RESPONSE TO THE 2009 REVIEW OF THE BARRETT ADOLESCENT CENTRE

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Text of the original review is changed to Red for statements that are not factual. NB: Statements on which there are simply differences in matters of opinion are left in the original black font. Statements in Red are either untrue, inaccurate or incorrect. There are 50 instances in which errors of fact have been highlighted in red.

Responses are written in Blue. The response to an untrue, inaccurate or incorrect statement is headed FACT. A response to a difference in a matter of opinion is headed COMMENT.

Recommendations which are based on non-factual statements are deleted. The recommendations which are left are worthy of implementation and at times, debate. In addition, Appendix 1 contains an evaluation against criteria developed for adolescent inpatient units in the United Kingdom.

Compiled by Trevor Sadler and staff members of Barrett Adolescent Centre

2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

Reviewers: Garry Walter, Martin Baker, Michelle George

BACKGROUND

For a considerable period of time, concern has been expressed about the role, function and capacity of the Barrett Adolescent Centre (BAC) to provide an appropriate, effective and safe service for its client group. Most recently, the ACHS indicated concerns about the capacity of BAC to provide safe care. The local governing body has decided that environmental changes (including relocation) are necessary. These have been agreed to and are underway.

The present review has been commissioned in the knowledge that the proposed environmental/geographical shift will take place. The reviewers were asked to focus upon the philosophy and clinical practices of the unit, with a view to assessing whether the unit is safely meeting the needs of the consumer group, and to make recommendations for change and improvement.

PREVIOUS REVIEWS AND REPORTS

ACHS Review

In a recent accreditation survey by the ACHS, BAC received a "High Priority Recommendation" from the ACHS to ensure that immediate modifications are made to improve patient and staff safety. In making this and other recommendations, the ACHS observed:

- Patients admitted to BAC have severe and complex clinical pictures;
- BAC has limited choice over which patients it accepts;
- In the Park Hospital redevelopment, BAC has lost access to facilities;
- There are aspects of BAC's configuration and related building issues that are dangerous;
- There has been an increase in critical incidents;

- There has been an increased use of "Continuous Observation".

The ACHS made a number of other recommendations around staffing and infrastructure needs.

DOH Brief

A brief to the Director General of Health in Queensland noted that the profile of consumers treated in BAC had changed since the opening of the new Acute Child and Youth Mental Health Beds in Queensland and that BAC was now treating more complex and impaired cases. Apparently, the Acute Units are now referring to the BAC if there are no obvious community placement options.

FACT: Since the commissioning of Acute Units, referrals have always been on the grounds of clinical severity, complexity persistence and impairment. Community placement options are not relevant – the only consideration is the need for intensive treatment and rehabilitation.

This has resulted in more complex cases in BAC and even less "referral out" options. In support of this contention is the fact that Average Length of Stay in BAC has risen from four months in 1994 to ten (8) months in 2006.

McDermott Review

This review considered: the impact of critical incidents on BAC; current risks at BAC; BAC management practices, staff, environment and systemic issues; and, BAC responses to critical incidents. The recommendations included:

- Admission criteria and a more clearly defined target group;
- Better Risk Assessment in the admission process;
- Improvement of the risk monitoring process, especially the "Risk Assessment Tool";
- Improving the relationship with other parts of Park Hospital;
- Pro more certainty about the future of BAC.

Also included were recommendations about staff training, whether the unit is open or locked, the material fabric of the Unit, and the role of BAC within Queensland Mental Health Planning.

Community Visitors Report

This report noted that:

- BAC was over Census;
- BAC had clients in it who were over age;
- "The Unit is not of a standard to safely house medium to long term residents";
- "Not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis".

FACT: There is an expectation that as adolescent will participate in groups which are likely to progress their treatment. This is discussed in greater detail in further comments made under Model of Care.

Queensland Nurses Union

The Union had written a letter of concern, specifically around the injuries sustained by a nurse trying to apprehend a client who had run away.

CRITICAL INCIDENTS

In addition to the above reports, the present reviewers were provided with three incidents to consider. The local governing body believed these to be emblematic of the difficult issues BAC faces and expressed a desire for the reviewers to examine these incidents within the broad purpose of the review. These reports related to [redacted] women who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

- All the patients were [redacted]
- All were near or over the age of 18 years.

