able to be dimmed. Southern DHB has not commented on whether the lights were dimmed overnight on this particular night, and there is no record in the progress notes of this having occurred.
50. Ms A said that it was extremely uncomfortable trying to sleep on the cold hard surface, especially as the blanket would not wrap around her completely, and she did not want to lie on the top of the blanket because the nurses observing her through the window and

door would see her naked. She stated that the staff left the lights on full all night, so it was impossible to sleep.

51. At 4.30am on 11 November 2013, two nurses recorded an 8-hourly assessment of Ms A. It states that she was lying covered with a blanket and appeared to be sleeping. It records that the doctor had been consulted and seclusion was to continue.

Entry to room

52. The progress notes and seclusion recording form state that the room was entered at 8am on 11 November 2013 to provide food and fluids and to assess Ms A, and again at 9.35am to provide fluids. The progress notes state that she was sitting on the “[plinth]” wrapped in a seclusion blanket, and that she refused risperidone.³ She was provided with fluids.
53. At 11.05am, the room was entered again. The progress notes state that Ms A was again sitting on the “[plinth]” wrapped in a “gown/blanket”. The notes record that she was “provided with [a] gown”, and was observed by a nursing student with Ms A’s consent. The seclusion recording form states that a mattress was brought into the room and Ms A was told that they were working towards moving her to the locked unit.
54. Southern DHB stated:

“We are sorry there was a delay in offering the gown to [Ms A]. It is unclear from the clinical records why this did not occur sooner. This is not standard practice, although such interventions need to be individualised to ensure the safety of the patient involved.”

55. Subsequently, Ms A was reviewed by another psychiatrist, Dr B (time not recorded), who noted in the Southern DHB progress notes that Ms A said that her suicidal thoughts were less strong that day, although the previous day she had had suicidal thoughts.
56. Dr B recorded in the Southern DHB progress notes that the plan was to return Ms A to the clinic that day.
57. The progress notes state that at 1pm the room was entered to allow “clinic staff” to assess Ms A’s mood and mental state. At around 1pm, the seclusion was suspended, and at 2pm it was terminated. Ms A was returned to the clinic.

Seclusion — Mental Health and Intellectual Disability Service (Otago) guideline

58. The Seclusion — Mental Health and Intellectual Disability Service (Otago) guideline (Southern DHB’s seclusion guideline) was released in 2011.⁴ It provides that there must be adequate staff to restrain a patient if required, and to “use four staff to place [patients] in seclusion, more if indicated”.

³ Risperidone is an antipsychotic medication mainly used to treat schizophrenia, bipolar disorder, and irritability in people with autism.

⁴ The 2011 guideline was subsequently replaced by the Restraint Minimisation and Seclusion Guidelines — MHAID Service (District) Southern DHB 80039 V1, which was introduced in 2014.

59. The Southern DHB seclusion guideline also states: “Clinical assessment will determine the items/clothing permitted in the seclusion room.” It requires that the “Seclusion Recording Form”, Electronic Incident Form, and Health Record documentation be completed.
60. The Southern DHB seclusion guideline requires there to be an eight-hourly review of a patient in seclusion — to be completed each shift.

Further information — Southern DHB

61. Southern DHB stated that Ms A’s short transfers to the locked unit during the six weeks preceding 10 November 2013 had involved the use of seclusion, tear-resistant clothing, or a seclusion room. Southern DHB said that options used were dependent on the degree of co-operation and the risk Ms A presented with, and as directed by the psychiatrist from the clinic.
62. Southern DHB stated that on 10 November 2013, the clinical notes indicate that Ms A displayed a high level of volatility and a high self-harm risk, and that she was unwilling to provide assurance or willingness to be safe or to co-operate with the healthcare providers present. Southern DHB said: “The evidence available indicates that [Ms A] was very aggressive.” In response to the provisional opinion, Southern DHB noted that Dr C supported the use of seclusion on 10 November 2013.
63. Clinic notes do not refer to Ms A being aggressive; rather, they refer to her running away, and to her lack of co-operation with staff. The Southern DHB notes also do not refer to any acts of aggression by Ms A other than a reference in the seclusion recording form at 8.30pm on 10 November 2013 to her having “continued to struggle [and] try [to] bite staff”.
64. In response to the provisional opinion, Ms A stated that she objected to the assertion that she was highly aggressive. She said that she resisted restraint, but that this was because of fear rather than trying to hurt anyone. She said that aggression to others has never been a feature of her illness.
65. Southern DHB stated that it was not psychiatric hospital nursing staff who decided to seclude Ms A, as they responded to a request from clinic staff that seclusion was required. Southern DHB said that clinic staff, including Dr C, were “the primary decision makers regarding the plan to use seclusion and how to manage [Ms A] in seclusion” and, if the psychiatric hospital staff had not agreed to seclusion, the alternative would have been to return her to the clinic.
66. Southern DHB said that its current seclusion guidelines are less restrictive, and allow patients to retain normal clothing, the same bedding as the rest of the unit, and access to an en suite bathroom and water.
67. With regard to continuation of the seclusion once Ms A had settled to sleep, Southern DHB stated that she was still medically under the care of the clinic, and there were no beds on the locked unit and, although she could have been returned to the clinic, that was not

considered, as nursing staff on the locked unit were waiting for clinic staff to arrive “to assess input needs”.

