Figure 4.1: Relative frequency of Critical Incident Type

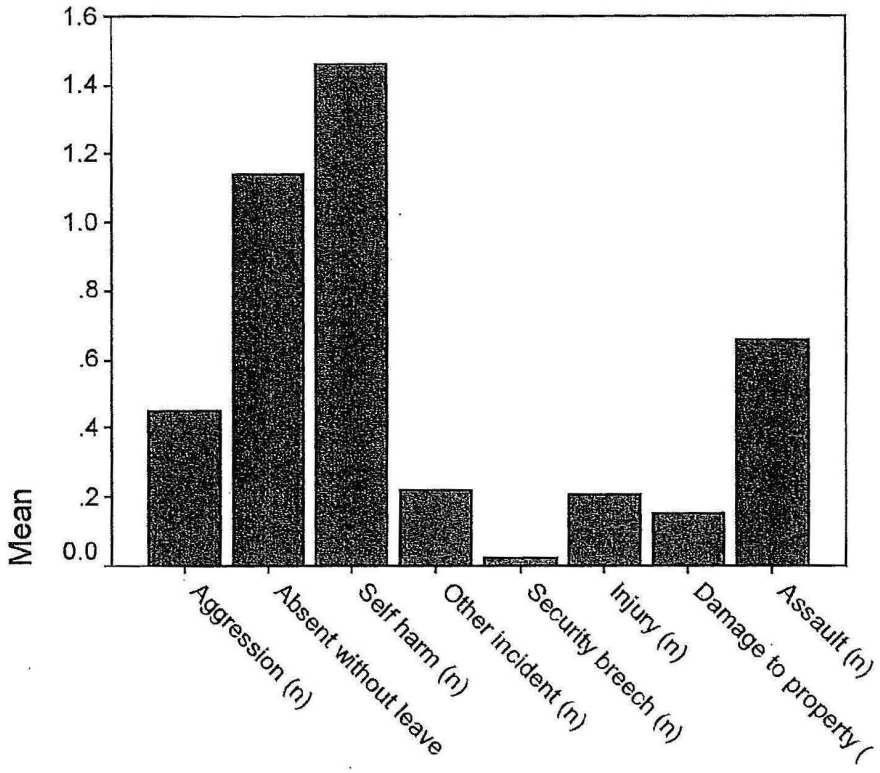

Figure 4.1 above depicts critical incident by incident type.

Self-harm was the most common critical incident occurring at the BAC. During this reporting period there were 134 incidents of self harm occurring in 33.7% of the critical incident patient sample. If self-harm occurred the patient was likely to do so on multiple occasions, given only 10.4% of the self harm group did so on only one occasion. In contrast approaching half of the sample (43.3%) of the self-harm group did so on 10 or more times. Self harm was significantly more likely to be perpetrated by female patients (female mean self harm = 2.703, male = 0.714, T_{70} =-2.232, p = .029). There was no correlation between patient age and number of self harming incidents. Self harm by gender is graphically represented in Figure 4.2.

