ST2.2	New Horizons of Nursing Practices	13:15 Theatre 1

Transitional Care of Paediatric Patients

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In the past, children with many diseases would not live to adolescence. Medical advancement today helped more than 85% of children born with chronic medical conditions to live to adulthood. In Hong Kong, we lack a planned transition programme to prepare the youth with chronic illnesses to leave adolescent services by the age of 18 with necessary knowledge and skills to maintain health-promoting behaviours and utilise adult care services properly. As a result, there are over-aged patients not ready for adult care service, overloading the paediatric service. From 2009 to 2010, the outpatient headcounts of diabetes mellitus and systemic lupus erythematosus were 29% and 31% respectively. They were under age 18 being taken care of paediatricians in Hospital Authority (HA). Good transitional care provides adolescents with a coordinated, uninterrupted and developmentally appropriate transfer to adult healthcare. The opposite can cause undesirable medical complications and even death.

To align with HA's strategic plan and the service needs of the upcoming Hong Kong Children's Hospital, a new transition initiative has been developed with reference to overseas experience. The key principles include patient empowerment, engagement with adult service and good compliance to medical treatment. However, challenges still exist.

Last summer, an innovative 'iCan' project was held in collaboration with patient resources centre to promote transitional care in Queen Mary Hospital (QMH). It was a voluntary service scheme and patient engagement programme for the adolescents with chronic illnesses. The project helped the participants to identify their personal strengths and enhance their self-image; equipped them with knowledge and skills for problem-solving and creative thinking; and established a mutual support network and platform to serve others in hospital.

In QMH, the transition programme was piloted for rheumatology adolescents in last December, and the first phase on diabetes mellitus patients aged 15 to 16 onwards was started since February 2014. Transition paediatrician and nurse coordinated the programme and produced specific educational materials. Potential patients were selected and interviewed during clinic visits. By using questionnaires and other transition tools, nurses identified clients' special needs and provided counselling and anticipatory guidance on healthcare and other transitional issues. Self-administration of medication and appointment arrangement are examples of concerns. Regular interviews and reviews will be done during subsequent clinic visits, aiming to help adolescents develop skills in communication, decision-making, self-care and maximise healthcare independence. Start early and plan well in advance will facilitate better process, smooth transfer and continuity of care. Feeling being abandoned could be avoided if adolescents and parents have the opportunity to prepare emotionally for the change. The programme plans to extend target diseases and include younger age group in later phase. Ongoing monitoring and evaluation will be done for future improvement.