68. Southern DHB said that over recent years, clinical staff working across the service have been involved in a number of seclusion reduction strategies using The Six Core Strategies framework and, more recently, a concerted effort has started on working towards the Health Quality & Safety Commission’s aspirational goal of achieving zero seclusion by 2020. Southern DHB said that both these pieces of work are linked to workforce development activities, where there has been a focus on Trauma Informed Care and other workforce culture related changes. A review group made up of key clinical staff from within the wider service now reviews seclusion episodes.

The clinic — further information

69. The clinic stated that the decision to transfer Ms A to the psychiatric hospital was “due to it being considered that she could not be safely contained in the open environment at [the clinic]” because she had left the grounds without permission.
70. The clinic stated that Ms A was not co-operative with attempts by staff and Police to assist her, and required “some degree of physical restraint” to be transferred to the psychiatric hospital in a police car. The clinic stated that once patients have been transferred to the psychiatric hospital, their management is a collaborative process, and “[i]f there are any acute situations that occur (e.g. a patient self-harming or becoming aggressive) then this is also managed at the time by [locked unit] staff according to their own management processes and protocols although they would let [clinic] staff know about it subsequently”. Psychiatric management generally remains with the patient’s regular clinic psychiatrist rather than being transferred to one of the locked unit psychiatrists.
71. The clinic stated that the routine care of a clinic patient while in the locked unit, such as regular observations, medication administration, assessment, and documentation of mental state, is provided by locked unit nursing staff.

Ministry of Health publication

72. The Ministry of Health publication “Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992” (2 February 2010)⁵ sets out a number of requirements for seclusion, including:
- The longest interval between recorded observations should be 10 minutes.
 - An attempt should be made by a suitably qualified clinician at least once every two hours to enter the room to assess the physical well-being of the patient. If the attempt is unsuccessful, a record of why must be noted on the reporting form.
 - Once every two hours, an assessment of mental state should be recorded.

⁵ <https://www.health.govt.nz/publication/seclusion-under-mental-health-compulsory-assessment-and-treatment-act-1992>.

- If over the course of one admission the cumulative hours of seclusion exceed 24 hours in a four-week period, reassessment in the form of a case management conference should occur.
 - A specific form must be used to record the use of seclusion, and must be supported by clinical notes. In addition, each service must develop a method of recording the 10-minute and two-hourly observations.
73. Within eight hours, there should be a documented clinical consultation with the responsible clinician, communication of care requirements to the following shift verbally and in the patient's plan, and a psychiatric assessment of the patient. The Ministry of Health publication states that seclusion may be appropriate, inter alia, for the control of harmful behaviour that cannot be controlled adequately with psychological techniques and/or medication. It states that seclusion should be used with extreme caution where there is the presence or likelihood of self-injurious behaviour.
74. The Ministry of Health publication states that a person in seclusion should be allowed as much of his or her normal clothing as possible within the dictates of safety, and should not be deprived of his or her personal possessions.

Further information — Ms A

75. Ms A stated: "It was probably the worst, most humiliating and dehumanising thing I have ever experienced and it makes me immensely terrified of getting unwell again."

Responses to provisional opinion

Ms A

76. Ms A's responses have been included in the "facts gathered" section where appropriate.
77. Ms A said that she cannot see how a mattress and pillow could be used to harm oneself. She stated:

"I do accept that I presented a significant risk to myself, however I do not believe that this risk necessitated seclusion, nor the treatment that I received whilst in seclusion. I believe I could have been managed on a locked ward without being secluded. What I experienced on that occasion was incredibly dehumanising and continues to affect me."

Southern DHB

78. Southern DHB's responses have been included in the "facts gathered" section where appropriate.
79. Southern DHB provided further clinical records. It accepted the recommendations in the provisional opinion.