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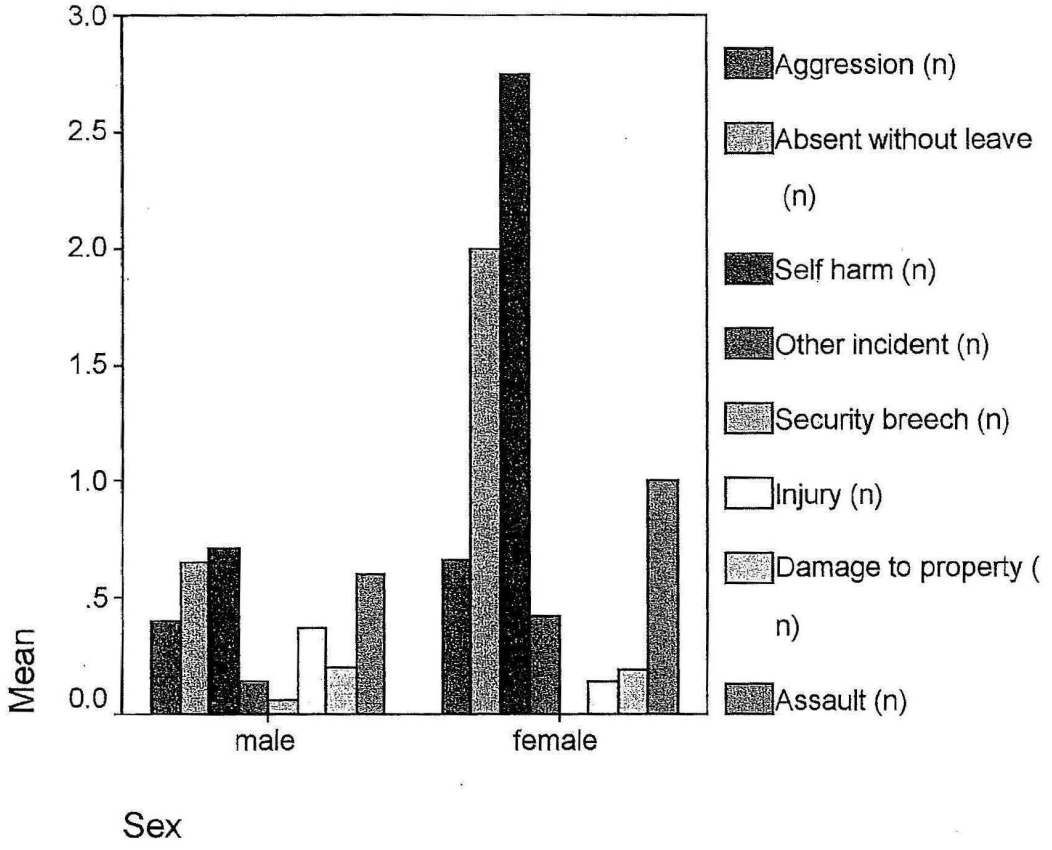
Figure 4.2 Critical Incident category by Gender



An **absent without leave (AWOL)** critical incident was recorded 104 times during the reporting period. 41 individuals were involved in one or more AWOL incidents, 22.2% of the CI sample had at least one AWOL incident. AWOL incidents were less likely to be multiple than self harm incidents: 54% of AWOL patients did so on only one occasion, 83% between 1 and 3 occasions and only 15% on more than 6 occasions. Significantly more female patients were involved in AWOL incidents (mean female AWOL = 2.000, male = 0.657, $T_{69} = -2.470$, $p = 0.016$). There was a trend ($p = .076$) for AWOL incidents to involve older patients.

An incident of **assault** was recorded 50 times during the reporting period. 33 individuals were involved in one or more assault incidents, 25.3% of the CI sample had at least one assault

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incident. Similar to the AWOL data, multiple incidents of assault was uncommon, 69% of patients were involved in one assault incident rapidly declining to 12% involved in two assaults and 18% in more than 2 assaults. The data suggests some tolerance to an act of assault: 2 patients were involved in 4 assaults, 3 patients in 5 assaults, 1 patient in 6 assaults. There was no gender or age difference in patients involved in assault incidents.

An incident of **aggression** was recorded 41 times during the reporting period. 24 individuals were involved in one or more aggressive incidents, 17.4% of the CI sample had at least one assault incident. Similar to the AWOL and assault data, multiple incidents of aggression was uncommon, 67% of patients were involved in one aggressive incident declining to 21% involved in two assaults and 12% in more than 2 assaults. Three individuals accounted for 4, 5 and 6 aggressive incidents respectively. There was no gender or age difference in patients involved in assault incidents.

No separated analysis was performed on low prevalence incidents such as injury (n = 20, 4.3% of all incidents), 'other' (n = 20, 4.3% of all incidents), property damage (n = 19, 4.1% of all incidents) and security breach (n = 2, 0.4% of all incidents).