FACT: [redacted] before [redacted] was discharged

- All exhibited severe and complex self-harming behaviours;
- All had been given diagnoses that did not seem to adequately reflect the chronicity, severity and complexity of the behaviours;
- Referral on to Adult Mental Health Services or other more appropriate services did not appear to be an option that had been realistically considered for any of the patients.

FACT: This is difficult on two counts.

1. [redacted] and would not be admitted into an Adult Mental Health Service.
2. The team considered referral to an Adult Mental Health Service for the [redacted] However there were concerns that the Adult Mental Health Service lacked adequate resources to treat this [redacted] mental health disorder.

The reviewers conducted an incident and file review of the cases and have incorporated considerations around the incidents into the broader observations and recommendations of the report.

On the basis of the above materials, meetings with stakeholders and key staff on 26 and 27 February 2009, and attendance at a staff/stakeholder ongoing education meeting, we offer the following observations and recommendations:

FACTS:

1. Time spent with key staff was very limited. Many were running the second part of a Recovery Intensive off site.
2. Two of the reviewers attended part of this, but a part which we thought would be least relevant to them.
3. The value of having a single meeting with a group of ten staff key to many interventions running a two day workshop over lunch is doubtful.

4. Although they met with staff responsible for delivering a number of specific therapeutic interventions over lunch, staff reported that they appeared to be interested in only one particular aspect of the therapeutic program – that of adventure therapy. (We had spent the previous three hours of that morning describing the some of the therapeutic interventions, and more were described the next day – a fairly comprehensive account.)
5. Although an outline of the Model of Service Delivery was presented initially the first day for their consideration, so that they could ask specific questions of the Director the following day, they did not follow up with any questions, nor were interested in exploring it further.)
6. The available nursing staff on the unit on the day consisted predominantly of new staff and casuals with only one experienced staff member in the morning shift, and two on afternoon shift as experienced nursing staff were attending or presenting at the workshop.

OBSRVATIONS AND *RECOMMENDATIONS*

Governance

In terms of both corporate and clinical governance, a number of the usual mechanisms, processes and systems for ensuring proper governance did not appear to be in place at BAC. Specifically, there did ***not*** appear to be:

- Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;

FACT: The Park – Centre for Mental Health and the West Moreton South Burnett Health Services District (as the Governing Body for most of the time since the 2003 Review) have always actively overseen the quality of clinical care through a variety of mechanisms. Some of these are documented in the ACHS Reviews of the District.

- Clear local policies that are integrated with wider policies aimed at managing risks;

FACT: The policies utilised by the Barrett Adolescent Centre are those of The Park – Centre for Mental Health and the West Moreton South Burnett Health Services District. These include policies for managing risks. These policies are implemented at the Barrett Adolescent Centre.

- Procedures for all professional groups to identify and remedy poor performance;

FACT: The reviewers noted later in the report that they did not specifically ask about performance reviews. These are regularly conducted for all nursing staff, all health professional staff and the psychiatry registrar. Had they asked specifically, they could have been pointed to documented evidence of processes in place to identify and remedy (within the constraints of Public Service procedures) the poor performance of a few staff

- Much in the way of Quality Improvement activities. A comprehensive approach would include consideration and use of
  - Clinical guidelines/Evidence-based practice;
  - Continuing Professional Development;

FACTS: Unfortunately the terms Clinical Guidelines, Evidence-based practice and Continuing Professional Development refer to complex issues that are not as easily dealt with in two lines. They will be discussed individually:

Clinical Guidelines. Various clinical guidelines are published for disorders or behaviours seen in the adolescents. Reference is made to these individually because the applicability to adolescents varies according to the condition or behaviour.

