

Exploring the experiences of young people nursed on adult wards

Linda Dean and Sharon Black

Abstract

This paper reports on a study of experiences of young people aged 14 to 18 years who were nursed on acute adult hospital wards in NHS hospitals in England. In spite of British government guidelines, young people from 14 years of age continue to be admitted to adult wards in the UK. Although much has been written about the transition of the young person to adult services there is little research about the experiences of young people who are nursed on adult wards. Hermeneutic phenomenology was used to explore the lived experiences of eight young people who had been nursed on adult wards between 2004 and 2010. Data were collected in 2010. In-depth interviews were recorded, transcribed and analysed using Colaizzi's framework (Colaizzi, 1978). Themes explored included expectations of what the experience may be like, young people's first impressions of the ward environment, the feelings of the young person while in hospital, the attitudes of people towards them including—both staff and other patients, and finally, future admissions and how they would cope with readmissions. Better provision needs to be made for young people including appropriately trained staff, adolescent friendly environments and areas in adult wards that are dedicated to adolescents.

Key words: Young people ■ Adult wards ■ Phenomenology

Every year, around 1 in 11 children receives specialist outpatient care in hospital, and around 1 in 10–15 is admitted for inpatient care (Department of Health (DH), 2007). The DH (2011) published guidelines stating that, if admitted to hospital, young people should be nursed in age appropriate environments and should be supported by registered children's nurses. This reflects earlier European guidance (European Association for Children in Hospital, 2002) which stated that children under the age of 18 years should not be admitted to adult wards. Literature reporting on the experiences of young people indicates that inappropriate environments and negative attitudes of staff have an adverse effect on their experience (Steinbeck and Brodie, 2006; Viner, 2007).

Linda Dean, Senior Lecturer in Children's Nursing, University of Bedfordshire; Sharon Black, Programme Lead for Nursing and Care Specialties, Oxford Brookes University [AQ1: Please check that your job titles are accurate and up-to-date]

Accepted for publication: January 2015

Background

There is a paucity of literature on this subject and the main focus is on young people with complex needs (Fleming et al, 2002; Dovey-Pearce, 2005) or those with mental health problems (Allen 2009). [AQ2: This ref missing from list. Please supply] The study aimed to explore the experiences of young people who had been nursed on adult wards. For the purpose of this study a young person was defined as someone up to and including the age of 19 years-old (Royal College of Nursing (RCN), 2003). The Department of Health (DH, 2006) noted that staff who work in paediatric environments are not confident that their colleagues in adult services possess the skills required to give appropriate care to young people. This reflects the patient experience, with Ostlie et al (2007) identifying that many 18-year-old patients found the abrupt change from child to adult wards difficult, due to being nursed with predominantly older people and staff not always treating them appropriately. The most important factor for young people in hospital is for nurses to have a child nursing qualification which should include caring for adolescents (Shaw et al, 2006). There is no nationally agreed process for the training and education of primary care professionals in adolescent health (Coleman and Schofield, 2006).

The quality criteria (DH, 2011) indicate the importance that is placed on adolescent care, specifically the environment that adolescents are nursed in, and the importance of staff being trained in the care of adolescents, but to date there have been no further developments in establishing such education for health professionals. The competencies for preregistration nursing education in the UK (Nursing and Midwifery Council (NMC), 2010) require students on adult nursing pathways to be able to give care to children and young adults. This indicates that there is some recognition that the needs of young people are specialised. For example, young people cannot always express their wishes as eloquently as adults and may be misunderstood, resulting in frustration for staff and the patient. Young people might display emotions such as fear, anger, denial, or physical symptoms such as pain or exhaustion, as violent outbursts, rudeness or non-communication (RCN, 2008).

Steinbeck and Brodie (2006) in Sydney, Australia undertook a study to explore the experiences and feelings around the issues of transitioning from child to adult services. Part of this study focused on the feelings of young people who had been nursed on an adult ward and asked them how the experience compared to their previous experience of a paediatric ward. This study was run as a forum for a day and 27 young people attended who were aged between 16 and 28 years. It was

facilitated by an external consultant.

The respondents identified issues including: the shock of being with older patients, lack of prior orientation to adult services, the lack of family-centred care which they had become accustomed to in the paediatric setting, and the impact of having to repeat their medical history which was required by the new care team. Although these young people were aged between the ages of 16 and 28, it was interesting to note that even the young people in their twenties identified similar issues to being nursed on adult wards to those of the younger age group. They felt that the adult environment was dull and boring for young people. They felt that staff were less caring on adult wards due to being so busy. They also identified that there were too many rules such as tighter appointment times, and more restricted visiting within the wards. The rapid developmental changes and strong independence needs of the adolescent make hospitalisation a particularly emotive experience. There is a need for young people to hold on to the normal aspects of their life while in hospital, but they often have a perception that nursing staff are busy and disinterested (Hutton, 2004). Isolation from their peers and boredom are both aspects that adolescents find difficult to deal with. This may be misinterpreted by nursing staff as difficult and unacceptable behaviour when in fact the adolescent is displaying the normal behaviour of his or her age group. If staff were used to dealing with adolescents they would not consider it to be a problem, but see it as acceptable behaviour. Steinbeck and Brodie (2006) asked their sample how they felt their admissions to hospital could be improved. The response was 'a change in the nurses' attitudes and approach and to speak in plain English'. If hospitalised they wanted to be in a ward with other young people or 'at least to be grouped with young people like me'.