Opinion: General comment

80. The Ministry of Health publication states that seclusion should be used with extreme caution where there is the presence or likelihood of self-injurious behaviour, but it may be appropriate for the control of harmful behaviour occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication.
 81. There should be a robust rationale for seclusion, which is documented appropriately. In cases where seclusion is appropriate, consumers must be provided with appropriate care throughout the seclusion, including the manner of seclusion, monitoring, and record-keeping.
 82. In this case, I have not considered whether it was appropriate to restrain and seclude Ms A, nor whether the decision to continue the seclusion following the eight-hour review was appropriate, because the focus of her complaint was the manner in which she was treated while she was secluded, rather than the fact of seclusion. It would also be difficult for me to assess whether the initial decision to seclude was appropriate, owing to the passage of time and the evidence available to me.
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Opinion: Southern District Health Board — breach

Introduction

83. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any failures in the provision of those services. A number of Southern DHB staff failed to comply with the Southern DHB seclusion guideline and the Ministry of Health publication regarding the requirements for seclusion. In my view, the treatment of Ms A following the decision to admit her to the psychiatric hospital is a service failure that is directly attributable to Southern DHB as the service operator.
84. Ms A, who was in her late teens at the time, was a young, vulnerable consumer with a history of being mentally unwell. On the evening of 10 November 2013, Ms A left the clinic, and staff had concerns for her safety. The Police transported her to the psychiatric hospital and took her to the secure unit.

Restraint and manner of seclusion

85. Ms A was placed in seclusion at around 8.30pm, soon after her arrival at the secure unit. She said that a number of nurses held her down and forcibly removed all of her clothing, including her underwear. She said that once she was naked, the staff pushed her onto the floor, left the room, and locked her in. It is clear that she found this treatment humiliating.
86. The 10-minute observations on the seclusion recording form state that Ms A was “resting quietly” or “appears asleep” for the majority of observations from 10.50pm until 7.50am.

87. Ms A was given a tear-proof blanket as bedding. She was not provided with a mattress, pillow, or gown. She said that she spent an uncomfortable night trying to cover herself with the tear-proof blanket, and was unable to sleep because the lights were left on full. Southern DHB said that it is standard practice to leave the light on to enable observation checks of patients in seclusion; however, the lights are able to be dimmed. Southern DHB did not comment on whether the lights were dimmed overnight on this particular night. There is no record that the lights were dimmed, and I accept Ms A's account that the staff left the lights on full all night. In my view, the lights should have been dimmed as much as possible whilst still allowing staff to monitor Ms A.
88. The Ministry of Health publication states that a person in seclusion should be allowed as much of his or her normal clothing as possible within the dictates of safety. The Southern DHB seclusion guideline states that a clinical assessment should be conducted to determine the items and clothing permitted in the seclusion room.
89. Although Southern DHB stated that there was a risk of Ms A using clothing for self-harm, there is no documentation in clinic notes or the Southern DHB notes of an assessment of her risk of self-harm apart from the references to risk in the Treatment Plan/Review. I note that although the room was entered twice on the morning of 11 November 2013, at 8am and 9.35am, a gown was not provided until 11am that day. Southern DHB apologised for the delay in offering the gown to Ms A.
90. My expert advisor, Dr O'Brien, advised that it was not reasonable that Ms A was not provided with a gown, mattress, or pillow. He stated: "Apart from having to endure the discomfort of sleeping on the floor with no support for her head, it is undignified for anyone to be deprived of all clothing." Dr O'Brien noted that Ms A was being observed every 10 minutes, and that this could have been increased to continuous observation if it was thought that there was a risk that she would use a gown to harm herself. He said that it is hard to imagine how a mattress and pillow could be considered a risk.
91. Dr O'Brien stated that sometimes mental health nurses are faced with the need to use restrictive practices such as committal, forced use of medication, restraint, and seclusion. However, he added:

"Even in such adverse circumstances care can be provided with sensitivity, respect, and dignity. Even under conditions of coercion consumers will appreciate attempts to provide care respectfully. Of all the learning that can be taken from this incident, the point that would make the most immediate impact on [Ms A's] experience of care is the simple provision of every day comforts."
92. Dr O'Brien advised that failing to provide a gown, mattress, or pillow was a moderate departure from accepted practice. I agree with this advice, and consider that Ms A's dignity was not respected.
93. The records indicate that on 11 November 2013 Ms A was settled from at least 8am. The seclusion room was entered at 8am to provide food and fluids and to assess her, and at 9.35am to provide her with fluids. The room was entered again at 11.05am and 1pm.

However, Ms A was not given clothing until 11.05am, the seclusion was not suspended until around 1pm, and the seclusion was not terminated until 2pm.

94. I am not able to make a finding that the denial of clothing and bedding was a punitive action or intended to humiliate Ms A; however, I consider that these actions were unacceptable and unkind.

