

Improving acute care for adolescents and young adults on medical admission units: The interventions that matter

CA Whicher, R Shah, H Gleeson, L Vaughan & L Albon

It had become a familiar routine. My seventh admission with diabetic ketoacidosis (DKA) in a year. Each time I was admitted it was the same; a DKA protocol, a diabetes specialist nurse visit, and a few questions from the doctors checking if “everything is okay?” On each admission, I would be discharged home after a couple of days. We all knew I’d be back again within a month or two.

It is well recognised that adolescents and young adults (AYAs) are more likely to take risks and act impulsively.¹ In healthcare this may manifest itself as being less likely to adhere with treatments, more likely to experiment with alcohol and/or drugs and to access acute services rather than general practitioners (GP).^{2,3} Through developments in cognitive neuroscience it is now thought that this behaviour is potentially related to profound brain restructuring; mainly in the prefrontal cortex and limbic system.⁴ This neuro-cognitive development continues into the late twenties and is also shaped by individuals’ environments and experiences.⁴ With this greater understanding of developmental neuro-biology and the choices that young people make, it is now clear that an AYA-specific bio-psycho-social approach by health care professionals (HCPs) is needed to enable the delivery of high quality care for these individuals.

AYAs are increasingly accessing acute care in adult settings. They account for 36.6% of accident and emergency attendances and up to 20% of inpatient care.⁵ AYAs are a vulnerable group. Mortality within this group has increased such that deaths in patients aged 10 to 19 years are now greater than in children in the first four years of life.⁶

Training in AYA issues may be suboptimal and 70% of medical specialist trainees in 2014 reported minimal or no specific AYA training.⁷ This is concerning, as the UK has some of the worst healthcare outcomes for AYAs in Europe.⁸

While dedicated transition clinics in outpatient services are now common practice and can attract additional tariff, for example Best Practice Tariff for AYAs with Diabetes, young adults with acute needs may sit uncomfortably within the existing structures for delivering acute and ongoing adult patient care.

The Royal College of Physicians (RCP), aware that the current situation is suboptimal, published an acute care toolkit (ACT) for AYAs in October 2015.⁷ The toolkit discusses some of the key areas that, at least in part, are current barriers in providing “high quality and developmentally appropriate care”.

Building trust and rapport:

The ACT firstly addresses the myth that some AYAs can be viewed as easy patients. While a minority can cause HCPs significant anxiety with rare diagnoses and enhanced nursing needs, the majority are self-caring and require little nursing support. However, building the rapport and trust required to address critical psychosocial issues with AYAs, requires 3 things:

1. Time. This is needed to explore not only the presenting medical issues, but also to assess these wider psychosocial factors which impact on a young person’s presentation and future self-management.
2. Privacy. This is required to reassure the AYA that sensitive issues can be discussed in a safe environment. A curtain around a bed does not deliver true privacy. Additionally, the AYA should be offered time alone apart from parent or carer to be able to freely discuss issues – it may be that this is best facilitated at the time of the examination, where the carer/parent can be asked to leave to maintain the AYA’s dignity.
3. Good communication skills. This is paramount. HCPs need to understand that AYAs have different social and cultural norms from adults. Confidence and empathy are needed to bridge these differences without accidentally causing the AYA to disengage.

As such it is recommended that all staff involved in the care of AYAs should receive training to enhance knowledge and confidence for those in regular contact with AYAs. (Box 1). This could be facilitated as part of local and regional training schemes for all clinical staff from Foundation to

CA Whicher

Diabetes and endocrine specialist registrar
Queen Alexandra Hospital,
Cosham, Portsmouth

R Shah

Core Medical Trainee
Queen Alexandra Hospital,
Cosham, Portsmouth

H Gleeson

Consultant Physician
United Hospitals
Birmingham Trust,
Raddlebarn Road, Selly
Oak, Birmingham

L Vaughan

Consultant Physician
Chelsea and Westminster
Hospital, 369 Fulham Road,
London

L Albon

Consultant Physician
Queen Alexandra Hospital,
Cosham, Portsmouth

Correspondence

CA Whicher
22 Highfield Lane,
Southampton
SO171PZ
Email: clareshinton@
hotmail.co.uk

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Box 1: E-learning for Healthcare (E-LfH) Adolescent Health programme⁹

www.e-lfh.org.uk/programmes/adolescent-health

Consultant level, linking to appraisals, ARCPs and personal development plans.