Although, this article was of Australian origin it was interesting to note that many comments and suggestions made by the participants echoed those that have been made by participants who have been involved in studies within the UK. Suggestions which included youth-friendly environments, better food, flexible rules, privacy, longer visiting hours and allowing their friends onto the wards would appear to be common to all young people regardless of where they live.

There has been little research that focuses on young people's experiences of hospitalisation. Studies undertaken appear to take a multi-faceted approach and explore feelings of adolescents regarding attendance at clinics, attitudes of staff towards them and the age they would like to start attending adult clinics.

A study by Viner (2007) compared the experiences of young people between the ages of 12 and 17 years who had been admitted to hospital on children's wards, adolescent units and adult wards. Compared with being in an adolescent ward, 15 to 17-year-olds were less likely to report excellent overall care in an adult ward and less likely to report feeling secure, having confidentiality maintained, feeling treated with respect, confidence in staff, appropriate information transmission, appropriate involvement in own care, and appropriate leisure facilities. This was a large study with 8855 participants and the author concluded that the data supported

Box 1. Interview questions

- When you were told you were going to an adult ward what did you expect?
- When you arrived on the ward what was it like?
- What were the attitudes of the staff towards you?
- What were your impressions of the other patients?
- How could the experience have been improved upon?
- Is there anything else you would like to tell me?

Box 2. Colaizzi's seven-stage process of analysis

- Reading the transcribed interviews to obtain a feel for them
- Returning to each transcript and extracting significant statements
- Formulating the meaning of each statement
- Organizing the formulated meanings into clusters of themes
- Integrating the results into a description of the phenomenon being studied
- Formulating an exhaustive description of the phenomenon
- Asking participants to read the findings as a final validating step

the continued development of adolescent wards in larger district general hospitals.

Soanes and Timmons (2004) used a purposive sampling technique to gain the views of chronically ill children who were undergoing or about to undergo transition to adult services. This study focused on the general experiences of young people undergoing transition, but did include their views on hospitalisation.

In their study, seven young people agreed to participate. A dominant theme within this research was the adolescents need to feel comfortable, in terms of familiarity with staff, the environment and other health professionals. Responses appeared to demonstrate that young people wanted to be nursed in an informal atmosphere and once they were transferred to adult wards it was a more serious environment. The general consensus was that it would be difficult for young people to share common interests and enjoy themselves with such a broad age-range of patients within adult services, and a more serious environment would impede this further. However, two of the young people that they interviewed felt that a paediatric ward was also inappropriate as all of the toys were inappropriate for their age group and the nurses treated them as children, even when they were adolescents.

This study identified that many older children would aspire to be nursed on an adult ward if they were being admitted to hospital. They said that children's nurses could be patronising and that being surrounded by toys all day was inappropriate. However, once they had undergone an admission to an adult ward young people felt that this was not the answer to the care that they required. It is recognised within the study that wherever young people are nursed there is a need to adjust the environment to make it appropriate to their age group.

There were some limitations to this study, which were recognised by the researchers. The principal researcher was inexperienced, although this may have been an advantage in that she was close in age to some of the participants which may have made them more comfortable to speak openly with her. They recognised that this was a very small scale study and having taken all participants from a youth club service may mean that they are not representative of the wider populations. Taking these limitations into account it is

Table 1. A summary of participant characteristics (pseudonyms have been used to ensure confidentiality)

Identifier	Gender	Age in years when admitted	Year of admission	Length of admission in days	Previous experience of children's ward
Harriet	Female	16	2006	5	Yes
Peter	Male	13	2005	3	No
Mel	Female	18	2007	20	No
Sara	Female	17	2005	21	Yes
Kevin	Male	16	2008	2	Yes
Jo	Female	15	2006	9	No
Evette	Female	14	2005	6	Yes
John	Male	17	2009	0 (1 night)	No

recognised that further research in this area is needed.

Research carried out by Dovey-Pearce et al (2005) using interviews and focus groups examined various aspects of managing type one diabetes in children. Although this study focused on young people with diabetes, it was evident from the study that these young people had much in common with other young people who had undergone hospital admissions due to complex needs.

