Suitability of the paediatric setting for hospitalised adolescents

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As maturation cannot always be related directly to chronological age, the parameters of adolescence are difficult to define. In general terms, the period 10–20 years provides useful boundaries and incorporates the transitions from childhood to adolescence and adolescence to adulthood. Adolescence is a relatively healthy time compared with other age periods, but although morbidity and mortality are low, young people present a wide range of medical and surgical disorders, psychiatric disturbance, sexually related problems, and the consequences of risk taking behaviour. While their health needs are met principally at primary care level, adolescents requiring medical and surgical care in hospital present complex and controversial problems. Worldwide, there is still limited recognition of the special health care needs of this age group, although there are increasing numbers of children with chronic or life threatening diseases surviving into adolescence. In addition, although the demographic trend in western society suggests that the numbers of children and adolescents will fall, there is likely to be growing recognition of the social and economic importance of the health of teenagers.

Very few all adolescent units and associated services have been set up in the UK, with the exception of those within the psychiatric service, established regionally since the late 1960s. Generally, adolescents continue to be nursed with either adults or children, and both settings may provide unsuitable facilities. In this respect, a succession of recommendations, made over the last 30 years, has been largely ignored, despite the considerable number of adolescent admissions. In Glasgow, for example, inpatient admissions aged 12–20 years, in 1988, represented 12% of the estimated adolescent population of the Greater Glasgow Health Board area. Those admitted to the Royal Hospital for Sick Children (RHSC) comprised 8% of the total admissions, increasing slightly to 9% in 1990. Similarly, 9% of admissions to general hospitals in 1990 were adolescents (information from the Management Information Services Unit, Stobhill General Hospital, Greater Glasgow Health Board, 1990).

The general failure to implement recommendations for improving adolescent health care and the increasing numbers of hospitalised adolescents provided the impetus for a descriptive study (1990), in Glasgow, of the psychological, social, and environmental needs of adolescent inpatients at RHSC. The findings, which provide empirical evidence of the continuing need to improve adolescent health care, constitute the framework of this review. Additionally, consideration is given to the underlying reasons for delay in supporting change.

Review of recommendations

Recognition of the need for change in adolescent health care has been expressed for many years, commencing in 1959, with the Platt report. Recommendations included, for example, the desirability of separate accommodation for adolescents, and the suggestion that teenagers should not be able to overhear potentially upsetting adult patient conversations. In 1976, the DSS report recommended that staff caring for adolescents should have enhanced training to help them meet young people's needs, although special care was regarded as unnecessary. Adolescents' educational needs have also been considered, although Warnock pointed out that education is a 'right' and is 'desirable' in hospital, but is not a legal requirement.

In 1985, the British Paediatric Association made detailed recommendations concerning accommodation, education, and transfer to adult services, while also pointing out some of the problems inherent in nursing adolescents with either adults or children. It was suggested that a special ward for teenagers would be beneficial because their developmental needs were of greater importance than their 'system specialty' disorders. Issues such as the need for privacy were addressed, as were facilities for recreation and education, including suggestions that there should be rooms where youngsters could be noisy or quiet. It was argued that transfer to adult services should involve consideration of levels of maturity, the wishes of the youngster and local arrangements, rather than rely simply on age. The unsuitability of paediatric wards was discussed, highlighting the potential feelings of frustration and embarrassment felt by adolescents who were nursed with children. Adult wards were regarded as equally unsuitable for teenagers, whose anticipated 'childish' behaviour was likely to be unacceptable to many adults, and, in particular, being nursed with adults with degenerative diseases was considered inappropriate.

The World Health Organisation has contributed to the recommendations about adolescent care. In 1986, for example, it suggested that adolescents might be uncomfortable with staff used to dealing with children and that, generally, adult wards were insensitive settings for this group. Special training for staff working with adolescents was advocated, because it was felt
that the communication skills and attitudes of this staff group were of crucial importance. Several professional bodies, including the Royal College of Nursing,14 15 supported the concept of separate wards for adolescents, set apart from those for adults or children. More recently, the National Association for the Welfare of Children in Hospital15 (renamed ‘Action for Children’ in 1991) made explicit recommendations for the hospital care of adolescents and these are supported by the Department of Health.16

There appear to be several reasons for the failure to implement many of the recommendations. Firstly, inadequate staff training, concerning the special needs of both healthy and sick adolescents, stands out as an issue of overriding importance and means that teenagers are not acknowledged fully as a distinctive patient group.17-21 Although their medical needs are met, there has been a widespread failure to develop services and expertise for their psychological welfare.22 The fact that only a small number of adolescent wards has been established,23 outside psychiatry, has contributed significantly to the relative unavailability of opportunities for theoretical and practical training.

A second group of reasons concerns change in the pattern of care delivery and all the implications of acknowledging another category of patients. This would involve, in particular, additional funding requirements and generate uncertainty about optimum staff deployment. The establishment of separate accommodation, for example, could result in the reduction of patient numbers in other wards, with the possibility of consequent staff reallocation depending on their interest in adolescent health. Attitudes towards adolescents as a group can often be negative and if a perceived threat, such as the transfer of patients from one ward to another, is added, it would not be surprising if medical and nursing staff lacked motivation for change. Further, the introduction and implementation of new training programmes could incur significant financial and manpower consequences.

Despite the plethora of recommendations, there has been little systematic research providing evidence about the merits of special services for adolescents. It may have to be accepted that many of the more costly recommendations will not be implemented until it is demonstrated that meeting the emotional and social needs of hospitalised adolescents actually enhances their medical outcome, as well as reducing expenditure. However, there is a growing body of medical and nursing staff who are interested in adolescent health, and it is possible that the opportunities for service reappraisal, associated with NHS reform, may create the climate for innovative change.

**Shortcomings and solutions in a paediatric setting**

Although the findings of the RHSC study cannot be generalised, it is likely that some or all of the shortcomings may occur in other paediatric settings. The solutions to the problems have different resource implications and are grouped accordingly. The present review is not concerned with the quality of technical nursing and medical treatment.

**MINOR RESOURCE IMPLICATIONS**

Many deficiencies are likely to be remediable using minimal resources, and should be considered even if funding is insufficient for more far reaching modifications.

**Guidelines for adolescent patients**

Adolescents are often unsure of what they are allowed to do in hospital and may be reminded for what they regard as normal behaviour.6 In this context, printed guidelines or ‘house rules’, setting out the limits for acceptable behaviour, would be beneficial.

**In-service training**

In general, paediatric staff are not kept up to date specifically with progress in adolescent health care. In-service training provides a valuable medium for this purpose and could take the form, for example, of a regular multidisciplinary forum.

**Communication**

Some paediatric staff and adolescents experience difficulty talking openly and comfortably to each other; for example, teenagers often resent being spoken to as if they are either adults or children.4 Such difficulties may perpetuate unresolved adolescent worries about being unwell or suffering pain.6 It is essential, therefore, that staff dealing with adolescents be trained to communicate effectively with them.24 Adolescents have a right to be considered and responded to according to their maturation stage, thereby fostering the mutual trust that forms the basis of a therapeutic relationship.25

**Recognition of social and recreational needs**

Boredom can be a major problem for hospitalised adolescents, particularly those with chronic conditions,5 and activities in children’s wards are likely to be considered inappropriate. Peer company is essential, but is often lacking, especially in children’s hospitals, because adolescents tend to be scattered in small numbers throughout the specialist wards.6 A centrally arranged youth group can provide a valuable opportunity for teenagers to meet, providing the nursing staff are well informed about its existence and function.6

**Independence**

Adolescents may be restricted unnecessarily by hospital policies geared appropriately for children. Public telephones, for example, may be inaccessible because they are outside the wards, which patients are not allowed to leave unaccompanied.9 This limitation may increase the sense of isolation often experienced in
hospital, yet could be easily remedied, for example, by the installation of mobile telephones.

Privacy
Every patient has the right to privacy, but this may tend to be neglected when adolescents are nursed with children. In the absence of an adolescent ward with appropriate structural provision for privacy, teenagers should be accommodated in individual cubicles. Although one of the main functions of a cubicle is to accommodate resident parents, under some circumstances, adolescents' needs may be paramount. Even when this is not possible, privacy during washing and bathing, or during medical examination, should be maintained scrupulously by the use of adequate screening.

Consent
Staff used to dealing with children or with adults may lack awareness of adolescents' precise legal rights when considering consent to treatment. Adolescents have the right to consent, if considered mature enough to understand the implications of intervention, but in practice, it is usually the parents who are asked to agree to treatment and adolescents are rarely involved in the process.

MODERATE RESOURCE IMPLICATIONS

Hospital policies
Policies set for children, concerned for example with restrictions on television viewing, may be quite inappropriate for adolescents and need radical reappraisal and appropriate modification. However, some decisions can be controversial; for example, although ward kitchens are appropriately out of bounds to children, there may be mixed feelings among paediatric staff about unsupervised adolescent access to these areas, until appropriate safety provisions have been introduced.