The RANZCP published clinical practice guidelines for the treatment of Anorexia Nervosa[1] (2004). The treatment approach at BAC was consistent with the recommendations of these guidelines for at least a decade before they were published, with the exception of utilisation of a Dietitian. (We have certainly utilised the excellent services of Dietitians employed by The Park since at least 2004.) At no stage did the Reviewers ask questions about our treatment approaches to adolescents

[1] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*

with Anorexia to determine whether it consistent with these guidelines. These guidelines also raise issues of difficulties with guidelines. They point out clearly the lack of evidence for clear treatment approaches (thus challenging the notion that there are clear evidenced- based treatments). They were also published 5 years before the review was completed. Thus there is a further five years of research on which to build clinical practice. Unfortunately, in the case of management of eating disorders, treatment approaches have not substantially advanced. The most important advance from our perspective is the emerging recognition of the concept of Severe and Enduring Eating Disorders.

The RANZCP has only published guidelines for adults with self harm[2]. As Clinical Leader of the CYMHS Collaborative on Self Harm I concur that the literature supports a distinction between adult and adolescent self harm. Approaches to adult self harm can not necessarily be translated to adolescents. The NICE clinical guidelines on self harm[3] are for primary and secondary care. As far as these guidelines are applicable (given this is a quaternary care environment), our practice is consistent with these guideline. They are currently developing a paper on "*Self harm (longer term management")*, with discussions continuing through until 2011.

The Reviewers were presented with evidence of our treatment approaches in adolescents with PTSD secondary to sexual abuse, including our experience with psychological treatments listed in the Australian guidelines for the treatment of PTSD[4]. (The *practice parameters for the assessment and treatment of children and adolescents with PTSD* from the American Academy of Child and Adolescent Psychiatry was published in 1998. Although relevant in many areas, it is considered

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[2] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm (2004) Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm *Australian and New Zealand Journal of Psychiatry 38:868–884*

[3] National Collaborating Centre for Mental Health Royal College of Psychiatrists' Research Unit (2004) The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care *National Institute for Clinical Excellence National Clinical Practice Guideline Number 16*

[4] Forbes D, Creamer M, Phelps A, Bryant R, McFarlane A, Devilly GJ, Matthews L, Raphael B, Doran C, Merlin T, Newton S. (2007) Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder *Australian & New Zealand Journal of Psychiatry* 41:637-648

too old to be a credible practice guideline. The NICE guideline[5] is limited, but consistent with the Australian guideline.) The reviewers sought no further specific information than what was presented to them.

In summary, recommendations of Clinical Guidelines have been incorporated in day to day practice of the Barrett Adolescent Centre. They are regarded as standards by which to monitor programs, but because of their static nature, not as criteria for improvement.

Evidenced-based Practice. This is a more valid marker of a Quality Improvement Activity. The term is often loosely used, so I will incorporate definitions from the Sicily Statement on Evidenced Based Practice. The process of evidenced based practice is conceptualised in five steps

1. Translation of uncertainty to an answerable question.
2. Systematic retrieval of the best available evidence.
3. Critical appraisal of evidence for its validity, clinical relevance and applicability.
4. Application of the results in practice.
5. Evaluation of performance.

These are particularly important processes in interventions with adolescents with persistent, severe and complex (in terms of co-morbidities and family functioning) disorder with impairment who have already not responded to the more straight forward evidenced based treatments (as far as they exist for many of the disorders we see). The Reviewers recommendations around evidenced based treatments (see later) are indications of the failure to appreciate the clinical relevance, and application of this in practice. Evidence for an evidenced based approach in this population will not be found in asking for a list of treatment approaches for a particular disorder, but rather asking clinicians about the decision making processes around the application of certain interventions at any time, the evidence base for those applications, and what

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[5] National Collaborating Centre for Mental Health Royal College of Psychiatrists' Research Unit (2005) Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care National Institute for Clinical Excellence National Clinical Practice Guideline Number 26

would lead them to choose one intervention at one time for one adolescent, and another intervention for another adolescent.

Had the Reviewers asked key staff about the process of Evidenced Based Practice, they would have been shown clear evidence of activities and literature around Steps 1 – 4 of this process. Staff expected to be questioned on this in detail in the limited time that was allocated to spend with the Reviewers, given the nature of the Centre. Limited presentations of some of the evidenced based rationale for our treatment approaches were outlined, but not followed up by the Reviewers. Indeed the Recovery Intensive being run at the time of the Review was a presentation of the incorporation of evidenced based approaches into practice, and developing evidenced based practice in a complex environment.

