EXHIBIT 220

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Minister's Office RecFind No:	MO: 11002997
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	QCOS/013693 (PT 2)

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Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: Chief Executive Officer, Darling Downs - West Moreton Health Service District

Date requested: 22 May 2011

Action required by:

Action required
☐ For approval
☐ For meeting
☐ With correspondence
☒ For Information

Other attachments for Ministerial consideration
☐ Speaking points
☐ Draft media release
☐ Ministerial Statement
☐ Question on Notice
☐ Cabinet related document

SUBJECT: **Update and Finalisation - External Review Report of Barrett Adolescent Unit**

Proposal

That the Minister:

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

Urgency

1. Routine.

Background

2. The Barrett Adolescent Unit provides mental health inpatient rehabilitation services (15 beds) for young people aged between 13 and 17 years who require extended inpatient care and treatment for a mental illness. The Unit provides a Statewide service and referrals are received from mental health services throughout Queensland.

3. In January 2009, an external review of the Barrett Adolescent Unit was commissioned to examine reported consumer clinical incidents and make recommendations regarding the safe care of consumers of the Barrett Adolescent Unit. This included measures to:

   a. manage the mix and acuity of consumers attending the Unit;

   b. ensure that arrangements for transferring care are timely and safe;

   c. enhance the capacity of the Unit to safely manage high levels of behavioural disturbance;

   d. review the progress, appropriateness and models of care; and

   e. ensure the appropriate handover of care, including to and from other medical services.

4. The final report from this review was received by the District on 29 September 2009 (Attachment 1).

5. The reviewers considered previous review reports, concerns raised by external parties, details of particular clinical incidents and also conducted meetings with key stakeholders and staff.

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6. A total of 55 recommendations were made under the domains of Governance, Clinical Model, Nursing Model of Care, Patient Journey, Treatment Evaluation, Clinical Leadership, Nurse Staffing Profiles and Nursing Staff Training and Education.

7. The final report and recommendations were released to staff within the Unit, along with an action plan for addressing the issues raised in the recommendations.

8. Staff within the Barrett Adolescent Unit have undertaken a range of actions to address the issues and these are contained in the final action plan report (Attachment 2).

9. It is proposed that the report and recommendations have been actioned and that this matter is now finalised.

Key issues

10. The recommendations arising from the 2009 Review of the Barrett Adolescent Unit have been substantially actioned.

11. The outstanding recommendations (detailed below) are contingent upon the completion of the Statewide Model of Service for the Adolescent Extended Treatment and Rehabilitation Inpatient Service, via the Mental Health Alcohol and Other Drugs Directorate and associated relocation to the Redlands Hospital. These recommendations will continue to be progressed via usual business processes:
    a. a model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service; and
    b. identified role and function to be incorporated into future planning as a component of the relocation of the service to the Redlands Hospital.

Consultation

12. Not applicable.

Financial implications

13. There are no financial implications.

Legal implications

14. There are no legal implications.

Elected representative

15. Not applicable.

Remedial action

16. No remedial action is required.

Attachments

17. Attachment 1 – Barrett Adolescent Review (2009)

    Attachment 2 – Final Action Plan Report of the 2009 Review of the Barrett Adolescent Unit

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Recommendation
That the Minister

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

APPROVED/NOT APPROVED

NOTED

GEOFF WILSON
Minister for Health

/ /

/ /

Senior Policy Advisor/
Policy Advisor

7 / 7 / 11

Minister's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Endorsed by:
Katrina Mathies	Shirley Wigan	Pam Lane	Dr Tony O'Connell Acting Director-General
Director, Mental Health Services	Executive Director Mental Health	District Chief Executive Officer	
Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	
14 June 2011	14 June 2011	14 June 2011 21 June 2011	

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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. 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 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;
- Providing more certainty about the future of BAC.

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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".

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 three young 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 female;
- All were near or over the age of 18 years;
- 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.

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:

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:

1. Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;
2. Clear local policies that are integrated with wider policies aimed at managing risks;
3. Procedures for all professional groups to identify and remedy poor performance;
4. 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;
    - Clinical Audits;
    - The effective monitoring of clinical care deficiencies;

- Research 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.

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.

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

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.

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.

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. 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.

Communication around continuity of care of clients in the unit, but particularly between nursing staff on each shift and between shifts, is poor and poorly documented.