Monitoring

95. The Ministry of Health publication states that the longest interval between observations should be 10 minutes, and the plan of care whilst Ms A was in seclusion was for 10-minute visual observations. Southern DHB stated that she was observed, but the room was not entered overnight to enable her to sleep. Southern DHB has provided HDC with records of the 10-minute observations.
96. In addition, the Ministry of Health publication states that an attempt should be made to enter the seclusion room every two hours to assess the physical well-being of the patient and undertake a mental state assessment. Unsuccessful attempts should be recorded. The Ministry of Health publication also recommends that within eight hours there should be documented clinical consultation with the responsible clinician, communication of care requirements verbally and in the patient's plan to the following shift, and a psychiatric assessment of the patient.
97. Southern DHB staff did not enter the room overnight. The reason given by Southern DHB for this, and supported by the progress notes, is that it was to allow Ms A to sleep. The overnight seclusion recording form states that she was "resting quietly" or "appears asleep".
98. Dr O'Brien advised that if Ms A had been asleep, it would have been unreasonable to wake her. I agree. Therefore, I am not critical that Southern DHB staff did not enter the room overnight to undertake the two-hourly assessments and the eight-hourly psychiatric assessment.
99. I note that the evidence available to me indicates that Ms A was monitored appropriately during her time in seclusion.

Conclusions

100. As set out above, a number of Southern DHB staff failed to comply with the Southern DHB seclusion guideline and the Ministry of Health publication, and with the accepted standard of care for nursing staff. DHBs are responsible for ensuring that staff comply with its policies and provide care of an acceptable standard. Southern DHB failed to ensure that staff complied with its policies and provided care of an acceptable standard in a number of ways.
101. In my view, the manner of seclusion, over a period of approximately 18 hours, including removing Ms A's clothes, not providing her with a mattress, pillow or gown, and not dimming the lights overnight, meant that Southern DHB failed to respect Ms A's dignity

and independence and, accordingly, breached Right 3 of the Code of Health and Disability Services Consumers' Rights.⁶

Recommendations

102. Southern DHB has agreed to provide a written apology to Ms A. The apology should be provided to HDC within three weeks of the date of this opinion, for forwarding.
 103. Southern DHB has agreed to undertake the following steps, with input from a consumer advisor, and report back to HDC within three months of the date of this opinion:
 - a) Provide training to psychiatric hospital mental health staff on restraint, seclusion, and the Code of Health and Disability Services Consumers' Rights.
 - b) Review its restraint minimisation and seclusion guidelines to ensure that they provide sufficient guidance on seclusion practices in line with the current Ministry of Health guidelines and any guidance from the Health Quality & Safety Commission.
 - c) Review the seclusion policy to provide specific guidance on the provisions consumers should be provided with when placed in seclusion, including clothing and bedding.
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Follow-up actions

104. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Southern DHB, will be sent to the Health Quality & Safety Commission, the Ministry of Health, the Director of Mental Health, the Mental Health Foundation, Te Ao Māramatanga New Zealand College of Mental Health Nurses, and Te Pou o te Whakaaro Nui, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

⁶ Right 3 states: "Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual."

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Anthony O'Brien (RN, PhD, FANZCMHN) on 24 October 2018¹:

"Preamble

I have been asked by the Commissioner to provide expert advice on case number C17HDC00410. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my training as a nurse in 1974. I qualified as a registered male nurse in 1977 (later changed to registered general nurse) and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. I am a duly authorised officer under the Mental Health (Compulsory Assessment and Treatment) Act (1992). My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Ms A] by Southern District Health Board (DHB) mental health service on 11 November 2013. I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Ms A] by Southern DHB was reasonable in the circumstances, and why.

In particular please comment on:

1. The reasonableness of [Ms A] not being provided with a gown, mattress or pillow.
2. The adequacy of any observations undertaken.

¹ Southern DHB provided further clinical records in response to the provisional opinion including additional progress notes and the seclusion recording form. The new information did not relate to the manner of seclusion. This advice was provided prior to receipt of that additional information.

3. The adequacy of any assessments undertaken.
4. The adequacy of the documentation and clinical notes for this period of seclusion.
5. A general comment on the appropriateness of the manner of seclusion.
6. Any other matters in this case that you consider warrant comment.

I have also been asked whether I consider expert advice is provided by another specialty.