Table 4.2 below, highlights the significant relationship between the most common variables with significant bivariate correlations between incidents reported as aggression and assault, AWOL and self harm, assault and AWOL and self harm and AWOL. The example of self harm and AWOL is graphical depicted in Figure 4.3. Whilst a higher order factor such as gender may be found following multivariate analysis with a larger sample size these results suggest that multiple forms of critical incidents cluster in individuals. The clinical implication is that if a patient is involved in one form of critical incident, the clinical staff should be aware of the potential for further incidents in that as well as in other domains of critical incidents.

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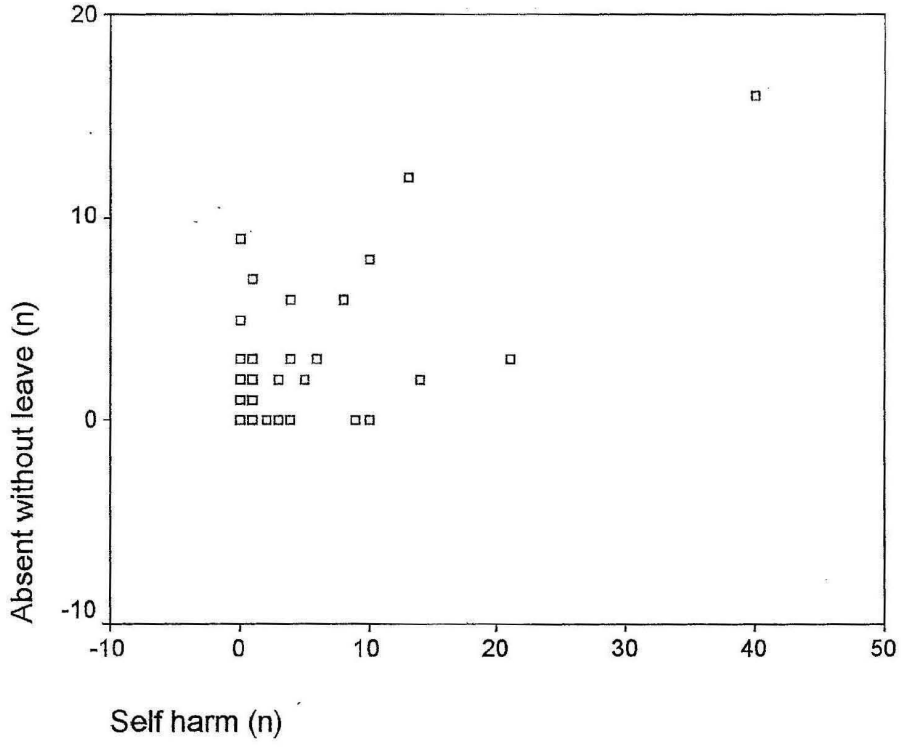
Table 4.2 Summary of Bivariate analyses (Pearson's correlation) of the four most common critical incidents

	Aggression	Assault	AWOL	Self harm
Aggression: p (2-tailed)		.000	.000	.000
Assault			.033	NS (.183)
AWOL				.000

Figure 4.3 Simple Scattergram of AWOL versus Self-harm incidents



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4.4 Current service delivery model

The BAC model was described to the review team as a milieu therapy model with adjunctive therapy mainly in the form of adventure therapy, individual therapy and psychopharmacology. The medical support to the BAC and hence the medication prescribers were the BAC Director and a psychiatry registrar. Individual therapy was provided formally primarily by allied health professionals. The form of individual therapy depended on the therapist: cognitive – behavioural and psychodynamic approaches were cited. It was not clear whether all adolescents were offered individual therapy, and on what grounds it was offered. The nursing case management role is also central to the therapeutic process, and during the course of an admission, would constitute a significant long term relationship for the adolescents admitted. Several staff members noted the current limited family therapy capacity due to an unfilled allied health position.