Recommendations:

1. *That generally accepted mechanisms of clinical and corporate governance are introduced or enhanced within BAC. These would include:*
2. *The State and hospital should give a clear determination of the role and function of BAC.*
3. *This information (about role and function) needs to be disseminated in written form to all stakeholders.*
4. *The role and function should be operationalized and a reporting framework developed such that the unit is shown to be fulfilling its function.*
5. *That a procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.*
6. *That an integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.*
7. *All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.*
8. *Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.*

9. *All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.*
10. *That a system for managing, responding to and analysing complaints be introduced to improve community and client satisfaction with BAC.*
11. *That Performance Review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.*
12. *That audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.*
13. *Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.*

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit.

The reviewers had a number of interventions described to them; however, Milieu Therapy and Adventure Therapy were the two overriding interventions highlighted as encapsulating the clinical approach of the programme.

Typically, **Milieu Therapy** is a form of psychotherapy that involves the use of therapeutic communities. It has been used as a viable treatment modality for children for over fifty years in residential and inpatient settings. Milieu Therapy is potentially a powerful therapeutic tool when individual dynamics and the social system can be combined in a planned and meaningful way to manage and change behaviour and relationships in settings such as BAC.

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There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence. Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

Adventure Therapy is the creation of opportunities to explore the unknown in a safe environment through team based adventure activities. This therapeutic approach has the capacity to engage adolescents and young people. There is a small body of literature about the intervention and, while the data about effectiveness from that literature is equivocal, its use at BAC is not contraindicated. Its drawbacks, however, are that it is not an activity that can be intensively introduced into the day to day running of the unit and that as a stand-alone intervention its outcomes are poor.

It is noted that the loss (as reported in early reviews) of positions and facilities will have compromised the capacity of BAC to successfully implement structured out of hours activity and the Adventure Therapy Programme.

The A1-A7 programs are behaviour management programs employed to manage difficult and challenging behaviours. It has been previously noted that they have been used for many years without documented evidence that they are effective or that they have been systematically reviewed.

A previous review conducted in 2003 recommended the BAC close the programs for several days each year to invest time in program review, management, procedural and training issues. There is no evidence that this recommendation has been acted upon.

The recommendation made previously (2003) to close the program for several days to undertake review and development activities is considered to remain integral to the successful functioning of BAC.

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

Time and effort could be directed at identifying interventions, other than continuous observation, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance. Pursuing the idea of a high dependency unit may prove to be the most judicious use of human and financial resources.

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities. The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

It is worth emphasising that while it may be argued that the various types or aspects of treatment – Milieu Therapy, Adventure Therapy - described above have a role, these should not be the cornerstone of a contemporary treatment program, nor the optimal "model of care". For example, patients with eating disorders may benefit from using the "Maudsley Eating Disorders Model", those with challenging personalities may warrant Dialectical Behaviour Therapy (DBT), etc.

Finally a previous review noted that "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" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

Recommendations:

1. *A model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service.*
2. *The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.*
3. *That the increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.*
4. *If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate training and supervision for staff provided.*
5. *That Adventure Therapy may continue but, if so, this should be seen as a component part of an overall therapeutic approach.*
6. *That interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.*
7. *The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.*
8. *Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.*
9. *Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.*

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to

reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

During the visit, some nursing staff identified that it was particularly stressful being allocated to escort duty, during which time the nurse is required to be a continuous escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

Recommendations:

1. *Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation & Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).*

   [Patient allocation sees an individual nurse allocated to a group of patients and undertaking total patient care for that group. It has the advantages of providing personalised and holistic care while increasing the sense of autonomy and accountability and allowing more opportunities for communication with other health professionals. Team nursing involves dividing work between a group of nurses who are allocated to care for a number of patients. The Team Nursing Model strengths are identified as improving collaboration, flexibility and time efficiency as well as having a supportive/teaching function. The Combination Patient Allocation & Team Model combines the strengths of team nursing with patient allocation.]

Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;
- The remoteness of referring services, making the above patients difficult to manage;
- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were 9 inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients (3 out of 9) were over the age of 18 years. [redacted] meaning length of stay for them was approaching 2, 3 and 4 years respectively.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

***Recommendations*:**

1. *That advice be provided to referring agencies about the nature of the services offered by BAC.*
2. ~~*That clear inclusion and exclusion criteria be formulated.*~~
3. *That referral forms for referring agencies be updated.*
4. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
5. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
6. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*
7. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*
8. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
9. *That responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.*
10. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
11. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
12. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
13. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
14. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on*

clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.

15. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
16. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
17. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

Recommendations:

1. *Routine use of standardised outcome measures.*
2. *Additional (specific) measures be used for the specific disorders managed by the unit (eg depression rating scales for those patients with depression etc).*
3. *Regular use of patient and parent/carer satisfaction surveys.*
4. *Affiliation with an academic unit to facilitate treatment evaluation.*
5. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet. In relation to nursing, while nursing staff reported

that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

Similarly, it was unclear whether the Nurse Unit Manager and the Director attended regular meetings in their roles as providing the leadership group at BAC.