In relation to the above issues I have been asked to advise on:

- a. What the standard of care/accepted practice is;
- b. If there has been a departure from the standard of care or accepted practice, how significant a departure it is.
- c. How the care provided would be viewed by my peers.
- d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I have had the following documents available to me for the purpose of writing this report:

1. Letter of complaint from [Ms A]
2. [Ms A's] statement of further concerns.
3. Response from Southern DHB dated 25 January 2018.
4. Further response from Southern DHB dated 30 April 2018.
5. Further response from Southern DHB dated 4 July 2018.
6. Clinical notes from Southern DHB covering the period 6 November 2013–11 November 2013.
7. Relevant policy documents from Southern DHB, including:
 - a. Restraint minimisation and safe practice policy (Document 68818)
 - b. Restraint minimisation and seclusion guidelines (Document 80039 — not started until 2014).
 - c. Memorandum of Understanding between Otago DHB (later Southern DHB) and [the clinic] relating to care of patients transferred from [the clinic] to Southern DHB mental health services and other matters, dated 3rd June, 2008.
 - d. Seclusion — Mental Health and Intellectual Disability Service (Otago) guideline Southern DHB 29159 V4
8. Response from [the clinic] to HDC dated July 17, 2018.
9. Clinical notes from [the clinic] from 8 November 2013 to 30 November 2013.

10. A discharge summary and clinical notes from [the Emergency Department] dated 15 November 2013.
11. A discharge summary written by [Dr B] on December 3, 2013, at the time of [Ms A's] transfer to [another] DHB.
12. Medication charts from [the clinic] from 6th September 2013 to 15th November 2013.
13. Mental Health Act papers from 8 August 2013 to 13 September 2013.
14. [Discharge summary from the clinic].

Background

The events related to this case occurred on a single night over 10/11/13 and 11/11/13, and relate to care provided by Southern DHB to [Ms A]. The reason for the long delay in resolving this complaint is that files at Southern DHB were unavailable due to asbestos contamination. One effect of this delay is that several individuals who had a role in [Ms A's] care are either retired or no longer employed by Southern DHB. It is my opinion that unavailability of some relevant staff does not impact on the main issues of the complaint, which are to do with a single seclusion event.

[The clinic] is an independent entity but operates with a Memorandum of Understanding (MoU) with Southern DHB. One particular aspect of the MoU has to do with emergency provisions for patients who are unable to be cared for in the open (unlocked) environment of [the clinic]. In these instances patients are transferred to [the psychiatric hospital], typically for very short periods of time, for example 24 hours. The Memorandum of Understanding does not make a specific reference to the use of seclusion. At the time of the events in question [Ms A] was subject to a compulsory treatment order under section 30 of the Mental Health (Compulsory Assessment and Treatment) Act (1992) (MHA). [Dr B] was her responsible clinician under the MHA.

Outline of events

The complaint relates to an episode of seclusion provided at the secure unit at Southern DHB's [psychiatric hospital] the night of 10–11 November 2013. [Ms A] was at that time [in her late teens] and was an inpatient at [the clinic], a private inpatient mental health facility. [Ms A] had been an inpatient at [the clinic] for almost two months, and her time there had been marked by persisting thoughts of self-harm, acts of self-harm, and at least one other transfer to [the psychiatric hospital] for overnight secure care.

On the evening of 10 November, at around 1915 hrs [Ms A] left [the clinic] and staff there had concerns for her safety. [Clinic] staff pursued [Ms A] in a car, and called Police when it became evident that she was not going to cooperate with their requests for her to return. When Police arrived [Ms A] had climbed a tree in a park, [and had harmed herself]. Police removed [Ms A] from the tree, and with [clinic] staff used restraint to prevent [Ms A] absconding again, and to transport her to [the psychiatric hospital]. Notes record that five minutes restraint was used at the side of

the road before [Ms A] was placed in a police car for transport. [A staff member from the clinic] rode in the police car with [Ms A] to the hospital. She arrived there at around 2030 hrs. The plan was for [Ms A] to be held overnight at [the psychiatric hospital]. The initial plan to admit [Ms A] to [the locked unit], [...] was changed to a plan to admit [Ms A] to [the secure unit]. It is important to note that the decision to use the [secure unit] was not made on the basis of risk, but because there was no seclusion room available in [the locked unit], and clinical risk assessment by [Dr C] had established that seclusion was necessary for [Ms A's] safety.

Once at [the psychiatric hospital] [Ms A] was admitted directly to [the secure unit] where she was immediately placed in seclusion. Her clothes were removed and she was given a tear-proof blanket as bedding, but no mattress, pillow or clothing. She spent the night on the floor of the seclusion room covered by the tear-proof blanket. The lights in her room were left on all night for the purposes of observation. [Ms A] was given a paper bed pan for toilet facilities. In the clinical records provided I did not see a note of what water [Ms A] was provided with. [Ms A's] treatment plan was for 10 minute observations while in seclusion.

At 0800am on the morning of November 11th [Ms A's] room was entered for the first time since 2030pm the night before, a period of 11.5 hours. [Ms A] was provided with food and fluids and her wound was inspected. Her mental state was assessed. The room was entered again at 1100 hrs and [Ms A] was given a hospital night gown to wear. Later, [Ms A] was reviewed by [Dr B] of [the clinic] and a decision was made to transfer her back to [the clinic]. The time of [Dr B's] assessment is not recorded. At 1400hrs the period of seclusion was ended and [Ms A] was returned to [the clinic]. Her total period of seclusion was approximately 17.5 hours.

The following section of this report responds to the Commissioner's questions.

1. The reasonableness of [Ms A] not being provided with a gown, mattress or pillow.

It is not reasonable that [Ms A] was not provided with a gown, mattress or pillow, especially for such a long period. Apart from having to endure the discomfort of sleeping on the floor, with no support for her head, it is undignified for anyone to be deprived of all clothing. The wording of [Ms A's] complaint makes it clear that she experienced extreme discomfort. There were risk considerations in [Ms A's] case. It is understandable that staff felt that they needed to maintain her safety, and they may have considered that an ordinary hospital gown presented a risk of further self-harm by attempted strangulation. This possibility of self-harm is indicated in [the CEO's] letter of 25 January 2018. Self-harm is known to occur in patients placed in seclusion. In his letter of 30 April 2018 [the CEO] states that the risk of [Ms A] using her clothing for self-harm was assessed by [clinic] staff as extreme, but that is not documented in any clinical notes written by [clinic] staff, or in the clinical notes of staff of SDHB. The SDHB document *Seclusion — Mental Health and Intellectual Disability Service (Otago) guideline Southern DHB 29159 V4* states that 'clinical assessment will determine the items/clothing permitted in the seclusion room'. There is clearly some discretionary decision making in this area. These concerns do not, in my opinion, justify depriving [Ms A] of all clothing, a mattress and a pillow. [Ms A] was being observed every 10

minutes, and this could have been increased to continuous observation if there was thought to be a specific risk that she would use a night gown to harm herself. In the case of the mattress and pillow it is hard to imagine how that could be considered a risk, and there is no documentation to indicate that.

If there is a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

I consider the lack of provision of a gown, mattress and pillow to be a moderate departure from accepted practice.

How the care provided would be viewed by your peers?

I believe this would be regarded by my peers as being an unacceptable departure from expected practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I am aware that all DHBs have revised seclusion policies in recent years. The SDHB policy provided does not provide specific guidance on what basic provisions (bedding, clothing etc) consumers should be provided with when placed in seclusion. This is also not covered in the Ministry of Health 2010 Guideline *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. The Ministry guideline does recommend that consumers should be permitted their personal clothing as much as possible, but it does not say what clothing should be provided if personal clothing is not permitted. My recommendation is that the DHB should review its current seclusion policy to consider whether the current reference to provision of bedding and clothing is adequate.

2. The adequacy of any observations taken.

The standard of care/accepted practice

The clinical notes state that the plan of care while [Ms A] was in seclusion was for 10 minute visual observations. The Transfer Plan/Review form completed on November 10 also documents a plan for 10 minute observations. This is the minimum standard recommended by the SDHB guideline and the Ministry of Health's guideline. However that guideline also states that an attempt should be made to enter the seclusion room every two hours for a mental state assessment. Unsuccessful attempts should be recorded, according to the guideline. Further, the guideline recommends that after eight hours there should be consultation with the responsible clinician, communication of care requirements verbally and in the patient's plan, and a psychiatric assessment of the patient. There is a similar provision in the SDHB guideline. A nursing note made on 11/11/13 documents a plan for '2hrly and 8 hrly review as per seclusion policy [...]'. No time is given but there is a previous note made at 0700 hrs on 11/11/13, so the note about 2hrly and 8hrly review must have been made between 0700 and the time of the next note at 0900hrs. There are no recorded observations between 2200 hrs on 10/11/13 and 0700 on 11/11/13. There is no record of the 2hrly or 8hrly reviews recommended in the Ministry of Health or SDHB

guidelines having taken place, or of a decision being made to defer these reviews. The SDHB guideline provides that 2hrly reviews can be deferred if a consumer is sleeping overnight. The 0700 note records that the room wasn't entered 'to allow for sleep'. In addition, there is no record of the 10 minute observations having taken place. The accepted standard of care is that each individual observation (i.e. six per hour) would be documented.

If there is a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

I consider the lack of documentation of 10 minute observations to be a mild departure from the standard of accepted practice. I consider the lack of specific documentation of the reasons for deferring 2hrly reviews and the review at 8hrs to be a mild departure from the standard of accepted practice.

How the care provided would be viewed by your peers?

I believe this would be regarded by my peers as being a mild departure from expected practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

In relation to the lack of documentation of the reasons for deferring the 2hrly and 8 hrly reviews, and the lack of documentation of 10 minute observations, my recommendation is that the DHB review its current seclusion policy to ensure that these Ministry of Health requirements for documentation are included, and there are appropriate documents available for recording of observations and reviews. I recommend that nursing staff are reminded of the requirements for these observations to be documented.