Certain aspects of the therapy programme seemed unclear to some staff. An example of this is the two week assessment period. Several staff were unsure about whether that still happened or not. In any case, there did not appear to be a formal review following the two week assessment, and nor was the outcome made overt to any of the relevant parties.

4.5 Current Admission Pathway

Figure 4.4 below, highlights the BAC clinical and administrative pathway from the first telephone contact with the BAC until a patient is accepted for an inpatient treatment stay.

Central to this process is the Community Liaison Officer's role. The role includes (1) Triaging telephone referrals, including the initial decision as to whether the patient seems acceptable, (2) presenting the case at the referral meeting, (3) completing the assessment interview with the registrar and (4) presenting the case at case the conference. The centrality of this worker clearly provides some consistency to the process, but may at some level not be appropriate. Issues include potential differences in the understanding of suitable referrals between the Community Liaison Officer and nursing staff or senior clinical staff.

Secondly, there is the potential for idiosyncratic practices or detailed understanding of systemic issues and processes residing in one individual and not generalising to the broader clinical team.

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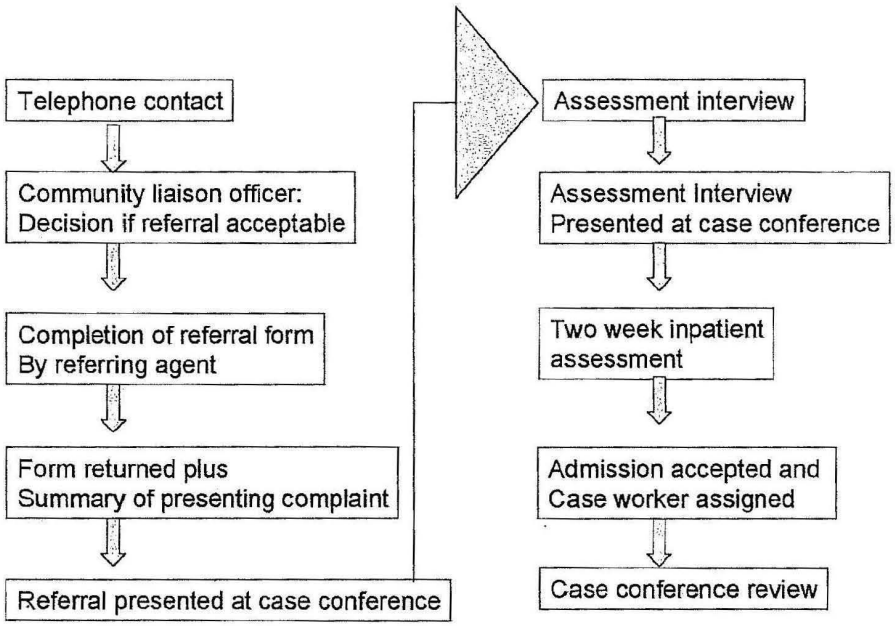
Another issue noted by several staff was that referrals were often considered at the end of the case conference. The identified problems arising from this process included staff having to

Figure 4.4: BAC Referral and Admission acceptance pathway



leave the meeting prior to discussing new referrals, time constraints on this item of discussion and fatigue at the end of an otherwise busy meeting. Given the importance of selecting appropriate adolescents for the milieu, it would appear that this process needs to be managed differently.

4.6 Treatment Model

Most staff stated that the BAC had an over-arching theme of working in a milieu therapy model with an adjunctive individual, group, family and adventure based therapy. A recent staff vacancy had diminished the availability family therapy. It was the opinion of the reviewing team that a more indepth understanding of the milieu model was not easily accessible either from staff or from the documentation provided. It was also apparent that whilst the senior and long serving

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members of the team appeared to have a common understanding of the meaning of this model, newer staff felt that they hadn't been orientated to this, and felt that they were expected to learn on the job. Given the importance of staff roles in 'maintaining the milieu', this would need to be addressed.