Recommendations:

1. *Appointment of an Executive whose members have clear roles and responsibilities*
2. *Clear delegation and succession planning (for example, when the Director, NUM, liaison nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).*
3. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*
4. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*
5. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on

weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*
2. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health.

There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

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Final Report of the 2009 Review of Barrett Adolescent Unit

Recommendation		Comments & proposed actions	
1.	**Governance**		
1.1	The State & hospital should give a clear determination of the role and function of BAC.	▪ Draft Model of Service Delivery developed ▪ Currently under consideration at the Statewide Child and Youth Steering Committee ▪ Review existing documentation ▪ Consult Mental Health Implementation Team regarding confirmation of role and function for Extended Adolescent Inpatient Service ▪ Identified role and function to be incorporated into future planning as a component of the relocation of the service to Redlands Hospital.	▪ Finalised ▪ Ongoing ▪ Finalised 2008 ▪ Finalised 2008 ▪ Ongoing review 2011 Role and function articulated within the Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health)
1.2	This information (about role and function) needs to be disseminated in written form to all stakeholders.	▪ Whilst awaiting finalising actions from 1.1, revisit current documents in relation to operation of Barrett Adolescent Centre ▪ Assess alignment with directions contained in report ▪ Modify/strengthen and redistribute as indicated.	▪ AETRC MOSD has been endorsed by the SWCYAG ▪ Information package forwarded out to referrers
1.3	The role and function should be operationalised and a reporting	▪ Establish review mechanisms including patient profiling in line with	▪ The AETRC MOSD profiles the patients who are likely to benefit from

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	Recommendation	Comments & proposed actions	
	framework developed such that the unit is shown to be fulfilling its function.	outcomes from 1.2 & 1.3.	admission to the BAC ▪ The AETRC MOSD provides for a referral panel including senior clinicians from the Children's Health District and the Metro South Health district on the referral panels and the six month review panel. This has yet to come into operation due to time pressures on staff from these Districts.
1.4	A procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.	▪ As appropriate. ▪ Review existing processes. ▪ Establish baseline/existing staff.	▪ Approved Role Descriptions are in place for all staff. ▪ All clinical staff registered maintain current registration with the appropriate registration authority, and maintain professional standards as per their professional discipline requirements. ▪ Medical credentialing in place ▪ Non-mandatory credentialing available to other clinical staff in line with professional discipline framework.
1.5	An integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.	▪ Review existing procedures and mechanisms, such as WH&S, PRIME CI, PRIME CF, Patient Safety Rounds, Clinical Review, Root Cause Analysis, Clinical Risk Management etc. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ In use as per The Park Processes

Recommendation		Comments & proposed actions	
1.6	All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.	▪ As above.	▪ Achieved. All incidents are reported and documented. Reviewed in a number of forums, eg specifically convened critical incident forums, case conferences and intensive case workups.
1.7	Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.	▪ Strengthen clinical record audit procedure/proforma. ▪ Incorporate results into quality improvement.	▪ Clinical record audit procedure in line with The Park process.
1.8	All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.	▪ Utilise existing process for procedure review and development to align with future directions	▪ As per Clinical Steering Committee and Park established processes.
1.9	A system for managing, responding to and analysing complaints to be introduced to improve community and client satisfaction with BAC.	▪ Review existing procedures & mechanisms. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ In line with Park and Q Health processes, clients can also access Community Visitor, CAG and Children's Commission.
1.10	Performance review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.	▪ Review existing HR practices, PADs ▪ Explore alternate options for professional supervision ▪ Assess alignment ▪ Establish/re-establish/strengthen existing.	▪ Achieved. Line Manager process for all BAC clinical staff PADs. ▪ All clinical staff receive clinical supervision regularly.
1.11	Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.	▪ Review existing procedures and mechanisms, such as Individual Case Workups, Clinical Review, HEAPS, Root Cause Analysis, Assess	▪ Clinical audits assigned to RN portfolios. ▪ BAC is implementing the use of CIMHA/POS entries/reports which can

