



# Transition to adult care

Greetings of the paediatric working group

May 2013

Kirsi Lindfors and  
Ki Lindqvist

# Kick off

- The task was given by the chief of the Paediatric clinic and the nursing director
  - Developing the transition process was a priority in 2012
  - The assignment was rhetorical
  - The goal was the best possible transition from paediatric care into adult care ⇒ an adherent, young long term patient
- Kick off –was in march 2012
  - Round table discussions as a base point for the working group ( diabetes, transplantations, intestinal disease, rheumatology, cardiology, oncology)
  - All groups had some various routines. The goal was set to form a multi-professional working group, a uniform check-list, structure of operation, web-pages, research-based thesis and patient passport.

# Working group

- Chairperson Ki Lindqvist and secretary Kirsi Lindfors
- Multi-professional representation from different disease groups, doctors and nurses in charge from the paediatric teams well as from the adult teams.
  - Including Åbo Akademi (2) and Tampere Univ. (1) master's degree students and dr. Silja Kosola From the City of Helsinki (defending her theses about long term ill teenagers' commitment to care in the spring2013)
- Working group members active actors
- Meetings about 2 / 6 months

# Achievements

- Results after the first year
  - Structure of operation
  - Common checklist / original checklist from Evelina Children's hospital, London
  - Shared CAMP-day 24.5.2013
    - Attending; transplanted -, rheumatic-, intestinal-, heart- and oncologic patients
    - Almost all patient organisations attended
  - "You are moving towards the adult unit" – leaflet to all diagnoses groups
  - A project plan presentation for 2013 to go on with this work (project was not approved)

# Transition model

## DIAGNOSISRELATED KNOWLEDGE

Nurse /doctor checks at each visit what the patient's level of knowledge is.

As help in self evaluation a degree from 0 to 100 can be used



A YOUNG PERSON'S TRANSITION TO ADULT CARE – an individual plan  
See another chart

## PAST

History of illness; getting ill and treatment

- Type of illness; inherited? , progressive? benign- /malignant
- surgery, medical phases (cytostatics aso.)

## PRESENCE

The adolescent has to know

- The own medication; it's side effects, expected effects, social security
- Diets and other restrictions
- Place for care, commitment, contacts, nurse and doctor in charge

## FUTURE

- Profession
- Family
- Healthy future; leisure, hobbies, way of life

Common to all

# Going on

- Pro Gradu from the student at Åbo Akademi
  - An interview where the young person's voice is meant to be heard
- Project with Tampere Univ. Department of Nursing Science
  - Survey of web pages in Finland and abroad
    - ⇒ Will be a base for future shared webpage
- Patient passport
- "Transition nurse" ?



Thanks for your interest!