4.7 Specific risk strategies

The **A1-A7 programs** are a series of behaviour management programs employed at the BAC. They are well documented, available to all staff as typed sheets and have been in use for many years. The review team noted the programs were developed before the current clientele with the more recent emphasis on externalising behaviour and consider the relevance of these programs to this client group is untested and there is no documented evidence that these programs change/effect behaviour. The programs could be seen to create a consistent response to behaviour, however, individual patients contexts differ, and a patient centred response that requires an adolescent to accept responsibility and participate in negotiating consequences may be useful. The review team felt that compliance with the 'A' program could be erroneously seen as the young person accepting responsibility.

Programs are a very 'public' response to behaviours. Some programs require restrictions to be in place for up to 48 hours. The review team were unsure that this fits with 'short, sharp and meaningful' consequences to behaviour. Further, the program would be 'monitored' by a number of staff over that period, leaving it open to interpretation. Indeed, some staff mentioned that they make modifications to the programmes when implementing them. Some consequences seem dissonant with the 'offence'; for instance a 48-hour response for a consistently untidy bedroom (A3).

More broad responses (other than A1-7) include '**suspension**' from BAC. Staff were of the opinion this was used more in the past, but homelessness and patients from geographically isolated areas make that impossible in some instances. Suspension was seen as a valuable response to some situations, as it allowed some "cooling off" and reflection on the part of the adolescent, and enabled a re-negotiation of expectations on return. The other advantage was that

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family members were involved, and their support in the process had the potential to strengthen the relationship between them and the BAC.

4.8 Staff issues

An overarching staff issue was the concerns by BAC staff that the ongoing funding uncertainty hampered the capacity of the BAC to recruit and retain high quality staff. Many staff members felt that staff would preferentially move to or apply to units with a more certain future.

There were a range of staff issues that individual BAC staff members felt were related to critical incidents on the unit. Certainly there appears to be a growing lack of confidence in the BAC and Park's ability to respond in a timely and safe way to unexpected incidents, and this is affecting morale. There is a current position open for a family therapist, and staff felt that this position would not only increase the range of therapy available at the BAC but also the skills of a family therapist in thinking systemically were also valued. The position remains unfilled due to the need to fund the increased staff required when a category red is in place. Staff noted that the gym equipment available at the BAC was presently not able to be used because of the lack of a qualified trainer who could supervise the use of this equipment. Staff noted that this was a source of frustration for many patients who enjoyed using gym equipment and this form of exercise was a pro-social use of energy.

There review team also heard many positive comments about the internal peer support within the BAC. However, there was a sense of resignation to the continuation of the untenable position of being uncertain about the future.

4.9 Environmental issues

Maintaining a safe environment includes the need to ensure that all equipment (including furniture) is well maintained, especially in high-risk areas. This is fundamental modelling, in that it gives the adolescents a clear message about the importance of living in a clean and functional environment. It also impacts on staff morale.

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The review team noted that whilst the main dining/ recreation areas appeared to be very clean, tidy and light, there did appear to be a lot of 'clutter' in other areas, including broken and unused equipment.

Added to this, the majority of staff cited concerns about the physical environment of the BAC. All staff stated that of the two accommodation corridors presented a considerable risk, especially the corridor furthest from the nursing station, which was not in line of sight of nurses. The other corridor was visible to nursing staff, however, the bedrooms at the far end of the corridor were still reasonably inaccessible. Staff also noted that the age of the building and the style of the building made for many small and out of the way spaces that were potential places for an individual to self harm or to hide belongings that were not allowed on the BAC and indeed this has been their experience.

The staff involved in the critical incident in which a chair was thrown through a glass window were very clear in their concerns about the extensive amount of glass in the unit. The likelihood is that this glass is not of a suitable strength to be in this type of unit, nor is it covered by a protective film that would stop the glass breaking into shards. It was of interest to note that the police liaison officer, who has some experience in matters related to physical safety of environments, has ongoing concerns about the safety of the environment at the BAC. It was the opinion of the review team that the building looked dated and that it would benefit from a process that established whether it could be improved by significant modifications or a new type of facility was required. A major advantage to the BAC was the space and parkland around the unit. However, this was not itself without problems in that the review team was told that the access to the oval had been recently restricted because of the oval being sold. In addition access to a nearby auditorium that had been fairly extensively used by BAC for badminton and other activities had also been stopped.

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4.10 Systemic issues

The relationship between BAC and the Park: Staff cited considerable uncertainty about the ability and willingness of staff members from other Park areas to be of assistance to the BAC during critical incidents. Indeed several examples were given including one response by other staff members of The Park to a critical incident, where the response included a 'drive by' and the discovery that a serious incident was occurring only happened fortuitously. Some staff noted that The Park redevelopment and the creation of more discreet service entities, in their opinion, diminished the ability of units to cooperate on the campus. Other staff noted, in their opinion, a campus wide lack of appreciation of both the type of patients seen at the BAC and the potential for dangerousness of the BAC patient group.

The relationship between BAC and the other CAMHS units: this was difficult to assess given comments were only available from BAC staff. It was stated by staff that the BAC received referrals from CYMHS teams in all regions and that suitable working relationships existed with other CYMHS units.

Staff team relationships: Staff reported excellent communication between school and nursing and allied staff, and the teaching staff reported that they feel very well supported by nursing staff if there is a problem. Teachers reported 'useful' things as being: peer support from other teachers; nurses on duty in the school; they don't ever feel that people are critical; they have regular meetings to discuss issues; they have regular meetings with the nurses to handover info; the common understanding that 'we're all here to help the kids'.

The BAC and the Brisbane Youth Detention Centre (BYDC): there had been several individuals referred from the Brisbane Youth Detention Centre which is geographically close to the BAC. Whilst there was an overall ethos of the BAC of giving youth "a go" and seeing who could benefit from the program, given the types of offence that have led individuals to be in the Brisbane Youth Detention Centre it is likely that this group is at greater risk of creating critical incidents on the BAC. In-reach services would seem to be more appropriate, but this issue is outside the scope of this review.

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Geographically isolated patients: It was the opinion of many staff that current patients were increasingly likely to be admitted from geographically very distant areas. Clear problems with such a regime included the decreased probability of visiting from friends and relatives, the diminished possibility of going on outings away from the unit with friends and relatives and the psychological implications of being dislocated from your local social network. In this regard there was some degree of double jeopardy: (a) you are going to a new residential environment which involves group living that the adolescent may have not experienced before and (b) this new residential experience is far from the normal place of abode and social networks. It was the opinion of staff that such individuals were more likely to be distressed through this process and this was a possible risk factor for critical incidents.

4.11 Risk Management Related Training

All Park staff attend compulsory training in manual handling, CPR, fire procedures and aggression management training (PART program, 3 days duration followed by refresher program). All staff spoken to believed that the PART program was both useful and relevant. Apart from the compulsory training, there does not appear to be any BAC unit based training.

4.12 Orientation of new staff

An orientation manual and checklist for new staff exists. This process covers all administrative requirements for new staff coming into the BAC, however there was some difficulty obtaining a copy of the manual, and it appears that the information needs updating in some areas. Several newer staff reported that they had not in fact been orientated to the unit.

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5. CURRENT RESPONSES BY THE BAC

Current responses to escalating issues include the use of the various behaviour management plans, and include completing documented risk management ratings. The review team noted that there was little coherence between documented risk and management plans on occasion. It was difficult to establish what the management plan was apart from the typed multidisciplinary plan, which prescribed generic interventions. Documentation of management plans following case conferences varied greatly in the notes reviewed.

Recent events have left several staff feeling very unsupported, and indeed with unresolved stress related issues. Whilst all staff who spoke to the review team felt that there was very good internal and informal support following incidents, the lack of formal review process and subsequent changes to policy, practice or procedure left staff feeling that there was little between then and the next incident. Recently there has been use of an external facilitator on two occasions, however, their role appeared more debriefing than process analysis.

