

Transition Guidelines

Ward support = Smooth transition
to adult health care



Background

The following guidelines were developed over a period of 8 weeks October – December 2005.

Transition of patients from paediatric to adult health care has been an ad hoc process in most areas of the Royal Children's Hospital (RCH) with the exception of a well developed transition process with patients who have cystic fibrosis and more recently a transition clinic for immunology patients. As the adolescent unit provides care for a significant number of older patients, training was provided to nursing staff as part of the RCH Transition project.

Informal, facilitated discussions were conducted for 30 - 40 minutes each week with all levels of nursing staff, immediately following the morning to afternoon nursing staff handover.

Approximately, forty nursing staff attended over the period, including a ward clerk and recreation coordinator. As a response to a group request, one presentation was delivered by the cystic fibrosis care coordinator, Judith Glazner. Also several nurses who had recent adult nursing experiences gave their impressions of the differences between paediatric and adult health care settings. These discussions were facilitated by the Transition Project Officer.

It was identified that during the course of performing normal nursing duties, nursing staff are in an excellent position to:

- informally discuss issues related to transition whilst carrying out other duties
- identify any concerns and provide support to patients and their carers
- perform an advocacy role for patients who may be experiencing stress around the issue of transition and refer on to appropriate health team members for specific assistance.

Aim

The aim of the discussions was:

- to raise awareness amongst the staff on issues of transition for patients about to be transferred to adult health care
- to gain some insight into issues for most patients around transition and how to integrate this understanding into daily work practices.
 - i.e. help patients to become more independent during their admission in terms of self management
- to identify strategies to use when talking with patients and medical staff about transition
- to understand the evolving process of transition at RCH and be familiar with some of the documentation required when transferring patients.

It was understood that unless there are exceptional circumstances, as per RCH policy, transition will occur in all patients who reach adulthood.

Discussion Points

- Families need to be included in the transition process, depending on the unique family dynamics.
- Patients will need to get to know a new team of health care professionals.
- Patients will lose access to recreation, education opportunities and peer support, *yet* gain increased freedom and autonomy, tertiary study and workforce support opportunities and other more age appropriate activities.
- Most young people will be expected to take a greater responsibility for own health care.
- Most adult physicians will expect the patient to participate in their own health care.
 - A challenge for patient graduates of the RCH is that most adult hospitals and physicians expect young adults to be SOLELY responsible – i.e. they are quite anti-parental/family involvement. As we all know, this is a two edged sword. In paediatrics, we can be accused of overly involving the family while those in adult hospitals can be accused of the reverse therefore we need to aim for some middle ground. However, the consistent feedback from parents of adolescents with CF at the Alfred is their frustration at their failure to be included in health consultations at all. I therefore think that we need to be creating accurate expectations within young people of the reality of what they should expect - and for their parents. Nursing staff are in a good position to discuss this.
- The DVD *Moving On* was shown and deemed to be an excellent education tool and needs to have a process for presenting to patients.

Suggested Guidelines

- Explore with patients positive aspects and acknowledge the negative aspects. Help patients to re frame aspects that they see as negative.
- In conversations with patients it is best to be realistic about adult hospitals.
 - i.e. remind them that older people make up the bulk of patients in adult hospitals
- Develop strategies for involving young people in managing their own health care.
- Good communication
 - i.e. discuss with a pt. that nursing staff will no longer be reminding them when to go to appointments, physio etc. There will be an expectation that patients will keep their own appointments, physiotherapy regimes etc
- Check first with health team or medical record re progress with the transition plan for a patient, particularly if you are unsure of how much has been discussed.
- If the patient does not know what the adult hospital is like provide advocacy role by liaising with their health care team and /or supporting them to ask their team about a site visit.
- This may be arranged and patient can identify specific departments, how they will access transport to the new hospital...etc
- Develop an understanding of resources available to patients transferring i.e. transition checklist, websites, CF DVD 'Moving on'

- If patients have had Social Work input please utilize this service in supporting patient undergoing transition
- Reassure patient that they will be supported by RCH staff through the process of transition.
- Transition is best managed by one key person. If patient has an inpatient care manager assigned to them, assist the care manager to compile nursing care transfer information.
- If you are unclear who is managing the transition of a patient, ask. The act of asking may prompt the health team to assign someone.
- Empower patients to manage their own affairs, don't immediately give answers, prompt them to come up with their own answers. 'Facilitate' don't 'solve'-they will benefit much more in the long term.

Useful Documents

(can be found at the website below)

www.rch.org.au/transition

1. Transition CHECKLIST

Refer to the transition checklist to help work through some of the skills required to prepare patients to manage their own health care in an adult setting

http://www.rch.org.au/emplibrary/transition/Transition_Checklist.doc

2. Transfer Summary Record

Use this document to collate information from all departments involved in the care of a patient prior to transfer

<http://www.rch.org.au/emplibrary/transition/TransferRecord.doc>

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