One 22-year-old respondent reported of his time in hospital following diagnosis:

'I ended up staying in hospital for a week and that was the worst week ever. I hated it... I was the youngest one there by about 60 years' (Dovey-Pearce et al, 2005: 413)

It may be that this comment was not emphasised sufficiently in the article as to how devastating this admission was on this young man. It was clear that he had found the whole admission a very negative and traumatic experience. Although he was 22 years old at the time of interview, the authors did not state his age at the time of admission. However, all participants were at least 16 years of age when they were admitted. Further findings from this study indicated that the experience of being in hospital following diagnosis was negative, for all of the participants. This was due to the volume of information needing to be absorbed, the number of staff seen, a lack of age-appropriate facilities and not always having the complexity of emotions that they were feeling acknowledged by staff.

There has been much discussion regarding the transition of the child to adult services (Dovey-Pearce et al, 2005), but there has been very little written on the unique health needs of older children being nursed in paediatric settings and young adults being nursed on adult wards. Children are now surviving into adult life with conditions that would previously have been fatal in childhood (DH, 2006). Conditions such as cystic fibrosis were very rarely seen in adult environments until recent years. With developments in health care these young people are surviving longer and therefore will require admissions to adult wards. Many adult specialists are unfamiliar with some childhood conditions and feel inadequate when treating young people with these conditions (Viner and Keane, 1998). [AQ3: This ref missing from list. Please supply]

An article by Baines (2009) aimed to raise awareness

regarding the process of transition for children with complex disorders. This article examined the problems associated with transition for those adolescents who specifically suffer from both type 1 diabetes and cystic fibrosis. She chose to focus on these conditions as they are two of the main long-term health conditions requiring patients to receive care from childhood and into adulthood.

Much of this article focuses on the actual process of transition with only a very small part looking at the actual admission of the young person to hospital. Baines (2009) states that in agreement with national policies, it is beneficial for adolescents to have their own units. These units should consist of a comfortable environment which is adapted to their needs. This is echoed by McDonagh and Viner (2006) who stated that placing young people in areas not specialised in meeting their needs may have negative implications for both their health and their wellbeing.

Young people with chronic conditions such as cystic fibrosis and type 1 diabetes may have undergone many previous admissions to paediatric areas prior to their transition to the adult services. In these cases it can be a huge cultural change for them when they are first admitted to an adult area. They have many specific needs and staff in adult areas may not have the time to fully address the needs associated with these patients who may require frequent admissions (Beresford and Sloper, 2000; Ishibashi, 2001; Hinton et al, 2002).

This paper presents the findings of this research study and implications for practice. Although this research was conducted in the UK there is evidence to show that these experiences of young people are shared globally (Steinbeck and Brodie, 2006; Ostlie et al, 2007).

Methods

A phenomenological study was deemed appropriate to answer the question: what are the experiences of young people nursed on adult wards? Phenomenology is used to understand shared meanings and embraces the study of the human lived experience (Walker 2011). There is no intent to generalise, theorise or predict outcomes (McConnell-Henry et al, 2011). Phenomenology becomes hermeneutical when its method is taken to be interpretive (rather than purely descriptive as in transcendental phenomenology). This orientation is evident in the work of Heidegger who argues that all description is always already interpretation (Van Manen 2011).

Heidegger (1962) proposed that people come to know

through their direct everyday involvement with tools, customs and other people, and that understanding comes from our participation in the events that make the world meaningful. What we encounter in our past stays with us as memories or as nearly forgotten experiences (Parsons 2010). Heidegger focuses on the experience of understanding and avoids the notion of 'bracketing' which is a feature of Husserlian phenomenology. Lowes and Prowse (2001) [AQ4: This ref missing from list. Please supply] acknowledge that it is neither possible nor desirable to exclude researcher preconceptions to achieve researcher objectivity in the pursuit of rigour. There may well be preconceptions and ideas regarding this research and Husserl [AQ5: Ref needed here. Please supply] believed that these should be bracketed or put to one side so that they do not influence the description of the respondent's experience. An inexperienced researcher may find this difficult to achieve as acknowledged by Hamill and Sinclair (2010). Koch (1995) believed that description cannot be separated from interpretation and considered that preconceptions are essential to understand how people experience phenomena differently. A reflective diary was maintained to write down observations. This allowed the researcher to keep a record of relevant information which might not have been obvious from a recording, such as emotional aspects.

Participants

A snowball sampling method was used to recruit participants (Clamp et al, 2004). Colleagues within the university setting were asked whether they could identify young people who had been admitted to an adult ward and would be prepared to participate in the study. Participants were then able to identify friends who had also been admitted to adult wards. The personal aspects that are inherent in these techniques often shorten the time required to assemble a participant group of sufficient size and diversity to be representative of the specific target group. The technique is often more efficient and sometimes less expensive than using traditional recruitment strategies to gather participants in proportion to the focus community (Sadler et al, 2010).