5.1 Review of case notes

Rather than provide outlines of individual cases and reported critical incidents, this section will details themes across the cases reviewed, including issues from case files and issues that arose when discussing cases with staff.

The review team found little evidence either documented or from staff report that a review of process related to critical incidents takes place. Risk management is not a theme that is easily found in case notes apart from the risk assessment forms. It was difficult to find specific and individualised plans that relate to self harm, aggression of AWOL incidents. This extended to the individual care plans, which were often not ungraded in general as well as specifically about

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risk. From a review of some notes, the level of risk assessed did not appear to influence decision-making in some instances.

AWOL was specifically mentioned in case notes with case note information and Staff report suggesting that the "retrieval from AWOL rate" is very high. Verbal report indicates that staff, with the aid of security staff, pursue young people in the local area, and will use physical methods to return young person to the BAC. If this occurred with a voluntary patient, the review team were unsure of the legality of such a procedure. Clearly a negative of the physical environment is the amount of open space that can be used to abscond too. It seems that many patients undertake a 5-minute walk across parkland to train station.

5.2 Review of Policies and procedures

It is a BAC policy to complete risk assessment relating to absconding, self harm and aggression: (1) prior to admission by the referring agent, (2) on admission, (3) reviewed at case conference and (4) post-incident.

The review team identified several issues with the risk assessment protocols. The risk assessment tools did not clearly indicated how to score or interpret the results of the assessment, and staff reported that they were not trained in its use. There was no clear pathway between assessment and a proactive management plan with the exception of placing the patient on a CAT RED. There was no available evidence that the risk assessment tool was relevant to or had an evidence-base in the adolescent population

Some risk assessment and management polices and procedures appeared overly universal for instance searching bags and rooms, locking bedrooms during the day, searching day patient's bags. Whilst such activities may have uncovered prohibited weapons or substances there was no evidence of the efficacy of such activities, no obvious audit of this practice and in the opinion of the review team, it has the potential to create a culture of mistrust. "Living up" to this mistrust may increase\the overall risk in the unit.

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Many staff demonstrated confusion between critical incident stress debriefing (CISD) and a risk review and management process. When CISD was mentioned the 'informal' nature of the debriefing was cited by some staff as useful.

A brief review of the adventure therapy programme manual was undertaken, as well as informal discussion with the coordinator. The standards set by several outside organisations in relation to adventure therapy, and the components of it, are adhered to in this programme. The low critical incident rate whilst adolescents (and indeed staff) are participating in the programme is testament to the adherence to those standards, and to the carefully planned and managed events. The philosophy of adventure therapy as explained to the review team and would appear to contribute to the risk management in this programme. The maintenance of equipment and emergency plans also contributes. Nevertheless, involving a group of adolescents presenting with psychiatric and behavioural problems does increase the risk factor. The fitness level of staff may present a risk at another level.

5.3 Review of Critical Incident process

The review team found little evidence that a review of processes related to critical incidents takes place in any consistent or meaningful way. Indeed many staff confused this question with the opportunity for staff support and debriefing following an incident, citing that an external facilitator has been used recently after a critical incident.

The review team are of the opinion the BAC needs to establish a process whereby incidents considered to have potentially major consequences are investigated.

The review team are of the opinion The Park needs to consider updating incident forums for the risk assessment to include looking at the

(1) actual outcome,
(2) potential outcome,
(3) likelihood of the event re-occurring and then
(4) looking in-depth at the responses. (A root cause analysis or similar process)

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This process needs to become the basis for change in practice as it related to risk and critical incidents. Such an analysis would include what happened, why and how it happened, what opportunities are there to prevent further occurrence. A response should consider communication, training and experience, fatigue and rostering, environment and equipment, rules, policies and procedures, and other barriers that become the evident. It will assist the staff to identify deficits in policy, procedure, education and skills of staff etc.