Recommendation		Comments & proposed actions	
		alignment ▪ Explore alternate options for the inclusion of external review/input ▪ Establish/re-establish/strengthen existing.	facilitate auditing /monitoring of case reviews, OIS reviews, and alerts. (This has since become a pilot for The Park).Clinical audits are forwarded to the Nurse Unit Manager who reviews and makes recommendations which are then forwarded to the relevant persons/committees. ▪ CIMHA processes are presented at the CIMHA reference group where improvements are identified and acted upon.
1.12	Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.	▪ Review existing handover processes, policies, procedures. ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Specific times are established for nursing handover and multidisciplinary team meetings, including case conferences, intensive case workups, and morning meetings with consumers. There are specific formats for each of these meetings and are recorded on meeting specific documentation eg consumers morning meeting book, case conference review sheet, care planning documents. ▪ Nursing handover is a well established routine consisting of the review of the ward report book and communication diary to identify prioritisation of care planning. Input is by all nursing staff.
2.	**Clinical Model**		
2.1	A model of care should be	▪ Review existing client assessment	▪ The AETRC MOSD developed and

Recommendation		Comments & proposed actions	
	formulated, based on the currently available evidence and the nature of clients presenting to the service.	and treatment planning.	endorsed by the SWCYMHAG in August 2010 ▪ Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health)
2.2	The recommendations made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.	▪ Not possible given nature of service. ▪ Review other approaches to facilitate this activity.	
2.3	The increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.	▪ Review Structured Day Program	▪ Reports from [PRIME] have been reviewed and have shown a trend for behavioural incidents that does not support the statement that unstructured time results in increased risk. One of the more significant aspects of adolescent development requires the ability to manage leisure time, eg unstructured time is developmentally appropriate, however, this is always with staff assistance and supervision if required.
2.4	If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate	▪ To be considered in line with the outcomes of recommendations 1.1 & 1.2	▪ BAC is not a therapeutic community. This is outlined fully in the *"Response to the Barrett Review 2009"* ▪ BAC utilises the Recovery Model ▪ Clinical Services Capability

Recommendation		Comments & proposed actions	
	training and supervision for staff provided.		Framework v3 2011 (Level 6, non-acute inpatient service, Child and Youth Mental Health) ▪ Key activities of the unit already in existence are identified in the AETRC MOSD
2.5	Adventure Therapy may continue but, if so, this would be seen as a component part of an overall therapeutic approach.	▪ As above	▪ The therapeutic approach is outlined in the AETRC MOSD. This is outlined fully in the *"Response to the Barrett Review 2009"* ▪ Adventure therapy is utilised as a component of the overall approach in BAU, which also includes Individual Therapy, Family Therapy, schooling and group programs.
2.6	Interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.	▪ Review existing interventions such as HDU, Structured Day Program and Individual Contracts ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ The statewide group that investigated seclusion and restraint in Adolescent inpatient units in Queensland, and which Barrett participated in, noted that the use of continuous observations significantly reduced the need for seclusion. Barrett was commended for its low seclusion rates considering the difficult nature of its clientele. Since the completion of the High Acuity Area it has been noted that disruptive behaviour can be more easily confined and afford more dignity to the patients and staff.

Recommendation		Comments & proposed actions	
2.7	The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.	▪ As per recommendation 2.1 and 2.6	▪ CIMHA used for all Intensive Case Workup's.
2.8	Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.	▪ As per recommendation 1.10	▪ Training needs identified as part of the development of the new unit and appropriate resources allocated.
2.9	Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.	▪ As per recommendation 2.6	▪ Clients are included in the care planning negotiations as part of the Intensive Case Workup process. Consumers sign off on their plans in conjunction with their care co-ordinators.
3.	**Nursing Models of Care**		
3.1	Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation &	▪ Review existing model ▪ Explore alternative models. ▪ Implement agreed model	▪ The nursing model of care in BAC is and always has been Primary nursing with elements of Case Management. ▪ The Toolkit for Nurses 2003 lists strengths and weaknesses of each

EXHIBIT 220

Recommendation		Comments & proposed actions	
	Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).		nursing model and upon review by the Barrett nursing team it was identified that the current model in use was the most suitable. The weaknesses of the Primary nursing model according to the Toolkit are more than adequately addressed by the Barrett nursing team. This is outlined fully in the *"Response to the Barrett Review 2009"*
4.	**Patient Journey**		
4.1	Advice be provided to referring agencies about the nature of the services offered by BAC.	▪ Review and update existing service brochures ▪ Review existing referral and intake processes ▪ Implement agreed processes	▪ Service brochure for referrers was established and separate ones for DChS. Referral processes have continued to be reviewed and adjusted based on review of admissions and changes in referral trends.
4.2	Clear inclusion and exclusion criteria be formulated.	▪ Review existing criteria ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Previous criteria exist but not always adhered to due to elements of other referring services. ▪ The MHD has instructed that exclusion criteria not be included in the latest version of MOSD's. However, the endorsed AETRC MOSD does contain reference to patients unlikely to benfit from treatment. ▪ The Clinical Services Capability Framework v3 2011 (Level 6, non-acute inpatient service, Child and