Special consideration

The Toolkit outlines twelve AYA scenarios which need additional consideration. This includes those with chronic conditions who have been lost to outpatient services (and the opportunity to potentially re-engage them), those with medically unexplained symptoms or frequent admissions, and those frequent attenders with issues related to substance misuse or mental health problems. These AYAs are at particular risk and need multidisciplinary reviews to improve outcomes and prevent future admissions. A thorough psychosocial and health assessment is particularly relevant. Generic questions are unlikely to explore potentially complex issues and we know that if ‘you don’t ask, they won’t tell.’ The HEADSS interview¹⁰ (Box 3) provides an excellent framework for all HCPs to use. This should be conducted in a conversational style with signposting of personal topics to come. For example, ‘I’m going to ask you about some things which are usually private and personal; I hope you’re ok with

Box 2: Top tips

- Be warm, positive and respectful
- Reiterate confidentiality
- Sit at the same level and observe body language, including your own
- Explain, explain, explain! If you cannot easily explain, draw.
- Offer a choice within a ‘no choice’ situation e.g. “you need to stay in hospital, would you like your mum to be with you?”
- Use ‘when and then’ statements e.g. “when you have had your blood test then you can go for a coffee.”
- Don’t promise what you may not be able to deliver
- Offer opportunity to talk without parents/carers present

that?’ When concerns are raised, individual trusts should provide clear resources and referral pathways.

My last admission was different. The doctor asked me what it was like at home, what I enjoyed doing and what I thought I might do after college. I saw that my mood had been up and down with all the hospital admissions, and I felt isolated because of my diabetes and the time I have spent in hospital away from my friends. We talked about my alcohol use, even about drugs and sex and I felt nothing was off limits. It was good to talk about me and not about my diabetes and sugar levels.

Box 3: HEADSS

Home Who do they live with? Where? What are relationships like at home? What do parents and relatives do for a living? Ever institutionalized? Recent moves? Running away? New people in home environment? Education and employment School/grade performance–any recent changes? Any dramatic past changes? Favourite subjects–worst subjects? (include grades) Future education/employment plans? Any current or past employment? Activities On own, with peers (what do you do for fun? where? when?) Sports- any regular exercise? History of arrests?	Drugs Use by young person? Use by peers? Use by parents/carers? (include tobacco, alcohol) Amounts, frequency, patterns of use/abuse Car use while intoxicated? Source–how paid for? Sexuality Orientation? Degree and types of sexual experience and acts. Number of partners? History of pregnancy/abortion? Sexually transmitted diseases–knowledge and prevention? Contraception? Comfort with sexual activity, enjoyment/pleasure obtained? History of sexual/physical abuse? Suicide/Depression Sleep disorders? Appetite/eating behaviour changes? Feelings of ‘boredom’? Emotional outbursts and highly impulsive behaviour? History of withdrawal/isolation? History of past suicide attempts, depression, psychological counselling? History of suicide attempts in family or peers? Suicidal ideation (including significant current and past losses)
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I was put in touch with a liaison psychiatrist and, over a number of sessions, I began to trust her. I took a leap of faith and confided that I'd left home at fifteen as a result of physical and emotional abuse from my father. It felt like a weight had been lifted.

The ACT takes into account the fact that AYAs can vary considerably in their physical and emotional development. Some may be very reliant on parents or carers and, as such, flexible visiting times and places for them to stay on the ward are needed. The level of parental involvement, however, should be dictated by the AYAs themselves and sensitively given the opportunity to be seen alone. The lack of peer interaction can be detrimental for all AYAs and therefore Wi-Fi and mobile phone free-zones are a real problem for this group.

Whole systems approach:

Finally the ACT also gives suggestions for models of care whilst recognising that there is no preferred model and each hospital faces different operational and organisational challenges. However, a number of key components have been recognised as contributing significantly to high quality care for AYAs.

Many AYAs are used to an open door strategy in paediatric services, with direct access to assessment units/paediatric wards. As such adult services are encouraged to adopt a 'no wrong door' policy. This requires integrated acute care services (emergency departments, ambulatory care, AMUs, ambulance services) along with communication with GPs and mental health teams.

