REFURBISHMENT OF THE BARRETT ADOLESCENT CENTRE

There are three reasons to refurbish the Barrett Adolescent Centre.

1. To provide the best physical environment in which to deliver therapeutic services
2. To provide a safe environment
3. To provide and environment suitable for adolescents which does not contribute to behavioural disturbance.

The redevelopment of the former Wolston Park Hospital and its transformation into The Park - Centre for Mental Health has had an adverse effect on the Barrett Adolescent Centre and its capacity to deliver services to adolescents. These are listed in the table below. At the same time adolescents are presenting with more severe and complex problems, with longer average lengths of stay, and less support from their families. Many need to be prepared for independent living, because of the lack of family supports.

Change	Impact
Loss of the Barrett A high dependency area	Adolescents needing high levels of care have required continuous observations for prolonged periods, or the ward has needed to be locked. Both of these are aggravating, either to the affected adolescent or both.
Loss of the auditorium in Barrett B	This provided an out of ward area for evening physical recreational activities, e.g .badminton, indoor soccer etc.. This provided an outlet for adolescents, particularly in the shorter evenings of Autemn to Spring, and helped reduce the disgruntled feelings of being confined.
Loss of the Occupational Therapy area in Barrett B	Life skills assessments now need to be conducted in crowded, shared facilities - e.g. the shared kitchens, with frequent interruptions.
Loss of the Barrett B dining area.	Adolescents now have to eat on the ward in the front entrance. The tables encroach on their recreational space.
Loss of woodworking area in Barrett B	Although this occurred some years ago, it meant we no longer had access to a popular rehabilitation activity
Loss of houses where the High Secure Area is now.	Previously adolescents who are quite unwell could have limited day/overnight leave with their parents in a situation where help was readily available. Now they cannot go on leave until they are considerably better. Many are aggravated by the prolonged lack of leave. In addition, the loss of houses means that adolescents in independent transition to the community have to stay on the unit for longer periods, when they could be supported in semi-independent living. This also can contribute to aggravation.

Change	Impact
Loss of oval, tennis courts and practice cricket nets.	Outdoor recreational activities are confined to the immediate vicinity, without proper facilities. The more sport minded adolescents complain about the lack of variety.
Loss of the Riverside ballroom, Nyanda Park	Again, these provided recreational facilities away from the unit, which enhanced the sense of getting away form the unit.
Loss of immediate access to staff from other areas in an emergency.	Although staff from other areas respond as quickly as they can, they are now much further from the unit, compared with their previous locations. This means that the unit must have a greater capacity to immediately contain incidents.

During this time acute adolescent inpatient units have been introduced. Although adolescents are very positive about the physical setting of the unit, and generally positive about the programs, they are almost always negative about the ward environment compared to the acute inpatient units. Other factors also come into play. As the unti has developed a stronger rehabilitation focus, we have acquired a variety of equipment which requires storage. As the length of stay has increased, the lack of flexibility in being able to increase the numbers of one sex or the other has seen an escalation in the waiting list.

Suggestion	Notes
Amplimesh on all windows	Needs to be secure enough to stop absconding, but safe in fires. Reduces the visual impact of security cf current bars.
All loose ceiling tile areas in patient areas to be replaced by fixed ceilings.	Reduce risk of absconding into ceiling. Reduce possum droppings into ward.
Roof in both buildings to be repaired to stop leaks.	

