

Analysing the knowledge among clinicians on the relevance of HEADSSS assessment in young people and improving the assessment structure using quality improvement methodology

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Introduction

The HEADSSS assessment is an internationally used tool to help give structure and framework to the assessment of an adolescent patient.^{1,2}

Objectives

To analyse the knowledge among doctors in the emergency department, paediatrics and acute medicine on the relevance of using the HEADSSS assessment tool (Home life, Employment, Alcohol, Recreational drugs, Smoking, School and interests, Sexual activity, Sexuality, Sleep and mood, Self harm, Safety, friendship, relationship), to study how often the tool is being used and confidence levels among clinicians on performing the assessment. To propose measures to make doctors more aware of its relevance and developing a poster to help execute the assessment in a structured and organised manner.

Materials and methods

The initial phase used a 35-question survey, aimed at junior doctors to gauge current knowledge of management, awareness of currently available resources and enthusiasm for a new reference guide and teaching. The questions were developed both with a Likert scale (1–5; where 1 = strongly disagree and 5 = strongly agree) and with free text space where applicable. The next stage, which is currently in progress, is to design teaching sessions by paediatric emergency department consultants and developing a poster/reference guide to aid with the assessment. Finally, the survey will be repeated to see if knowledge base and confidence in handling the tool have improved.

Results

The initial survey was completed by 20 junior doctors at Ealing Hospital and Northwick Park Hospital (London North West

University Healthcare NHS Trust), who ranged in grade from foundation year 1 to specialty trainees. Question 34 was aimed to assess how often the 'complete' assessment was being done; <10% of the clinicians always did a thorough assessment. Moving on to the individual components of the tool, questions 1–16 were used to gauge how often the clinicians enquired about the individual components of HEADSSS during their consultation; this demonstrated that 70% always take history on alcohol, drugs and smoking, but at the other end of the spectrum, <10% always ask about interests, relationship, friendship, sleep and sexuality. Questions 16–32 were multiple choice questions to analyse the confidence levels of the doctors on assessing the individual elements of HEADSSS; this demonstrated that >85% were confident on taking history on alcohol, drugs, smoking and self-harm, but <55% were confident on asking about sexuality and sexual history. One hundred per cent of those surveyed felt that a new reference poster and teaching would be helpful to their clinical practice.

Conclusion

The initial survey suggests a lack of knowledge among clinicians on the relevance and methodology of using the individual components of the HEADSSS assessment in young patients, and demonstrated an enthusiasm for a new reference poster and teaching. We hope to roll out the posters, organise the teaching sessions and then repeat the survey. Once that cycle is complete, there will be some indication as to whether a new and expanded HEADSSS assessment poster would be a useful accessory for clinicians in the overall structured assessment of young people. ■

References

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