Eight participants were recruited (Table 1). They were all aged between 13 and 18 years at the time of admission. All were emergency admissions, although the author did not deliberately choose participants for this reason. It could be that planned admissions are more likely to be admitted to an appropriate environment as the admission could be rescheduled if no suitable bed was available.

This sample size is appropriate for phenomenological research as it allows for greater depth of investigation with a large amount of information being obtained in each interview. (Sandelowski, 1995). Principles of data saturation were adopted (Sandelowski, 1995; Morse, 2000), which is characterised by later participants repeating previous data with no new material being identified. On interviewing the candidates it was noted that responses were beginning to repeat what interviewees had said earlier and there was no new information being divulged.

Data collection

Face-to-face semi-structured interviews were carried out

to ensure a high response rate and allow the interviewer to seek clarification (Burns and Grove 2001). The interviews were carried out by a single researcher, recorded, and then transcribed verbatim to facilitate analysis. Participants were offered a choice of where the interviews would take place, to ensure that they felt comfortable. All participants opted to be interviewed in their home environment. Table 2 summarises the interview questions.

Ethical considerations

This study followed the RCN research guidelines (2009). The study was approved by the University ethics committee; NHS ethics approval was not required as these individuals were no longer patients and were now adults. Informed written consent was gained from all participants. Data were anonymised and kept securely. Participants were offered counselling should they have felt any distress following the interviews.

Participants were fully informed of the reason for the study and the process that would be followed to gain the information from them. The welfare of the research subjects is paramount and the participants must be made aware of what taking part in the study entails and the relevance of the study (Foddy 1993). The key points about the study were outlined in a participant information sheet, which was given to all potential respondents to allow them to make an informed choice as to whether they wanted to participate in the study. It was made clear to participants that even though they had agreed to participate in the study, they were free to change their mind and withdraw at any time should they wish to do so (RCN 2009).

The participant has the right to decide whether or not to give consent to take part in the study (RCN 2009). Each participant signed a consent form prior to participating in the study, once they had ample opportunity to read the participant information sheet. Participants were made aware that confidentiality would be respected at all times and they would not be identified by name in the study.

The researcher was responsible for ensuring that the benefits of participating in the study outweighed the risks to the respondents (RCN Research Society, 2003). There were no foreseeable major risks attached to this study, although there was a concern that unpleasant memories may have been revisited during the interview. For this reason, the participants were asked if they had any reason to think they may require counselling post interview. The university counselling service were consulted and offered to be available for counselling of participants should there be any trauma suffered. However, in reality all of the participants stated that they had enjoyed talking with the researcher and had not suffered any trauma from reliving their admission to an adult ward.

Data analysis

Colaizzi's (1978) seven-stage process of analysis was used as a framework for the analysis (Box 2). This framework has been used widely in phenomenological studies.

In addition to Colaizzi's seven-stage process of analysis, the Attride-Stirling (2001) analytical tool was used to assist in analysing the textual material that was produced during the

interviews. This tool allowed basic themes to be identified from the text. These themes were then grouped together into organising themes which in turn were grouped as global themes. This method of analysis allowed a systematic approach to analysing the data, which allowed the researcher to ensure that important that important data was not omitted from the findings.

Findings

Global themes that were identified during the data analysis included expectations of what the experience may be like, the young people's first impressions of the ward and the environment, the feelings of the young person while in hospital, the attitudes of people towards them including both staff and other patients, and finally, future admissions.

Expectations, first impressions and environment

Participants were vague about their expectations other than the age range of patients, although there were perceptions prior to their admission that the ward would be 'quiet and peaceful' (Peter) and it would be the sort of place where you could 'joke around and talk to other patients' (Mel).

It was clear that the young people had vivid memories of their first impressions of the ward. These impressions encapsulated the environment, the other patients, sounds and the staff who were present when they arrived on the ward.

'It was like some sort of nightmare where I was put somewhere that I really felt that I didn't want to be—it was such a strange environment' (Kevin)

On arrival on the ward participants reported feeling 'uncomfortable' (Mel) and 'scared' (Harriet). Within minutes of arriving, they recognised they would be with patients very different to them:

'I was really shocked—there was just no one there like me—they were all either old or crazy' (John)

Mel and Harriet felt this would be helped by being welcomed to the ward with a friendly face so that they would be put at ease; the nurses appeared to have little time to welcome them to the ward. Participants found this difficult as it was such an alien environment for them.

When asked how they felt about the environment, participants found it unsettling. Noises such as people coughing, nurses whispering, constant beeps and alarms, patients crying and also unknown sounds which were particularly frightening:

'It was so noisy—I was near the nurses' desk and they talked all night. The other patients just kept moaning and crying and calling out but no one seemed to go to them... it was very scary' (Sara)

Two of the young people reported seeing members of the opposite sex during their stay. Sara found being nursed on mixed-sex wards 'extremely uncomfortable'. Jo reported 'elderly men' from other bays wandering in as they wished which was 'not nice' and 'disturbing'.