For example a review of the incident when the window was broken by a thrown chair would have inevitably lead to an urgent need to ensure that all glass is replaced or protected in some way, as well as a change to the Park wide response process when a 'Code Black' is called. It may also have lead to changes in protocol related to outings and pro-active communication with others on the Park site prior to outings occurring. The failure to look at potential risk management issues resulting from service incidents could be seen as negligent.

5.4 Wider Park issues

It appears that issues related to **budgetary** processes are not necessarily transparent, and may not reflect the level of activity and risk profile of the BAC. Staff reported accruing extremely high numbers of TOIL hours, and felt they had little possibility of being able to take that time. Costs for provision of Category Red care need to be acknowledged, as there is an assumption that not filling staffing positions is to save money for cat reds. The belief is that the programme is compromised as a result of this. Capital works funding is an issue and is mentioned in the recommendation section.

5.5 Response to Codes

The review team noted an absence of an enforced protocol about who makes up the response team, and the timeliness and process of their response. Any review of critical incidents should include looking at whether this protocol was observed. There needs to be opportunities to practice this on a regular basis, and a process of review afterwards.

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6. POSSIBLE IMMEDIATE ACTIONS

Possible immediate actions are also detailed in the report recommendations. Whilst specific actions will be discussed the overarching need for a secure future for the BAC is an important action with a direct relationship to risk management.

6.1 Clinical Issues

6.1.1 **More clear admission criteria.** The review team felt the BAC should undertake a purposeful process to determine which patients are most likely to receive benefit from the BAC program, and how this fits with the current continuum of client care across SE Queensland. The review team were surprised with both the range of potential diagnoses of individuals at the BAC and the often stated ethos by all levels of staff of "having a go" with most types of presenting problems. A review of the target group need not only be diagnosis driven. For example a role for individuals with severe, persisting self-harm (therefore problem based) may be equally as valuable.

6.1.2 **Regular program review.** The BAC should consider closing the program for 1-2 days twice a year to invest time in management, procedure and training issues. Other inpatient units have been able to schedule regular program reviews. The potential benefits of this would significantly outweigh the costs.

6.1.3 **Structure**. The review team were interested in the relative absence of critical incidents at the BAC school, and on the adventure therapy programme. Small group size and highly structured time seem important determinants. Based on this observation the BAC staff should consider more structure in the after school and evening time.

6.1.4 **Group size**. Following on from 6.1.3 above the therapy group size seems very large and division of the group should be considered.

6.1.5 **"Home groups" within the BAC**. To further impart structure, control and a sense of belonging, the BAC staff should consider two home groups within the BAC program rather than one larger group of adolescents.

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6.1.6 **Drug and Alcohol detoxification**. Given greater numbers of youth with dual diagnosis, the BAC staff should consider developing a relationship with the Adolescent Drug & Alcohol Withdrawal Service to up-skill BAC staff in contemporary drug withdrawal management, as well as the possibilities of additions to the BAC therapeutic program on drug and alcohol issues.

6.2 Policies & Procedures

The review team identified a range of BAC policies that were several years over the documented time for review, or had been created more than 4 years ago and had not obvious review schedule. The BAC should invest in a quality activity to review and where appropriate update all policies. Policies should be written from a patient centred, risk management, point of view, and should be separate from procedures.

6.3 Risk Assessment Tool

The Park risk assessment tool does not clearly indicate how to score or interpret data. Further there is no available evidence that the risk assessment tool is relevant to the adolescent population. The review team feel that there should be greater scrutiny of the tool as it relates to the prediction of further critical incidents and the more general outcome of that individual at the BAC. Note that part of this increased scrutiny is the new data analysis included in this report. Other analysis is possible with the BAC collection of HoNOSCA and CBCL data.

6.4 Decisions following on from the risk management process

Some risk management strategies seem to be universal at the BAC, for example searching bags and rooms, locking bedrooms during the day and searching day patient's bags. The danger of

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