3. The adequacy of any assessments undertaken

The standard of care/accepted practice

Some of the comments made in question 2 above are relevant here. The Ministry of Health guideline is clear that a mental state assessment should be undertaken every two hours, and this was not done. Similarly the psychiatric assessment required after eight hours was not undertaken. These requirements can be considered the accepted standard of care. I do think it is relevant that [Ms A] was apparently asleep during the hours of 2200–0700, and it would seem unreasonable to wake her to assess her mental state. The SDHB guideline extends this discretion to staff. In noting that this is an area of discretion, the fact that [Ms A] slept all night begs the question of why seclusion was continued. The psychiatric assessment required after eight hours was not provided until after 1100 hrs, five hours after it was due.

If there is a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

I consider the lack of any face to face assessment until 0800hrs to be a mild departure from care.

How the care provided would be viewed by your peers?

I believe the lack of two hourly mental state assessments would be regarded by my peers as being a mild departure from expected practice. I believe the lack of psychiatric assessment after eight hours would be regarded by my peers as being a mild departure from expected practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

In relation to the lack of 2hrly mental state assessments and 8 hrly psychiatric assessment, my recommendation is that the DHB review its current seclusion policy to ensure that these Ministry of Health requirements are included, and there are appropriate documents available for recording of observations and reviews. If it has not already happened I recommended that nursing staff are reminded of the requirements for these assessments, and the need to document, with reasons, any circumstances in which the requirements are not met.

4. The adequacy of the documentation and clinical notes for this period of seclusion.

The standard of care/accepted practices

Some of the comments made in questions 2 and 3 above are relevant here as they relate to documentation. The documentation of the reasons for seclusion, outlined in Incident Form [number] is adequate, although as I have mentioned in the overall comment below, the use of seclusion for reasons of risk of self-harm runs counter to the guideline of the Ministry of Health. The standard of accepted practice is that all formal observations such as those made on patients in seclusion are documented. The plan to observe [Ms A] every 10 minutes is clearly documented in the nursing notes, (twice) on 10/11/13. However the 10 minute observations should all have been individually recorded.

There is no documentation of the rationale for using seclusion as required by the SDHB and Ministry of Health guidelines. Appendix Three of the Ministry of Health guideline provides templates for the authorisation of seclusion, extension of seclusion for more than eight hours, and ending of seclusion. The SDHB guideline refers to a 'seclusion recording form' (18897 — not provided) which I have assumed is similar to the Ministry's form. There is no evidence of these documents or any equivalent in the records provided.

If there is a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

I consider the lack of documentation of the 10 minute observations to be a mild departure from the accepted standard of care. I consider the lack of documentation of the authorisation for seclusion to be a moderate departure from the accepted standard of care.

How the care provided would be viewed by your peers?

I believe the lack of documentation of the 10 minute observations would be regarded by my peers as being a mild departure from expected practice. I believe the lack of documentation of the authorisation for seclusion would be regarded by my peers as being a moderate departure from expected practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I recommend that nursing staff are reminded of the requirements for all formal observations to be individually documented. The current SDHB Restraint Minimisation and Seclusion Guidelines do not specifically refer to practices such as frequency and documentation of observations, need for a document of authorisation of seclusion, and review frequency. These may be included in associated document 29159 (not provided) referred to in the Restraint Minimisation and Seclusion Guidelines. The relevant documents should be reviewed to ensure they provide sufficient guidance on seclusion practices, in line with the Ministry of Health guideline.

5. A general comment on the appropriateness of the manner of seclusion.

The decision to utilise seclusion

It appears that the decision to admit [Ms A] to [the psychiatric hospital] was also a decision to place her in seclusion. There is no documentation of [Dr C]'s authorisation of the use of seclusion apart from the nurses' report of [Dr C's] decision. At some point in the process of [Ms A's] transfer to [the psychiatric hospital] the decision to utilise seclusion was made, although such transfers do not always involve seclusion. [Dr B's] letter of 17 July 2018, notes that seclusion is a 'relatively rare event'. The Ministry of Health guideline states (page 5) that 'Seclusion should be used with extreme caution (original emphasis)' ... 'in the presence or likelihood of self-injurious behaviour'. The guideline does leave room for seclusion to be used in the case of potential for self-harm when it states (page 5) that seclusion may be appropriate for 'the control of harmful behaviour occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication'. However the balance of guidance seems to be against the use of seclusion in cases such as that of [Ms A]. In particular, the general aim of containment had been achieved through [Ms A's] placement in a locked ward and it is not clear, and certainly not documented, that seclusion was necessary to prevent further self harm.