Participants stated that they were very different from the other patients whom they were placed with. Other patients

were described as 'old' (Kevin) 'confused' (Harriet) and 'irate' (Evette). Five participants wanted to be able to have a conversation, especially once they were feeling better but this did not appear to be possible.

'A lot of the patients were confused. They'd be undressing... One old lady came and fiddled with my insulin drip coz she thought it was a phone. She came and started pressing the buttons, which obviously had I been asleep, I wouldn't have known and that would have been quite unsafe' (Harriet)

As well as visiting times being restricted, participants said that it was an unpleasant environment for their friends to visit due to the sights that they might be faced with.

'My friends didn't like coming coz they felt embarrassed... They felt uncomfortable as the old people would ask them to do things for them that were like personal' (Evette)

Feeling scared

Participants reported feeling scared or frightened. The invasion of personal space was common among participants as was the feeling of being unable to escape.

'It was horrible, just being there. As much as I knew that I couldn't go home, I did not want to be there at all' (Sara)

'I was scared, really scared. I had a drip in each arm and couldn't get out of bed so it was terrifying coz they [the other patients] would come and look at me. A lady next to me who was sat out of bed in her chair... kept putting her hands out to feel what was around her and running her fingers through my hair. That was really scary as I couldn't get away from her' (Harriet)

There was also a sense of responsibility for the other patients in the bay as there were so many occasions when the nurses were not within sight. This situation caused additional stress and fear.

'I kept having to call the nurses, and if patients tried to get out of bed I had to call them. I felt responsible, you know like I had to keep an eye on them' (Harriet)

Participants felt that the experience would have been improved if they had been allowed to have visitors at any time of day. They would have liked their parents to stay until they went to sleep. Respondents reported that their parents were 'ushered off the ward' (Peter) or 'had to leave fairly quickly' (Mel).

'I did ask if my mum could stay with me coz I was so scared and they just said 'No, we don't do that here'. She wasn't allowed to stay over at all... it would have made a massive difference if

she had been allowed to stay. I thought the staff would laugh at me if I pushed it too much' (Sara)

Staff attitudes

Participants gave varying reports of nurses' attitudes towards them, but feeling patronised was common. However, attitudes were dependent on which nurses were on duty.

'They (the nurses) treated me like I was about 5 years old—I could not believe how patronising they were all the time—but then they spoke to all of the patients like that—like they were small children' (John)

John also noted that the nurses were 'just too busy', and asked 'loads of questions but did not really listen to the answers' This made him feel that he was 'on a conveyor belt' and no one was really interested in him as a person.

However, there were occasions when the nurses would be lenient and would be flexible regarding visiting, and these occasions appeared to make a huge difference.

'Some of the nurses would bend the rules and let a visitor pop in during the morning but most of the nurses wouldn't let people in out of visiting hours. That was like a real treat but you kept expecting someone to come and send them away' (Peter)

Participants felt the doctors did not speak to them very much at all. When seeing them on ward rounds they would 'not explain things well' (Mel and Evette) or 'they would talk about you rather than to you' (Sara). They commented on seeing lots of different doctors so they would often have to repeat their history.

'They were all pleasant but it seemed like every other day it would be a new doctor and then it would be explaining what was wrong with me and everything all over again' (Mel)

'I chose to be nursed on an adult ward but I would rather go back to the children's ward' (Evette).

Future admissions

The environment made participants question whether they would agree to being admitted to hospital again in the future, even if this was 'against medical advice'; they would have to be very ill to choose to go back to an adult ward. This put some participants at risk with one participant allowing her illness to deteriorate to such a level that she needed an intensive care unit admission.

'I have been admitted since but I know I should have gone in sooner. I just kept trying to get better at home, but I knew I would have to go eventually... I wouldn't want to go back there' (Harriet)

Discussion

The findings of this study revealed that the experience of

being in hospital was very different from that which young people expected. Soanes and Timmons (2004) suggest that often young people opt for adult services, only to find that they regret the move and want to return to child services. This could be for a variety of reasons including attitudes of staff, fixed visiting hours, the type of environment, and being away from their peers.

The expectations of the young people did not correspond with the reality of the experience. On admission, participants said they were not welcomed by the staff and felt they were not always understood by the nurses. Caspari et al (2004) states that the manner in which the patient is received on the ward is important in terms of the patient's self-worth. For young people dealing with the stress of being admitted to an unknown environment, a warm welcome would make a positive difference. The RCN (2013) states that:

'where young people will be exposed to adult clinical inpatient settings, preparation should include helping young people to understand how some patients may behave, so that they feel less anxious if they encounter difficult or frightening behaviour' [AQ6: Do you have a page reference for this direct quotation?]

In Norway, Ostlie et al (2007) noted that although efforts can be made to place young people together on adult wards, this may not always be possible due to the small numbers of adolescents admitted to these areas. This suggests that the problem of young people feeling out of place on an adult ward is an international problem rather than being confined to the UK.

This present study's findings illuminated the discomfort of teenage girls when in this situation, which has not been previously highlighted. Research examining the issues of patients in mixed bays has focused on adult patients and has found that older people feel uncomfortable in mixed sex environments. However, Baillie's (2008) study found that women in their 40s and 50s expressed discomfort about mixed-sex bays. The Department of Health (2005) stated that a mixed-sex ward was acceptable as long as there were separate sleeping areas and separate bathrooms. However, participants in this current study reported patients of other sexes being confused and wandering into the area where they were being nursed. Baillie (2008) acknowledged the issue of partially dressed male patients wandering into female bays and participants in this present study felt that their dignity was not always maintained. Research carried out by Matiti and Trorey (2008) identified privacy as being a problem on adult wards and recognised that in many cases dignity is not being maintained. The safeguarding of patient dignity is likely to result in a greater sense of wellbeing that will assist recovery (Williams and Irurita, 2004). All health professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of the care they offer (Department for Children, Schools and Families, 2010).

Boredom is a major problem for young people in hospital. Young people need age-appropriate recreational facilities (Birch et al, 2007). Boredom can be relieved by having

open visiting as having access to peers and parents provides young people with a sense of security and comfort (Norton-Westwood, 2012). The attitude of ward staff appeared to be that there were no exceptions to the visiting hours if patients were on the main ward, although if they were in a side room there was some flexibility. The ethos of family-centred care for children and young people is well recognised and this has impacted favourably on allowing open visiting on paediatric wards (Plowright, 2007). Evidence suggests that open visiting policies can be beneficial to both the patient and their families as they can decrease anxiety (Moola, 2009).

All participants reported feeling 'scared' of unknown sounds. Although it could be argued that being scared is a normal emotion for adults admitted to hospital, for the young people who were undergoing their first experience of being admitted to an adult ward, this was a huge culture shock. An audit of parents in one children's ward (Pritchard and Howard 2006) suggested that 60% of parents felt the children's ward was too noisy, but were unable to suggest ways to address this. Although it may be said that children's wards generally will have a high level of noise, in this present study participants who had previously been on children's wards reported that this tended to be 'happier noise' with fewer unidentifiable sounds.

The young people found that staff attitudes towards them were varied. In a study by Jones et al (2003), doctors and nurses on adult wards were described as being impersonal and disease-focused, and it was reported by the young people in this present study that it was difficult to establish relationships with them. The RCN (2008) found that the attitudes and approaches of some health professionals to young people were seen at times as a barrier to appropriate care. Young people were expected to be 'difficult', but at the same time were expected to make health-related decisions. The lack of adolescent training received by nurses, who work regularly with young people, and the levels of support and supervision available are a concern that warrant further investigation, as highlighted by Lotstein et al (2005) and McDonagh and Viner (2006). The RCN (2008) recommends that health professionals build relationships and develop understanding between themselves and young people.

Participants felt they would be very apprehensive regarding a future admission. It was concerning that one young person was so frightened of being readmitted that she delayed her admission to the point that she required an intensive care bed. Interventions to reduce young people's stress during hospitalisation will not only reduce stress at the time but will also influence their future admissions (Coyne 2006).

Limitations of the study

The sample of eight participants in this study gives only a very small representation of the many adolescents admitted to hospital each year. In addition, the focus on the South East of England does not necessarily represent a national picture. However, the available literature does indicate similar problems elsewhere nationally and internationally. As there is so little literature related to this subject, this study is relevant and adds to this small body of literature.

It should be noted that for some of the participants there

was a gap of several years between the admission to hospital and the time of the interview. Therefore there is a possibility that the timeframe had changed their perceptions of their experiences. Nonetheless the memory of their experience is vivid and remains with them.

Due to the small number of respondents it was not possible to select those with a similar length of stay. It is recognised that the length of stay may well have an impact on how the young person would perceive his or her experience. Although the respondents did not specifically mention this in their responses it may be that the longer a young person is in hospital the more negative the experience may be. However, it could also be that those who have a longer admission may become more acclimatised to the environment and routine and see it in a more positive light as their stay progresses.

Conclusion

This study explored the experiences of young people who have been nursed on adult wards. The phenomenological approach with the use of semi-structured interviews allowed respondents to freely relay their experiences to the interviewer. It is evident that on the whole these experiences have been negative. The environment, other patients and staff attitudes were found to be contributing factors to the young person's experience. Healthcare provision needs to be reviewed to ensure that young people receive care in a safe and age-appropriate environment, from staff who have been trained in the specific care of adolescents. While it is acknowledged that it is not feasible that every hospital should have a purpose-built adolescent unit, there are simple changes that could improve the experience. These could include staff training, dedicated areas within adult single-sex wards, access to schooling for those young people studying beyond the legal schooling age, entertainment facilities and flexibility in visiting hours for young people. In addition, nurses need to consider how their attitudes and practice could enhance the experiences of young people in adult care environments.

BJN

Conflict of interest: [AQ7: Any sponsorship or sources of funding to declare?]

- Attride-Stirling J (2001) Thematic networks: an analytical tool for qualitative research. *Qualitative Research* 1(3):385-405. doi:10.1177/146879410100100307
- Baillie L (2008) Mixed-sex wards and patient dignity: nurses' and patients' perspectives. *Br J Nurs* 17(19): 1220-5
- Baines JM (2009) Promoting better care: transition from child to adult services. *Nurs Stand* 23(19): 35-40
- Beresford B, Sloper P (2000) *The Information Needs of Chronically Ill or Physically Disabled Children and Adolescents*. Social Policy Research Unit, University of York, York
- Birch J, Curtis P, James A (2007) Sense and Sensibilities in search of the child-friendly hospital. *Built Environment* 33: 405-416 [AQ8: Please can you check page numbers, I think this may be 33(4): 5-16 http://www.alexandrinepress.co.uk/sites/default/files/built_environment_33no4.pdf]
- Burns N, Grove SK (2001) *The Practice of Nursing Research: Conduct, Critique and Utilization*. 4th edn. WB Saunders, Philadelphia
- Caspari S et al [AQ9: Should it be just one author? This seems to be her PhD thesis] (2004) *The Golden Section, the Aesthetic Dimension, A Source to Health and an Ethical Concern*. Abo Akademi University Press, Finland.
- Clamp C, Gough S, Land L (2004) *Resources for Nursing Research: An Annotated Bibliography*. 4th edn. Sage Publications, London
- Colaizzi P (1978) Psychological research as the phenomenologist views it. In: Valle RS, King M, eds, *Existential Phenomenological Alternatives for Psychology*. Oxford University Press, New York
- Coleman J, Schofield J (2006) *Key Data on Adolescence*. 5th edn. Trust for the Study of Adolescence, Brighton
- Coyne I (2006) Children's experiences of hospitalization. *J Child Health Care*

- 10(4): 326–36
- Department for Children, Schools and Families (2010) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. <http://tinyurl.com/njncqys> (accessed 10 February 2015) [AQ10: There seems to have been a more recent version in 2013, author in that case would be Department for Education – did you want to refer to that instead?]
- Department of Health (2005) *Elimination of Mixed-Sex Hospital Accommodation*. The Stationery Office, London
- Department of Health (2006) *Transition: Getting it Right for Children and Young people. Improving the Transition of Young People with Long Term Conditions from Children's to Adult Services*. <http://tinyurl.com/phze4oq> (accessed 10 February 2015)
- Department of Health (2007) *Making It Better: For Children and Young People*. Report by the National Clinical Director for Children, Young People and Maternity Services. DH, London
- Department of Health (2011) *Quality Criteria for Young People Friendly Health Services—2011 edition* [Also known as *You're Welcome*] <http://tinyurl.com/o3nvpqx> (accessed 10 February 2015)
- Dovey-Pearce G, Hurrell R, May C, Walker C, Doherty Y (2005) Young adults' (16–25 years) suggestions for providing developmentally appropriate diabetes services: a qualitative study. *Health Soc Care Community* 13(5):409–19
- European Association for Children in Hospital (2002) The EACH Charter and Annotations. <http://tinyurl.com/qy3t3yd> (accessed 10 February 2015)
- Fleming E, Carter B, Gillibrand W (2002) The transition of adolescents with diabetes into the adult health care service. *J Clin Nurs* 11(5):560–7
- Foddy W (1993) *Constructing Questions for Interviews and Questionnaires: Theory and Practice in Social Research*. Cambridge University Press, Cambridge.
- Hamill C, Sinclair H [AQ11: Pubmed only lists 1 author, please confirm] (2010) Bracketing—practical considerations in Husserlian phenomenological research. *Nurse Res* 17(2):16–24
- Heidegger M (1962) *Being and Time*. Trans, Macquarie J, Edward Robinson E. Harper & Row, New York
- Hinton S, Watson S, Chesson R, Mathers S (2002) Information needs of young people with cystic fibrosis. *Paediatr Nurs* 14(6):18–21
- Hutton A (2004) Consumer perspectives in adult ward design. *J Clin Nurs* 14(5):537–45
- Ishibashi A (2001) The needs of children and adolescents with cancer for information and social support. *Cancer Nurs* 24(1):61–7
- Jones K, Hammersley S, Shepherd M (2003) Meeting the needs of young people with diabetes: an ongoing challenge. *Journal of Diabetes Nursing* 7(9):345–50 [AQ12: Can't find this issue in the archive, please confirm pages]
- Koch T (1995) Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *J Adv Nursing* 21(5):827–36
- Lotstein DS, McPherson M, Strickland B, Newacheck PW (2005) Transition planning for youth with special health care needs: results from the National Survey of Children with Special Health Care Needs. *Pediatrics* 115(6):1562–8
- Matiti MR, Trorey GM (2008) Patients' expectations of the maintenance of their dignity. *J Clin Nurs* 17(20):2709–17. doi: 10.1111/j.1365-2702.2008.02365.x
- McConnell-Henry T, Chapman Y, Francis K (2011) Member checking and Heideggerian phenomenology: a redundant component. *Nurse Res* 18(2):28–37
- McDonagh JE and Viner RM (2006) Lost in transition? Between paediatric and adult services. *BMJ* 332:435–6
- Moola S (2009) The impact of hospital visiting hours policies on paediatric and adult patients and their visitors. *Journal of Advanced Nursing* 65(11):2293–8 [AQ13: Cannot find this article on PubMed, but found listing on JAN archive where it gives the author as The Joanna Briggs Institute - <http://tinyurl.com/kdzswrc>. [DOI: 10.1111/j.1365-2648.2009.05150.x] Seems that this is a summary of a review by Smith et al, as one of a number of summaries, was Moola S the person who wrote the summary for J Adv Nurs?]
- Morse JM (2000) Determining sample size. *Quality Health Res* 10(1):3–5
- Norton-Westwood D (2012) The health-care environment through the eyes of a child – does it soothe or provoke anxiety? *Int J Nurs Pract* 18(1):7–11. doi: 10.1111/j.1440-172X.2011.01995.x
- Nursing and Midwifery Council (NMC) (2010) *Standards for pre-registration nursing education*. NMC, London
- Ostlie I et al (2007) From childhood to adult life with juvenile idiopathic arthritis (JIA): a pilot study. *Disabil Rehabil* 29(6):445–52
- Parsons K (2010) Exploring how Heideggerian philosophy underpins phenomenological research. *Nurse Res* 17(4):60–9
- Plowright C (2007) Visiting practices in hospitals. *Nurs Crit Care* 12(2):61–3
- Pritchard E, Howard E (2006) Parent questionnaires: are they effective for auditing services? *Paediatr Nurs* 18(5):37–9
- Royal College of Nursing Research Society: Nurses and Research Ethics (2003) *Nurse Researcher* 11(1):7–20
- Royal College of Nursing (2003) *Adolescent Transitional Care: Guidance for nursing staff*. RCN, London
- Royal College of Nursing (2008) *Adolescence: Boundaries, Connections and Dilemmas*. RCN, London
- Royal College of Nursing (2009) *Research Ethics*. 3rd edn. RCN, London
- Royal College of Nursing (2013) *Adolescent Transitional Care: Guidance for nursing staff*. RCN, London
- Sadler GR et al (2010) Recruitment of hard-to-reach population sub groups via adaptations of snowball sampling strategy. *Nurs Health Sci* 12(3):369–74. doi: 10.1111/j.1442-2018.2010.00541.x
- Sandelowski M (1995) Sample size in qualitative research. *Res Nurs Health* 18(2):179–83

KEY POINTS

- AQ14: Please write 4–5 short key points, of 1–2 lines each, that summarise the main content or 'messages' of your article

- ?????.

- ?????.

- ?????.

- ?????.

- Shaw KL et al (2006) Young people's satisfaction of transitional care in adolescent rheumatology in the UK. *Child Care Health Dev* 33(4):368–79
- Soanes C, Timmons S (2004) Improving transition: a qualitative study examining the attitudes of young people with chronic illness transferring to adult care. *J Child Health Care* 8(2):102–12
- Steinbeck K, Brodie L (2006) Bringing in the voices: a transition forum for young people with chronic illness or disability. *Neonatal, Paediatric & Child Health Nursing* 9(1):22–6
- Van Manen M (2011) Phenomenology online. <http://www.phenomenologyonline.com/credits/> (accessed 12 February 2015)
- Viner R (2007) Do Adolescent Inpatient Wards Make a Difference? Findings from a National Young Patient Survey. *Pediatrics* 120(4):749–55
- Walker W (2011) Hermeneutic inquiry: insights into the process of interviewing. *Nurse Res* 18(2):19–27
- Williams AM, Iruirita VF (2004) Therapeutic and non-therapeutic interpersonal interactions: the patient's perspective. *J Clin Nurs* 13(7):806–15