Suggestion	Notes
Entire ward adequately air conditioned	Reduce risk of dehydration in hot summer weather - a real risk for some adolescents
Sound proofed interview rooms	Lack of privacy a real issue when discussing sensitive issues.
Alternate access to bedrooms, bathrooms by staff e.g. doors that lift off or access through window screens.	Need access if room is barricaded.
Two to three bed high dependency unit	Needs bedrooms, ensuites, observations area, lounge/dining area. Would obviate some of the need for continuous observation, locked ward.
Bigger bathrooms	The current bathrooms are adequate for short term camps, but not for up to 8 - 10 adolescent girls living together for months. The lack of space, privacy inevitably leads to conflict.
Bath	For disabled access, relaxation in times of stress.
Two bedrooms sharing one bathroom	This is the standard in most modern hospitals. The adolescents would feel much greater comfort in privacy, cleanliness if fewer were using the bathroom.
Own cabinets in the bathrooms	Standard in other units. Reduces conflict about personnel items going missing.
Two bed bedrooms	Increase privacy, Reduce peer conflict
Adequate storage areas for personal belongings	Reduce conflcits over missing property
Two interview rooms in D block	Adolescents at risk need to be seen on that side, but there is a lack of space - often used as a bedroom.
	adolescents
Bigger pantry in adolescents' kitchen	For adequate stores of food, access to food.
Bigger oven in kitchen on ward	Need capacity to prepare own meals as much as possible.
Separate eating area with round tables.	Open up living space again for recreation.
Brighter colours on the walls	Very dull - contributes to keeping the mood low.

Suggestion	Notes
More skylights in wings leading to sleeping areas.	Very dull - contributes to keeping the mood low.
Separate cooking area for kids and staff	Optimise therapeutic programs
Reception area situated in main entrance to ward.	Greet, provide orientation and monitor visitors to the unit.
Visual observation of main entrance from nurses station.	Check potentially distressing visitors, adolescents absconidng,
Upgrade gym area	Increased structured physical activity to reduce aggression
Dedicated withdrawal rooms	Allow space for adolescents to retreat in safety to reduce
Dedicated rumpus room	Allow supervised private retreats for adolescents
Improving access to art room, e.g. external door, with room divided to allow free access for safe activities, but restricted access for unsafe activities.	Art a potent release for troubled emotions.
Ward craft room to be set up to be a multi-function room with extra power points and sinks	
Visitors room with tea and coffee making facilities	Need privacy to talk with adolescent. Have often driven an hour or more.
More TV's – with remote access to TV from time out room.	Adolescents with needs for prolonged observation/rest need to have access to what is happening outside.
Smoking area to be properly covered and with seating	Provide some degree of comfort for visitors
Bigger clinic area	Safe handling of medications, etc
Bigger examination/ treatment area.	Uncomfortable feelings for examination if in too close proximity
Indoor recreation room	Provide opportunities for more structured, varied activities.
Recreation hall, gym and pool	Provide opportunities for more structured, varied activities

Suggestion	Notes
More storage areas	Includes RSO equipment storage, sports storage, bigger shed to house horticultural and landscaping equipment and to do a manual arts program, built-in lockers in staff room in school.
Adolescents approaching discharge to have a separate place to prepare for leaving/flatette	
Common staff room	Facilitate interchange of information, team building
Improved area/ facilities for students to do homework - internet links between buildings and separate area for study on ward side	
Professional offices closer to the nursing station	Facilitate interchange of information, team building
3 classrooms of the same size as the current largest room in school	
Classrooms to be centrally at one end of school	
Bigger library	
Separate Principal's office	

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] who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

- [redacted]
- [redacted]

FACT: One was [redacted]

- [redacted];
- 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 young [redacted] who was aged [redacted] years. However there were concerns that the Adult Mental Health Service lacked adequate resources to treat this young [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

---

[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

[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 [redacted] 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, [redacted], aggression and change in medical condition (e.g. collapse) are recorded on PRIME.

2. A review of the charts of the three adolescents whom the Reviewers were asked to review (for up to 12 months prior to the Review in one adolescent or from admission for the other two 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.

Policies and procedures sighted had been in place a long time with little evidence of a review of their continued appropriateness.

FACTS:

1. It is unclear where the policies and procedures sighted by the Reviewers were located. It is possible old copies may have not been destroyed.
2. The Barrett Adolescent Centre follows the Policies of The Park which are updated at regular intervals.
3. There are Workplace Instructions governing particular procedures not covered by these policies. They had been written or updated by the Nurse Unit Manager in consultation with staff less than two years before the review. (The computer system had crashed, requiring all policies be re-written).

There did not appear to be a system in place to manage, respond to or analyse complaints either from within the client population in the unit or from the broader community.

FACTS:

1. At a formal level, The Park has clear procedures on managing and responding to complaints from adolescents or their parents. Barrett Adolescent Centre follows these procedures. Documented evidence of complaints and responses to complaints is available.
2. In addition, a Community Visitor from the Children's Commission visits monthly to meet with the adolescents. They provide written reports to The Park and the District.
3. The Children's Commissioner provided annual reports to the Director General and District Manager.
4. Barrett Adolescent Centre was the first CYMHS service to employ a Consumer Consultant (an older adolescent who had been a patient at BAC) to meet with adolescents, help them articulate complaints, and either represent these complaints directly, or support adolescents to voice complaints (and suggestions for improvements) at an monthly Administration Meeting with senior management of BAC. Actions for improvement are noted by staff, and reported back to the meeting the next month with regard to their progress. Minutes of these meetings would have been available to the Reviewers.

5. Finally, a meeting is held with adolescents and staff on four mornings a week to review the day's activities, and raise issues of concern or suggestions for improvement from both adolescent and staff perspectives. These meetings are minuted, and would have been available to the reviewers. The chairing of this morning meeting is the responsibility of the adolescents, as a means of assisting development of meeting skills, co-operation, and empowerment.

While we did not specifically ask about this issue, it is feasible that Performance Reviews are not a regular part of professional practice at BAC and, if they are, they do not appear to be targeted at assisting clinicians to maintain best practice and improve patient care.

FACT: See above comments about performance reviews.

BAC does not appear to have a framework which aligns with State legislation, Queensland Health policy directives, and local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working in the unit.

FACTS:

1. Medical staff. The psychiatrist is enrolled in the Continuing Professional Development program of the RANZCP. He has exceeded minimum requirements for the period he has kept records (2004 – 2009). This is part of his credentialing by The Park (in compliance with Queensland Health policy) as a child and adolescent psychiatrist, although he is not credentialed to administer ECT. Registrar training always exceeds the minimum RANZCP requirements for mandatory supervision.
2. Nursing staff. All nursing staff comply with the policies of Queensland Health policies for registration. Most have mental health endorsement, although this was not able to be a condition of employment in line with local policies. Credentialing for nurses is currently being developed and encouraged, even within the last 12 months since the Review process.
3. Allied Health. All allied health disciplines, (except Social work) have to be registered with the Office of Health Practitioner Registration Board, located in Charlotte Street. All Allied health are required to forward evidence to their Discipline Senior, of their continued registration on a yearly basis. An

April 2010 draft Queensland Health document[6] states: *"Unlike the process for medical practitioners, credentialing and defining the scope of clinical practice will not be required for all allied health professionals working in Queensland Health due to the rigorous verification processes that occur at point of employment by selection panels. It is the intent of the process that very few allied health professionals will be required to apply for credentialing and defining scope of clinical practice."*

Barrett Adolescent Centre has always complied with State legislation, Queensland Health policy directives and local protocols regarding staffing issues. That stronger credentialing and definition of the scope of practice could assist in recruitment and may promote professional development is undeniable. Such mechanisms for all professional groups are rudimentary at best

In the absence of this framework, aspects of recruitment, the capacity to adopt particular clinical models and a coherent approach to professional development and clinical supervision are all compromised. For example, it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.

FACTS:

1. As part of the process of redevelopment, the Mental Health Branch (now Directorate) in March 2008 organised a review of the Model of Care which was presented to senior CYMHS clinicians, including the Directors of most of the acute adolescent inpatient units. The model was presented to a broader forum of CYMHS clinicians in May 2006. The intention of both of these meetings was to provide an external review of the model.
2. The Director has presented the Model at his presentations to CYMHS psychiatrists at quarterly Grand Rounds at Spring Hill in 2007 – 2008.

---

[6] An Allied Health Clinical Governance Framework in Queensland Health. Discussion Paper (2010) Section 2.2 *Principles of credentialing and defining the scope of allied health professionals*