AYA liaison teams and/or dedicated clinical inpatient areas are suggested as alternatives to being cared for alongside other older adults. While it is not clear which model works best, a co-design patient centred approach where AYAs are integrally involved in the set up and review of acute services is highly recommended.

For young people, their previous experience of healthcare and the environment in which it is received potentially has a profound impact on future healthcare behaviour.

The Department of Health 'You're Welcome' quality criteria¹¹ cover eight key areas to make 'young people friendly health services'. This is currently being updated and it is likely to be used by commissioners as a benchmark to ensure high quality AYA services.

Life is a little better now. Together with my liaison psychiatrist, my social worker, GP and others, I am working through some of my problems. It doesn't happen overnight and some days are much better than others but I haven't been admitted now for over six months. I feel better supported and know where I can get help when things are really bad.

Box 4: Things to think about on your AMU and Ambulatory Unit

1. Does the unit have a lead nurse and doctor for AYAs?
2. Who is the Paediatric lead? Is there a system to handover frequent fliers or complex patients with specific needs?
3. Do you have trust guidelines for AYAs including:
 - Learning disability services
 - Specialist nurses
 - Alcohol and substance misuse services
 - Sexual health services
4. Do you collect data on AYAs? (number seen/diagnoses/complaints/untoward incidents)
5. Do you collect 'Friends and family' data specific for AYAs?
6. Number of HCPs on the unit who have had AYA specific training?
Options include:
 - Group session - RCP slide kit for ACT
 - Individual - E-LfH Adolescent health programme (Box 1)
7. Consider piloting the HEADSS framework to be used for all AYAs seen.

It is our challenge to meet the needs of AYAs – to have a greater understanding of the choices they make, their healthcare experiences, and how we can support self-management of acute and chronic issues. Every admission of an AYA to an AMU is an opportunity to have a positive impact on that young person, by seeing beyond the presenting complaint. By doing this we would give current AYAs in our services a holistic service appropriate to their specific needs.

Principles of high quality AYA care include privacy and confidentiality, clear communication and improved staff training and attitudes. These cornerstones are relevant for every patient in an acute inpatient setting. Delivering this holistic service for AYAs may therefore also improve care for all patients who access acute care.

Improving acute care is on everybody's agenda but the needs of young people often get overlooked. We want the help of members of the RCP and SAM to prioritise the recommendations in the RCP Acute Care Toolkit 13 for Acute Care in Adolescents & Young Adults. Please complete this survey and as a thank you for your time there is a chance of winning an iPad Mini.

<https://www.research.net/r/YAAtoolkit>

Conflict of interest

No disclaimers.

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References

1. L. Albon, L. Vaughan. Adolescents and young adults on the acute medical unit: how might we do it better? *Clinical medicine* 2014. Vol **14**. No **6**
2. Fortuna RJ, Robbins BW, Mani N, Halterman JS. Dependence on emergency care among young adults in the United States. *Internal medicine* 2010; **25**:663-9
3. Hagell A, Coleman J, Brooks F. Key data on adolescence. London Association of young people's health 2013.
4. Sarah Jayne Blakemore. The mysterious workings of the adolescent brain. https://www.ted.com/talks/sarah_jayne_blakemore_the_mysterious_workings_of_the_adolescent_brain
5. Hargreaves DS, Viner RM. Adolescent inpatient activity 1999-2010: analysis of English Hospital Episode Statistics data. *Arch Dis Child* 2013; **0**:1-4
6. Patton GC, Coffey C, Sawyer SM et al. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 2009; **374**:881-92
7. Royal college of Physicians. Acute care toolkit 13: Acute care for adolescents and young adults. London RCP, October 2015. <https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-13-acute-care-adolescents-and-young-adults>
8. Viner RM, Hargreaves DS, Coffey C, Patton GC, Wolfe I. Death in young people aged 0-24 years in the UK compared with the EU 15+ countries: analysis of WHO mortality database. *Lancet* 2014; **384**:880-92
9. E-Learning for Healthcare (eLFH). Adolescent Health Programme (part of the Healthy Child Programme). www.e-lfh.org.uk/programmes/adolescent-health/
10. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Paediatrics* 2004; **21**:64-90
11. Department of Health. You're Welcome quality criteria: making health services for young people friendly. London: DH, 2011. www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf