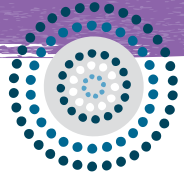
AGENCY FOR CLINICAL INNOVATION

NSW GOVERNMENT

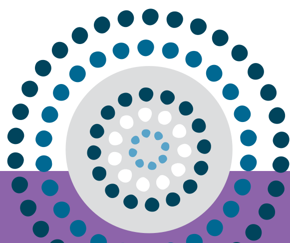
Transition: practical tips for health professionals

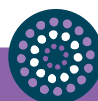


Keeping young people at the centre of your clinical care can foster independence and promote self-management.

1. You have a key role in supporting your patient to gain health independence and confidence. Ask them for their opinion in front of their parents/carers and value their responses.
2. Respect their privacy. Talk about confidentiality to enhance trust. Young people may provide informed consent from as young as 14 years old. www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx
3. Give them time. See young people by themselves when they are ready, which is usually around 14 years old. Allocate 5-10 minutes of the consultation and increase with subsequent appointments.
4. Check their psychosocial strengths and vulnerabilities and the impact in can have on their health. Complete a HEEADSSS interview or assessment.
5. Encourage good self-management – talk through how to recognise when they are unwell and what to do about it, including how to manage stress, low mood and anxiety.
6. Discuss how the balance of independence versus family and carer support changes with time and circumstances.
7. Normalise young people's exploration of limits and risk taking, altered sleep patterns and changeable moods. This is an expected developmental stage and will change. Talk about safety measures, healthy sleep and eating habits and regular exercise.
8. Give praise and constructive feedback; enhance the positives while recognising challenging conditions.
9. Talk about puberty and its impact on their chronic condition.
10. Learn how your patient's condition and medications will interact with alcohol, recreational drugs or risk taking behaviour.

GET THE FACTS





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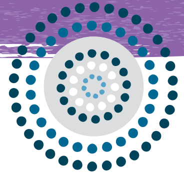
Checklist for clinicians



Use this checklist to help prepare young people with chronic conditions for transition

- [ ] Start early - identify young people aged 14 years and older
- [ ] Complete the transition readiness checklist regularly with young person and/or with the parents and carers. This will help inform the transition plan
- [ ] Meet with the young person and their parents and carers to plan their future healthcare and discuss any worries about leaving paediatric health services and/or starting adult health services
- [ ] Become informed about transition and what services and resources are available
- [ ] Ensure the young person has a trusted GP and include the GP in the transition planning
- [ ] Start to address the young person first in consultations and encourage them to ask questions
- [ ] See the young person on their own for part of the consultation, if appropriate
- [ ] Take every opportunity to educate the young person to learn about their chronic condition and aspects of their care so that they can manage independently, to the best of their ability
- [ ] Complete a HEEADSSS assessment to identify any psychosocial issues which may impact on compliance and adherence
- [ ] Develop a transition plan with the young person
- [ ] Provide the young person with emergency contact numbers and a care plan
- [ ] Once the young person turns 14 (dependent upon their capacity to comprehend), copy them and their GP into all clinical correspondence
- [ ] Discuss what the young person can expect in adult health services, including how to make appointments, how to get there, having their own Medicare card, etc.
- [ ] Identify with the young person where they will be referred to in the adult health service. Ask about preferences to see services within their local area, if possible, and how it aligns with other specialists they are seeing
- [ ] Encourage the young person to keep copies of their clinic letters and health record
- [ ] Refer the young person to Trapeze or ACI Transition Care Coordinators. They can assist you with completing transition plans and coordinate care. Contact the service if you have transition concerns or need further information
- [ ] Provide young people with a copy of the young person checklist

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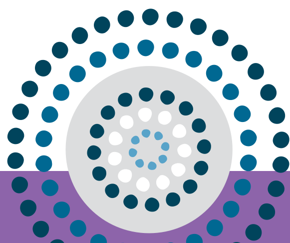

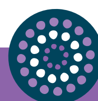

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