Several documents provided as part of this investigation refer to aggressive behaviour on the part of [Ms A] during the incident of 10 November and subsequent transfer to [the secure unit]. The letters from [the CEO] refer to [Ms A] as 'highly aggressive' (25 January 2018) and 'very aggressive' (30 April 2018). I can find no evidence of aggressive behaviour in the reports written at the time of the incident. Incident form [number] states that [Ms A] 'continued to struggle' but this appears to be her attempt to regain her liberty rather than to harm others. There is no statement of aggression towards others. The [clinic] nursing note describes [Ms A] as 'resistant' but not as

aggressive to others. Several other incident reports from [the clinic] (after the incident on 10/11/13) refer to self-harm but not to a risk of harm to others. Further to this there is no reference to aggressive behaviour or risk to others in [Dr B's] summary of events written on 17 July 2018 or his comprehensive discharge summary written on 3 December 2013.

Overall, it is not clear to me that the decision to utilise seclusion was thought through in relation to the available guidelines or to the practice standard of 2013. This especially relates to the use of seclusion for someone with risk of self-harm.

Care while in seclusion

It is hard to see any sound rationale for the decision to deprive [Ms A] of all her clothing and have her sleep on the floor without a mattress or pillow. I have commented further on this in question 1 above.

6. Any other matters in this case that you consider warrant comment.

General comment

A notable feature of the clinical notes is that although there is frequent reference to [Ms A's] suicidality, including numerous episodes of self-harm, there are no references at all to risk to others. There is no reference to a risk to others in the daily nursing notes, in [Dr B's] summary of events to the Commissioner (17 July 2018) or his comprehensive discharge summary (3 December 2013), or in [the trainee psychotherapist's] extensive psychotherapy notes from before and after the date of the complaint. In the clinical notes related to the evening of November 10 when [Ms A] left [the clinic] there is also no reference to risk to others. She is described as resisting attempts to persuade her back to [the clinic], needing police to remove her from the tree, and to detain her for the purposes of transport to hospital. There is reference to [Ms A] struggling (presumably with police and clinical staff when detained) but she is not described as presenting a risk to others. She was walked (in partial restraint) to the police car. The two Southern DHB incident reports of 10 November describe [Ms A] continuing to struggle but all the statements about risk refer to [Ms A's] risk to herself, not to others. Her treatment plan also records risk to self but not risk to others. I am left with the impression that [Ms A's] risk to others was overestimated.

[Dr B's] letter of 17 July 2018 suggests that use of seclusion may be a reason for transferring a patient from [the clinic] to [the psychiatric hospital], although as noted above the Ministry of Health guideline urges extreme caution in this use of seclusion. In this regard I note that the 2014 SDHB document 80039 (Restraint minimisation and seclusion guidelines — not in place at the time of this incident) specifically states (page 4) that 'seclusion is not justified if it is being considered for managing risk of self-harm'. Seclusion is not specifically mentioned in the MoU between SDHB and [the clinic], and if this is a possible expectation of care on transfer to [the psychiatric hospital] this may need to be considered in reviewing the MoU.

Whether advice should be sought from another specialty.

The substance of this case is [Ms A's] experience of seclusion, in particular not being provided with clothing, a mattress or a pillow. These are matters that fall within the practice of nursing, so I do not see a need to seek advice from another specialty.

Summary

Although this report has commented on many aspects of this episode of care, the substance of [Ms A's] complaint relates to the manner of her care in seclusion rather than the decision to use seclusion. She does not complain about restraint, use of police, or transfer to a locked facility. The main focus of her complaint is being deprived of the basic comforts of clothing, mattress and a pillow. In [Ms A's] words, 'It was probably the worst, most humiliating and dehumanising thing I have ever experienced and it makes me immensely terrified of getting unwell again'. Mental health nurses are sometimes faced with the need to use restrictive practices such as committal, forced use of medication, restraint and seclusion. However even in such adverse circumstances care can be provided with sensitivity, respect, and dignity. Even under conditions of coercion consumers will appreciate attempts to provide care respectfully. Of all the learning that can be taken from this incident the point that would make the most immediate impact on [Ms A's] experience of care is the simple provision of everyday comforts.

Documents consulted

Gallagher, J., & Sheldon, K. (2010). Assessing the functions of self-harm behaviours for dangerous and severely personality disordered males in a high secure hospital. *The British Journal of Forensic Practice*, 12(1), 22–32.

Mental Health (Compulsory Assessment and Treatment) Act (1992).

Ministry of Health. 2010. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Te Ao Māramatanga, New Zealand College of Mental Health Nurses (2012). *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition) Auckland, Te Ao Māramatanga."