ANALYSIS OF COMMON PROBLEMS REVEALED BY ADOLESCENTS DURING SCHOOL BASED LIFE SKILLS PROGRAMMES IN THREE SCHOOLS IN THE WESTERN PROVINCE, SRI LANKA

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Objectives World Health Organisation defines adolescence as the age group between 10–19 years. Globally, adolescent population is estimated to be 1.2 billion and in Sri Lanka adolescent population is approximately 3.8 million (1,2).

Adolescence is a period where the individual go through physical, mental and psycho-social changes (3,4). Common problems worldwide are substance abuse, accidents, violence and unintentional trauma, teenage pregnancies, sexually transmitted diseases, sexual relationships, psycho-social problems, and lack of life skills, nutrition related problems and non-communicable diseases (5).

Our main objective was to identify the common problems amongst adolescents in the Western Province of Sri Lanka.

Methods A descriptive cross sectional study was conducted in three mixed schools in Western Province from January to March 2017. We have analysed data gathered from voluntary participants following a life skills programme conducted for adolescents in the 10 - 16 year age group. Data was collected anonymously via blank papers distributed among students to write down any problems/questions or concerns they had. Upon analysis the team felt the importance of presenting this data in a scientific forum. Ethical approval was gained retrospectively from the Ethics Review Committee of Faculty of Medicine, University of Kelaniya, Sri Lanka. The frequencies were analysed manually.

Results A total of 309 responses were analysed. A sum of 106 (34%) of students raised concerns regarding the drug and alcohol abuse. 50 (16.1%) of students had problems regarding romantic relationships. Concerns regarding studying were raised by 40 (12.9%) students. 19 (6.1%) of the responses were regarding sexual abuse, internet and differentiation between good from bad romatic relationships. Concerns regarding studying were raised by 40 (12.9%) students. 19 (6.1%) of the responses were regarding sexual abuse, internet and differentiation between good from bad sexual relationships. Concerns regarding studying were raised by 40 (12.9%) students. 19 (6.1%) of the responses were regarding sexual abuse, internet and differentiation between good from bad

RAISING OUR HEEADSSS— A REVIEW OF THE USE AND DOCUMENTATION OF AN ADOLESCENT PSYCHOSOCIAL RISK ASSESSMENT INSTRUMENT IN AN IRISH UNIVERSITY TEACHING HOSPITAL

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Objectives Adolescence carries the highest rate of childhood morbidity and mortality outside the neonatal period. The HEEADSSS ( Home, Eating behaviours, Education/Employment, Activities, Drugs/alcohol, Sexuality, Suicide/Self harm and Safety) assessment is a widely accepted psychosocial screening tool. The World Health Organisation (WHO) recommends its’ use in all clinical adolescent encounters. Poor compliance with this recommendation results in missed prevention counselling opportunities and risk assessments. To date, there is no Irish data on the use of this screening tool. The aim of this review was to establish the compliance with HEEADSSS in an Irish context and establish the efficacy of a proforma.

Methods This three phase study took place over 8 weeks. Charts of all adolescent medical presentations to the emergency department (ED) over a month were reviewed as part of the initial phase. A standardised data collection form was used to ensure elements pertaining to the use of the HEEADSSS assessment were captured. The data was retrospectively analysed using descriptive statistics. The intervention phase was multi-dimensional. First, a survey was circulated for anonymous completion by the relevant healthcare staff (n=30) enabling precise identification of knowledge deficiencies. Following analysis and local presentation of the results, a comprehensive education session was facilitated. The final arm of the intervention phase involved the inclusion of a blank HEEADSSS proforma in clinical notes of all adolescent patients presenting to the ED, attached at time of nursing triage. One month after the adoption of this quality improvement initiative, a review was conducted on a random chart sample to assess adherence.

Results 103 patient records were reviewed as part of the control phase. Of these, 6.7% (n=7) had a complete HEEADSSS assessment documented, with 57.1%, (n=4) using the recommended format and all with parental accompaniment. An incomplete assessment was documented in 27% (n=28), most commonly addressing home and school life only. Abdominal pain was the most common presenting complaint (n=31), followed by chest pain and palpitations (n=20). Deliberate self-harm represented 14% (n=15) of presentations and only 4 of such cases had either a partial or complete HEEADSSS assessment completed. There were five repeat attendances with chronic non-specific symptoms. There was a 63% (n=19 ) response rate to the anonymous survey. While most were familiar with HEEADSSS ( n=14 ), 84% (n=16) denied receiving any training on how to use HEEADSSS and cited this as their main obstacle to using it. In the third, post intervention phase 50 charts were reviewed. A proforma was attached to all charts and filled out appropriately in 64% (n=32) of cases; an improvement of 57.3% following provision of a dedicated education and training forum. The assessment was most likely to be completed in the absence of parental accompaniment.

Conclusions The increase in the number of completed HEEADSSS assessments in the intervention phase suggests that the inclusion of a blank proforma in ED clinical notes results in a more comprehensive medical review of adolescent patients. Consequently, there is more opportunity for crucial intervention. Staff education and specific HEEADSSS focused training is beneficial.