Recommendation		Comments & proposed actions	
			Youth Mental Health) provides a service description outlining details of who the service is provided for.
4.3	Referral forms for referring agencies be updated.	▪ As per recommendation 4.1	▪ CN/CL now utilises CIMHA for referral information.
4.4	Service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to: - Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm. - Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders. - Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances. - Agreements with local Acute Mental Health Facilities with regard to the transition of older	▪ Review existing background documents. ▪ Partnership agreements be developed in accordance with Service Model & State Directions. ▪ Review MOS (Statewide).	▪ Ipswich Hospital CL Park patient transfer protocol developed. ▪ Management of physical complication of ED's managed at Ipswich Hospital, PA Hospital or Mater. ▪ Arrangements now in place with acute mental health facilities at PAH to assist with management of acute behavioural disturbances and for transition processes of older clients.

	Recommendation	Comments & proposed actions	
	adolescents from care at BAC to care in Adult Mental Health Services.		
4.5	Responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.	▪ Incorporated into referral.	▪ As per BAC clinical pathway.
4.6	The length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.	▪ Incorporate into referral and pre admission process.	▪ Treatment process often impact on these aspirational plans. However discharge planning is incorporated as a core component into each clinical review.
4.7	There is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).	▪ Review existing continuity of care/involvement protocols included in referral form. ▪ Assess alignment ▪ Establish/re-establish/strengthen	▪ We have continued involvement of the referring team at Intensive Case Workups and prior to discharge as recorded as a group POS in CIMHA.
4.8	Homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.	▪ This recommendation is contrary to the 4th National Mental Health Plan. The only appropriate exclusion criteria should be based on the inability to benefit from admission and the likelihood of detriment to the welfare of other young people.	▪ Continue to liaise with the Department of Communities regarding the provision of step down and supported accommodation for adolescents with severe and complex mental illness in line with the 4th National Mental Health Plan
4.9	The concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be	▪ Supported. ▪ Requires Statewide support and commitment.	▪ NGO services are accessed as part of transition programs when required. ▪ Continue to liaise with the Department

Recommendation		Comments & proposed actions	
	explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.	▪ Partnership agreements.	of Communities regarding the provision of step down and supported accommodation for adolescents with severe and complex mental illness in line with the 4th National Mental Health Plan
4.10	A target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.	▪ To be included as component of recommendations 4.1, 4.2, 4.3, 4.5, 4.6, 4.7.	▪ Currently every case review makes every effort to include the referring agency and other relevant agencies as part of the review. This provides opportunity for a detailed review of treatment within the Centre, as well as the capacity of the community to manage aspects of the young person's or family's care and begin the transition process. ▪ The AETRC MOSD includes the additional requirement for review by senior staff from the Children's and Metro South Health Districts if admission continues beyond six months. Because of time demands on staff, this has yet to be set in operation.
4.11	Planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.	▪ Review existing processes such as Clinical Care Review Meeting, Clinical Audit ▪ Assess alignment ▪ Establish/re-establish/strengthen	▪ Incorporated into the Intensive Case Workup process.
4.12	Regular (eg twice yearly) meetings	▪ Explore establishment of referral	▪ As part of the Qld Children's Health

	Recommendation	Comments & proposed actions	
	of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.	network	Services District CYMHS Key Skills training program site visits to Barrett occur several times a year. An overview of Barrett's function and services are presented to the participants who represent key referring agencies. This important process has been in place for several years. ▪ We also include the community service providers at Intensive Case Reviews.
4.13	Data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health.		▪ All referral data reviewed in regular reports by CNCL and at weekly intensive case workups –This data is entered into CIMHA and regular monthly reports are sent by District MHISSO to Director of Clinical Services at the Park.
5.0	**Treatment Evaluation**		
5.1	Routine use of standardise outcome measures.	▪ Review existing use of outcome measure in clinical care and treatment planning ▪ Review existing use of outcome measures in program evaluation ▪ Establish/re-establish/strengthen	▪ Outcomes are collected during Intensive Case Reviews, on admission and on discharge. Recent changes have included the use of the Teacher SDQ by BAC School.
5.2	Additional (specific) measures be	▪ As above	▪ Disorder specific scales are routinely

Recommendation		Comments & proposed actions	
	used for the specific disorders managed by the unit (eg. depression rating scales for those patients with depression etc).	▪ Explore options for Benchmarking with like services.	used. These are outlined fully in the *"Response to the Barrett Review 2009"*
5.3	Regular use of patient and parent/carer satisfaction surveys.	▪ Review existing ▪ Establish/re-establish/strengthen	▪ BAC's carer surveys are in line with The Park processes.
5.4	Affiliation with an academic unit to facilitate treatment evaluation.	▪ Explore options for affiliation	▪ Close links with UQ and QUT developed in allied health areas, but we and the universities lack resources to pursue evaluation. Currently discussions occur with Professor Len Bickman form Vanderbilt University, Tennessee who visited the unit in December 2010, who advised the Federal Government in 2000 on developing outcome measures for evaluation to pursue further models of evaluation. No comprehensive model of evaluation of all aspects of adolescent inpatient units exists in the world. This is outlined to some extent in the *"Response to the Barrett Review 2009"*
5.5	Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.	▪ Workgroup to be established in relation to recommendations 5.1, 5.2 to consider ongoing regular process	▪ Work Improvements Group has been established. Minutes of these groups go to the Service Improvement Co-ordinator at the Park and to all BAC staff.

Recommendation		Comments & proposed actions	
6.0	**Clinical Leadership**		
6.1	Appointment of an Executive whose members have clear roles and responsibilities.	▪ Review existing structures.	▪ The Barrett Adolescent Centre Management Committee comprises: - Dr Trevor Sadler - Clinical Director - Risto Ala-Outinen - Nurse Unit Manager - Kevin Rodgers - School Principal - Kim Hoang - Occupational and Leisure Therapist ▪ The roles of these members are clearly defined as are the responsibilities as defined in the role descriptions of these members.
6.2	Clear delegation and succession planning (for example, when the Director, NUM, Liaison Nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).	▪ Within HR practices.	▪ One of the priorities of the relocation of Barrett to Redlands Hospital has been the intention to give learning opportunities to those staff who have indicated they will be moving with the service. This has resulted in higher duties being undertaken by these staff. ▪ Relevant courses are given priority.
6.3	The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and	▪ BAU management team to review existing ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Achieved. ▪ Regular inservices provided on Family Therapy, Multisensory therapy, art therapy, sandplay therapy. The Director notifies all BAC staff of

Recommendation		Comments & proposed actions	
	innovative therapies, presented by people external to BAC, should be included.		seminars, workshops and courses relevant to BAC service. Seminars have been run and another is in the planning process for early 2011.
6.4	BAC should provide a regular (eg. quarterly) report to Park Hospital and State Mental Health about its programs and use of both tested and innovative approaches.	▪ Review existing processes ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Regular reporting is provided via Nurse Unit Manager's attendance at CSC, CRMC, Park management Committees. ▪ The Clinical Director attends the State-wide Child and Youth Mental Health Advisory Group. ▪ The CN/CL attends the Care Planning Committee.
6.5	The Nurse Unit Manager may benefit from adopting strategies to encourage the clinical nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.	▪ Explore options for specialist portfolio roles for CNs	▪ Specialist portfolio roles for the CN group and the RN's have been developed. ▪ CN's are encouraged to perform higher duties where available. ▪ CN's attend the Case Conference and Intensive Case Workup each week.
7.0	**Staffing Profiles (Nursing)**		
7.1	More robust interactions between nursing staff of BAC and other CYMH Services should be facilitated; one way to address this may be found in secondment activity	▪ Network of C&Y Psychiatrists and staff within District.	▪ Secondment not feasible at this time. Interactions between BAC and CYMHS services well developed.

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Recommendation		Comments & proposed actions	
	negotiated between services.		
7.2	The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.	As per recommendation 6.5	▪ Specialist portfolio roles adopted by CN's. ▪ Line Manager responsibilities allocated to CN's.
8.0	**Nursing Staff Training & Education**		
8.1	The role of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.	▪ Noted ▪ Professional development funds utilisation has been reviewed and BAU nursing staff have been well represented ▪ Revised EB arrangements now in place.	▪ Nursing staff regularly access Professional Development leave - funds are now part of the award conditions.
8.2	Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.	▪ Align with recommendation 6.3 - Access to Professional Development activities.	▪ Regular inservices provided on Unit and via The Park School of Mental Health education program. ▪ Journal Club established

Recommendation		Comments & proposed actions	
8.3	Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.	▪ Review existing clinical supervision model ▪ Assess alignment. ▪ Establish/re-establish/strengthen existing.	▪ Clinical supervision is available on ward and throughout the facility. At the time of the review the percentage of staff receiving clinical supervision was approx. 60% including 100% for medical and allied health staff. Nursing percentage has fallen since the dedicated clinical supervisor has resigned. Efforts have been made within BAC with input from the previous A/DON to access clinical supervision for nursing staff. Currently the Park has provided a list of clinical supervisors and the number of nursing staff accessing clinical supervision is increasing.

EXECSUPPORT - BR050182 MD09 - Returned for amendment

From: EXECSUPPORT
To: MD09-DarlingDowns-WestMoreton-HSD
Date: 20/06/2011 4:38 PM
Subject: BR050182 MD09 - Returned for amendment
Attachments: BR050182.pdf; BR050182 MD09 UPDATE & FIINALISATION EXTERNAL REVIEW REPORT BARRETT.doc

Hi

Please find attached BR050182 which requires amendments as outlined in the attached PDF document.

When making changes to the brief can you please use the attached Word document.

The updated brief is due back **by 27/6/11.**

Many thanks... Diane Cochran
ESU

EXHIBIT 220

This brief contains
very little detail
re the review report.
Please provide more
in way of summary

EXHIBIT 220

Minister's Office RecFind No:	11002997
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

Briefing Note

~~The Honourable Geoff Wilson MP~~
Minister for Health

15 JUN 2011

16/6/11 BY CM

Requested by: Chief Executive Officer, Darling Downs - West Moreton Health Service District

Date requested: 22 May 2011

Action required by:

Action required
☐ For approval
☐ For meeting
☐ With correspondence
☒ For Information

Other attachments for Ministerial consideration
☐ Speaking points
☐ Draft media release
☐ Ministerial Statement
☐ Question on Notice
☐ Cabinet related document

SUBJECT: Update and Finalisation - External Review Report of Barrett Adolescent Unit

Proposal

That the Minister:

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

Urgency

1. Routine.

Background

2. The Barrett Adolescent Unit provides mental health inpatient rehabilitation services (15 beds) for young people aged between 13 and 17 years who require extended inpatient care and treatment for a mental illness. The Unit provides a statewide service and referrals are received from mental health services throughout Queensland.

3. In January 2009, an external review of the Barrett Adolescent Unit was commissioned to examine reported consumer clinical incidents and make recommendations regarding the safe care of consumers of the Barrett Adolescent Unit. This included measures to:
   a. manage the mix and acuity of consumers attending the Unit;
   b. ensure that arrangements for transferring care are timely and safe;
   c. enhance the capacity of the Unit to safely manage high levels of behavioural disturbance;
   d. review the progress, appropriateness and models of care; and
   e. ensure the appropriate handover of care, including to and from other medical services.

4. The final report from this review was received by the District on 29 September 2009 (Attachment 1).

5. The final report and recommendations are critical across a number of domains and were released to staff within the Unit, along with an action plan for addressing the issues raised in the recommendations.

Minister's Office RecFind No:	
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

6. Staff within the Barrett Adolescent Unit have undertaken a range of actions to address the issues and these are contained in the final action plan report (Attachment 2).

7. ~~It is proposed that the report and recommendations have been actioned and that this matter~~ is now finalised.

Key issues

8. The recommendations arising from the 2009 Review of the Barrett Adolescent Unit have been substantially actioned.

9. The outstanding recommendations (detailed below) are contingent upon the completion of the Statewide Model of Service for the Adolescent Extended Treatment and Rehabilitation Inpatient Service, via the Mental Health Alcohol and Other Drugs Directorate and associated relocation to Redlands Hospital. These recommendations will continue to be progressed via usual business processes:
   a. a model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service; and
   b. identified role and function to be incorporated into future planning as a component of the relocation of the service to the Redlands Hospital.

Consultation

10. Not applicable.

Financial implications

11. There are no financial implications.

Legal implications

12. There are no legal implications.

Elected representative

13. Not applicable.

Remedial action

14. No remedial action is required.

Attachments

15. Attachment 1 – Barrett Adolescent Review (2009)

    Attachment 2 – Final Action Plan Report of the 2009 Review of the Barrett Adolescent Unit

QHD.005.001.3194

EXHIBIT 220

Minister's Office RecFind No:	
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

Recommendation
That the Minister

Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

APPROVED/NOT APPROVED	NOTED	NOTED
GEOFF WILSON **Minister for Health**	**Principal Advisor**	**Senior Policy Advisor/** **Policy Advisor**
/ /	/ /	/ /

Minister's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Endorsed by:
Katrina Mathies	Shirley Wigan	Pam Lane	Dr Tony O'Connell Acting Director-General
Director, Mental Health Services	Executive Director Mental Health	District Chief Executive Officer	
Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	
14 June 2011	14 June 2011	14 June 2011	16/ 6 / 11

EXHIBIT 220

EXECSUPPORT - BR050182 MD09 - Returned for Update

6/6/11 EXTN to 14/6/11

From: EXECSUPPORT
To: MD09-WestMoretonSouthBurnett-HSD
Date: 31/05/2011 12:53 PM
Subject: BR050182 MD09 - Returned for Update
Attachments: BR050182.pdf; BR050182 MD09 UPDATE & FINALISATION EXTERNAL REVIEW REPORT BARRETT.doc

Hi

Please find attached BR050182 which requires amendments as outlined in the attached PDF document.

When making changes to the brief can you please use the attached Word document.

The updated brief is due back **by Tuesday, ~~6/7/11~~.** 14/6/11

Many thanks... Mary Delahenty
ESU

EXHIBIT 220

EXECSUPPORT - Re: Fwd: BR050182 MD09 - Returned for Update

From: MD09-DarlingDowns-WestMoreton-HSD
To:
Date: 06/06/2011 1:30 PM
Subject: Re: Fwd: BR050182 MD09 - Returned for Update

Hi Nikki
Can we please have a 1 week extension on this item. Due to other issues or priority this will just take longer than expected to amend.

Thanks
Kylie

Kylie Beaver & Shireen Coupland
District Executive Office (MD09)
Darling Downs - West Moreton Health Service District

>>> EXECSUPPORT 2:18 pm Tuesday, 31 May 2011 >>>
Hi Kylie

Please find below as requested.

Kind regards

Nikki Joseph
Executive Support

>>> EXECSUPPORT 31/05/2011 12:53 pm >>>
Hi

Please find attached BR050182 which requires amendments as outlined in the attached PDF document.

When making changes to the brief can you please use the attached Word document.

The updated brief is due back **by Tuesday, 6/7/11.**

Many thanks... Mary Delahenty
ESU

EXHIBIT 220

Attention: Executive Support Unit

Please return to MOO9 noting for more background to be provided. What is this unit and why was an external review done? What are the outstanding recommendations & their remedial actions?

Please resubmit.

Thanks,

Wendy
ODG

30 MAY 2011

EXHIBIT 220

26 MAY 2011

Minister's Office RecFind No:	
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: Chief Executive Officer, Darling Downs - West Moreton Health Service District

Date requested: 22 May 2011

Action required by:

Action required
☐ For approval
☐ For meeting
☐ With correspondence
☒ For Information

Other attachments for Ministerial consideration
☐ Speaking points
☐ Draft media release
☐ Ministerial Statement
☐ Question on Notice
☐ Cabinet related document

SUBJECT: Update and Finalisation - External Review Report of Barrett Adolescent Unit

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Note the contents of this brief in relation to external review report of the Barrett Adolescent Unit.

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3. The final report from this review was received by the District on 29 September 2009. (Attachment 1).

4. The final report and recommendations are critical across a number of domains and were released to staff within the unit, along with an action plan for addressing the issues raised in the recommendations.

5. Staff within the Barrett Adolescent Unit have undertaken a range of actions to address the issues and these are contained in the final action plan report. (Attachment 2)

6. It is proposed that the report and recommendations have been actioned and that this matter is now finalised.

Key issues

7. The recommendations arising from the 2009 Review of the Barrett Adolescent Unit have been substantially actioned.

Minister's Office RecFind No:	
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

8. The outstanding recommendations are contingent upon the completion of the Statewide Model of Service for the Adolescent Extended Treatment and Rehabilitation Inpatient Service, via the Mental Health Alcohol and Other Drugs Directorate and associated relocation to Redlands Hospital. These recommendations will continue to be progressed via usual business processes.

Consultation

9. Not applicable.

Financial implications

10. There are no financial implications.

Legal implications

11. There are no legal implications.

Elected representative

12. Not applicable.

Remedial action

13. No remedial action required.

Attachments

14. Attachment 1 – Barrett Adolescent Review (2009)
    Attachment 2 – Final Action Plan Report of the 2009 Review of the Barrett Adolescent Unit.

EXHIBIT 220

Minister's Office RecFind No:	
Department RecFind No:	BR050182
Division/District:	MD09
File Ref No:	

Recommendation
That the Minister

~~**Note** the contents of this brief in relation to external review report of the Barrett Adolescent~~ Unit.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health
/ /

Principal Advisor
/ /

Senior Policy Advisor/
Policy Advisor
/ /

Minister's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Endorsed by:
Katrina Mathies	Shirley Wigan	Pam Lane	Michael Reid Director-General
Director, Mental Health Services	Executive Director Mental Health	District Chief Executive Officer	
Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	Darling Downs – West Moreton Health Service District	
23 May 2011	25 May 2011	25 May 2011	