Medicine administration
Many hospitalised youngsters have chronic conditions requiring regular medication, for which they may have assumed considerable responsibility at home, although this is denied them in hospital. Such inconsistency in expectations of responsibility and independence can be confusing at this impressionable stage, so modification in the current regulations covering medicine administration should be considered, encouraging self care by giving selected teenagers some responsibility for self medication in hospital. Nevertheless, despite possible psychological and economic advantages, this would require difficult decisions concerning policy change at both hospital and health board levels.

Noisy and quiet facilities
Limited recreational accommodation in most paediatric wards can result in adolescents being told to make less noise or having no opportunity to be alone. Whether in a separate ward or with children, adolescents need space for their own activities, and every effort should be made to create such facilities.

Education
The importance of continuing education and the lack of appropriate educational facilities are not always recognised by paediatric staff, although both issues are likely to cause concern for teenagers and parents. Education is vital for hospitalised adolescents and although difficulties exist, for example teaching small numbers in separate wards, these could be overcome by grouping all adolescents together whenever possible.

MAJOR RESOURCE IMPLICATIONS

Major changes will have serious implications in terms of funding, manpower, staff deployment, and structural change.

Professional training
Health care professionals of all disciplines are likely to have limited awareness of the psychological and social needs of hospitalised adolescents. Consequently, they are unable to recognise and meet their requirements. Basic training should incorporate a thorough understanding of the maturational needs and problems of healthy and sick adolescents.

Adolescent wards
The accumulated evidence suggests that adolescents dispersed in adult and paediatric wards may be disadvantaged. A strong case can be made, therefore, for them to be accommodated in purpose designed wards, away from younger children or adults, with day to day care provided by nurses with specialised adolescent training. Locally devised policies would determine whether all or selected adolescents could be admitted to such wards. Many benefits could be derived from such a development. Staff training could be implemented and enhanced, ensuring a nucleus of staff with the specialised knowledge required to care for adolescents. Independence and self care could be promoted and maintained; there would always be peer company and education would be facilitated. However, potential difficulties include the implications of combining patients requiring specialised nursing skills and the concentration of mentally disordered, non-compliant, or seriously ill patients. An overriding adverse perception may be that adolescents are more difficult to control as a group than they are in smaller numbers.

Transfer to adult services
The inevitable transfer of adolescents from paediatric to adult services is a complex and potentially stressful issue, raising important questions about its optimal timing and management. Preliminary discussions with adolescents
and their parents could help to bridge the professional gap between paediatric and general medical services. This should be initiated more than one year before transfer is due in order to assist the younger and family in coming to terms with the enforced break with familiar staff and environment and to influence any preconceived doubts about adult wards.

Joint clinics between paediatricians and medical staff from general hospitals need to be established in most specialties, gradually introducing new personnel and explaining the necessity for change. However, the geographical locations of some hospitals and existing commitments of senior medical staff involved are likely to necessitate considerable reorganisation.

Conclusion

There are undoubted deficiencies in the provision of the optimum hospital setting for adolescents. Although it is customary to highlight the adverse effects of care in adult wards, research referred to in this review indicates that the paediatric setting is also not immune from criticism. Difficulties can be identified readily and many defects that impair the experience of adolescent hospitalisation are rectifiable without major funding.

At a time when holistic patient care is at the centre of NHS reforms, the psychological and social aspects of the medical and nursing care of adolescents in children's wards and hospitals can no longer be neglected. There is no justification for managers, educationalists, and practitioners of all disciplines, working in paediatric settings, to overlook the shortcomings of staff training or the adverse effects of environmental deficiencies and outmoded operational policies on the quality of adolescent health care. While it could be argued that a comfortable, age appropriate environment with peer company will not necessarily have a direct influence on medical outcome, there is little research evidence on this issue. Nevertheless, there are some indicators of benefits—for example, facilitating pain relief by reducing anxiety caused by noise or lack of privacy. This illustrates the way environment and appropriate accommodation may have direct impact on actual medical outcome, with the added benefit of reduced costs, resulting from shortened stay.

While full acceptance of the necessity for major change may await evidence of the benefits in economic terms, fundamental decisions have to be made about the proper locus of responsibility for the care of hospitalised adolescents.

The current climate of change in the NHS provides opportunities that should not be missed for innovative developments. There is sufficient evidence already for health care purchasers to lay down a blueprint for adolescent services and the providers should 'grasp the nettle'.
