Transitions in Care

One campus – two worlds
OVERVIEW

• Background and extent of the problem for young people with chronic illnesses at Prince of Wales Hospital
• Specific issues during transition
• Initiatives and maps
• Case presentation
• Future directions
Background

• The Prince of Wales Hospital (POWH) is a tertiary referral centre for adults co-located on the Randwick Campus with the Sydney Children’s Hospital. A significant number of young people with chronic illness/disability elect to transfer to POWH for ongoing management.

• On average there are 28 young people as inpatients daily at POW across 14 wards (approx 6% of all in-patients). Many more are managed as outpatients- numbers unknown.
Specific issues during transition

**Adult world**
- Lack of youth friendly services – environment, activities, communication, leisure
- Lack of acknowledgement of the vital role of families
- Does not recognise inexperience
- Cared for by specialty medical staff
- Don’t follow up and remind young people about appointments

**One campus- two worlds**

**Paediatric world**
- Adolescent developmental concerns frequently not addressed
- Independence and self-management skills not actively developed
- Lack of engagement with GPs and adult colleagues

**gmct TRANSITION**

**SOUTH EASTERN SYDNEY ILLAWARRA NSW HEALTH**
Initiatives

Transition Care Working Group - multi-disciplinary group

Adolescent Admission form (nursing)

Adolescent Information Brochure

Transition Care Guidelines - road map for clinic attendances, planned and un-planned admissions

Medical Management Plan

SESIAHS Transition Care Committee

SCH School - ward visit for adolescent in-patients
Transition Care referral criteria

1st Adult Hospital Admission
Chronic Illness
Length of stay >5 days
Adolescent Growth & Development concerns
Psychosocial Issues
Therapy Non-Adherence
Communication Difficulties
Map 1

Clinic attendance

- Clinic Attendance booked
  - Attendance to all booked appointments
    - Yes: Inform Transition Care Coordinator on 9515 6362
    - No: Previous Referral to Transition Care Coordinator?
      - Yes: Continue to assess young person's knowledge of illness
      - No: Complete Referral to Transition Service (Appendix 3) and fax to 95156341
Map 2

Planned and unplanned admissions

- Booked Admission Aged 14-24
  - Adolescent on waiting list contacted by Transition Care Coordinator (TCC)
    - TCC provides adolescent with Youth Information Brochure
      - Attendance to Pre-admission Clinic?
        - Yes: Completion of Medical Management Form
        - No: Hospital Admission Aged 14-24
          - Hospital Admission Aged 14-24
            - Medical Management Plan completed?
              - Yes: Assigned Nurse to complete Youth Admission Form
              - No: Provide Youth Information Brochure
                - Are any of the Transition Care referral criteria met?
                  - Yes: Complete Referral to Transition Service (Appendix 2) and fax to 95166341
                  - No: Refer to Sydney Children's Hospital school if required
                    - Refers to Clinical Nurse Consultant if appropriate for ongoing support
                      - Refer to Pre-Admission Medical Management plan when required
One initiative which can be applied to all medical specialties
Case Presentation

Active medical issues

- Cerebral Palsy
- Severe developmental delay
- Epilepsy
- Scoliosis
- Gastrostomy
- Recurrent chest infections
- Increased oral secretions
Case presentation - continued

Inactive medical issues

- Fundoplication 2002
- Aberrant pulmonary vessel – coil inserted 2002
- Botox to salivary glands 2006
Transitions management- road map trial

- Referral to Transition Care Coordinator by paediatric team
- Generic information on transition provided to patient and family by Transition Care Coordinator
- Adult service and clinicians identified
- Comprehensive summary of medical, nursing and psychosocial issues prepared by Transition Care Coordinator and family
- All clinicians involved in care provided with medical mx plan
- Preferred wards (2) identified
- Staff education
Future directions

• Engagement of sponsors to increase access to leisure activities/equipment for carers
• Final ratification and implementation of maps
• Collaboration with SESIAHS Transition Care Committee
• Evaluation of the effectiveness of the Guidelines and pre-admission transition planning process
• Identify and report on the number of adolescents who do not attend out-patients and pre-admission clinic on a bi-annual basis
• Feedback from referral agencies
Contact details

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