Evidenced based practice is obviously a quality improvement activity that is ongoing. The volume of literature about any aspect of practice is enormous, so there will always be gaps. However, our biggest challenges are in steps 3 – 5, particularly around application in practice and evaluation of performance, and matching this with the aspects of patient values.

Continuing Professional Development: Had the Reviewers asked to see the Performance Reviews of staff, they would have seen adequate evidence of continuing professional development – supervision both within and out of the Centre, enrolment in higher education, attendance at workshops, conferences, courses, literature reviews, self directed learning (reading journals etc), preparing lectures providing supervision. Staff are regularly informed of upcoming workshops of relevance. Staff are regularly made aware of professional development activities. I am not aware of any regular staff who were asked about their Continuing Professional Development Activities.

- Clinical Audits;

FACTS: A number of clinical audits are conducted by The Park including critical incidents, the use of continuous observations as well as the use of seclusion and restraint. The latter is benchmarked against other adolescent units as part of a State wide collaborative on seclusion and restraint. These are reviewed by management in the Business Unit Meetings, and then discussed with staff. It is acknowledged,

however, that a greater range of clinical audits eg, around medication use could be implemented.

- The effective monitoring of clinical care deficiencies;

FACT: All significant incidents (including "near misses") are recorded on Prime, and are reported to the Director and Nurse Unit Manager. In the 15 months prior to the review, there were two incidents which were clear examples of deficiencies of clinical care (although one was not due to deficiencies of staff from the Centre.) One of these resulted in a Root Cause Analysis, the other in a Critical Incident Review. They contained clear comments about deficiencies of care, and the action taken was documented. Both these and other Critical Incident Reviews were available to the Reviewers had they wished to inspect them.

The charts of the three adolescents reviewed by the Reviewers contained numerous examples of critical incidents. Associated with these were extensive documentations of clinical decision making processes pre and post the incident.

- Research (see Appendix 3) and development;
- "Caldicott principles" to manage the collection and use of patient information;

To elaborate, the role of BAC in the hospital and State plan remains unclear. BAC does not feature in the hospital organisational charts, nor is its role articulated in a State-wide plan for child and adolescent mental health services. While patient safety was certainly a priority at BAC, there was a focus on physical environmental issues and less emphasis on a systematic approach that included formal reporting and documenting in the medical record for all incidents, including "near misses", and a process for reviewing incidents to inform staff and to effect change in client management to improve patient safety.

FACTS:

1. All incidents of absconding, self harm requiring medical attention, aggression and change in medical condition (e.g. collapse) are recorded on PRIME.

2. A review of the charts of the [redacted] whom the Reviewers were asked to review (for up to 12 months prior to the Review in [redacted] or from admission for the other [redacted] charts) showed that all significant events (including "near misses" were recorded on PRIME.
3. In addition there was corresponding documentation in the medical record for these PRIME events, although incomplete in one instance.
4. This incomplete documentation was noted in a subsequent Clinical Incident Review.
5. The charts contained comprehensive reviews by either the psychiatrist or registrar, with a review of the management plan. The latter included the development of comprehensive plans documented in the chart.
6. Specific plans were printed and placed in a prominent position in the nurse's station so that all staff were made aware of a consistent plan and approach.
7. These were further reviewed in the next case conference (with associated documentation).
8. A systemic review of the preceding eight weeks of both behaviours and management plans in the Intensive Case Workup was documented.

To support the above process and address other clinical documentation issues, regular reviews of medical records (file audits) are often used in other centres; this did not seem to be the practice at BAC.

FACTS:

1. Clinical chart reviews (currently and at the time of the review) are conducted on a quarterly basis.
2. The results collated by the Nurse Unit Manager.
3. The information is disseminated to staff at a regular staff meeting in the morning.
4. Any particular action taken is compiled in a report compiled and forwarded to the Service Improvement Coordinator at The Park. This is in line with standard procedures at The Park.
5. In addition, the Director reviews charts at Case Conference on Monday for information, and comments on information that is missing, poor documentation, and will speak to staff who fail to write notes. This is an ongoing process.