Literature Review of Telehealth Policy Development

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Review Purpose: To inform the Development of a National Standard Operating Procedure for the Management of Telephone or Video Enabled Care Clinical Practice

Telehealth Policy Literature Review

Introduction

Telehealth (TH) is an opportunity to truly integrate health and social care services according to the Agency for Clinical Innovation NSW Australia (2019) and to enhance the patient's journey and outcomes. With video enabled care (VEC), instead of admitting the patient to the system, the system is deployed to the patient, acute care facilities are freed up and access to mental health treatment is timely (Henriksen 2018). TH has been used successfully in a number of ways including the prevention of ill health in communities and to initiate self-management in patients with chronic diseases (Henriksen 2018). The Royal Australian College of General Practitioners (2020) advocates its use for protection of vulnerable patients; provision of medical certs and prescriptions; mental health consultation/counselling; routine chronic disease check-ups and where the trade-off between in-person consultation and staying at home favours staying at home for the patient.

The accelerated development of systems and platforms for video enabled care, on-line medicine prescriptions and electronic support systems (telehealth) because of COVID 19 necessitated, in Ireland, an evaluation of these new media for care. The evaluation was undertaken as the first step in a quality improvement measure to ensure that the highest possible standards of care are adhered to by clinicians using VEC. The second step in the quality improvement process is the development of national policy to stipulate these standards for information and clarity and this will be followed by periodic re-evaluation and revision. The standard operating procedure (SOP) contained in this document has been informed by the Report on the First National Evaluation of the use of Video Enabled Care in Ireland (Lane and Clarke 2021) which comprises a comprehensive synthesis of the views and experience of patients, clients and clinicians using telehealth, and by this review of international telehealth policy. A literature search was undertaken by the National Health Library and Knowledge Service Evidence team and the review undertaken. This review is presented below with references, where useful, to the recommendations from the national evaluation.

Definition

According to the joint statement from the WHO and the Pan American Health Organisation (Rubio et al 2016), e-health can be understood as the application of the internet and other related technologies in the health sector for the purpose of improving access, efficiency and the quality of clinical and corporate processes used by health organisations, physicians, patients and consumers in an effort to improve the health status of patients.

Bensemmane and Baeten (2019) make a useful distinction between phases or types of telehealth to provide clarity for the terms used. Tele-consultation refers to consultation between the health care professional (HCP) and the patient. This, when delivered on an on-screen platform, is termed video enabled healthcare in the Republic of Ireland. Tele-expertise refers to 2 or more HCPs consulting in the absence of the patient. Tele-monitoring refers to remote checks via patient and/or a device and tele-assistance refers to remote guidance of a medical act (Bensemmane and Baeten 2019). For the purpose of this review the term telehealth (TH) is used to comprise all of the above.

Bensemmane, and Baeten (2019) refer to the European Commission discussion (2008) about the need for TH for people with chronic diseases, for older persons' services and for communication with centres of excellence in the care of people with rare and complex disease. By 2018, however, the European Commission was noting the persistent disparity between nations in the development of TH and the fact that progressing pilot projects to usual practice seemed to pose difficulties (Bensemmane and Baeten 2019). In the wake of COVID 19, after an urgent drive towards enabling TH systems, there is potential risk of stalemate again as professionals return to in-person systems that they are comfortable with. Successful telehealth systems, however, have the possibility of broadening the availability and efficiency of healthcare and Ireland's strategic plans for the community to be the primary location for healthcare are otherwise being enacted. Digital health systems are part of the Sláintecare report recommendations and digital consultations are a logical addition to electronic healthcare records and electronic prescribing. It is important not to miss the opportunity to advance what has been achieved during COVID 19 and to develop TH against a robust set of criteria which will safeguard both patients/clients and HCPs.

Many of the papers discovered in this literature search focus on single health professions and patients but the principles can be seen to be transferable to other health professionals and non-patient clients or consumers of healthcare. In various countries and their states, guidelines have been developed by professional bodies specifically for their own professions. There is extensive overlap in the advice and guidance for TH across the papers reviewed. This literature review comprises the main principles of this advice and guidance.

Duty of Care

This is a common theme in the international policy literature with a strong focus on ensuring that recipients of healthcare are at no disadvantage when it is delivered electronically. Nurse Executives of New Zealand Inc. (2015) reminds nurse clinicians that the relationship and duty to provide care starts as soon as the nurse and the patient interact and that it continues throughout the care episode. They include all aspects of nursing care in this and caution that this and all ethical considerations remain the same with the use of telehealth. This means remaining aware of the limitations of telehealth for the purpose of their interaction and nurses are advised to remain within their scope of practice (Nurse Executives of New Zealand Inc. 2015). Variations of this theme of duty of care to the patient/client are seen through the policy literature to include etiquette, scope of practice, appropriateness for medium of care, digital literacy, code of professional conducts and jurisdiction considerations.

Clients, according to the New Zealand Psychologists Board (2012) should be adequately assessed before being offered teleconsultations so that healthcare delivery matches the patient's/client's requirements. These writers go on to list the ethical principles underpinning telehealth; competence, informed consent, responsible care, intake procedure (client must have the wherewithal to engage), documentation of the presence of a third party, inclusion of a complaints procedure, availability of alternatives, group ethical principles, management of cultural issues, adherence to ethics around working with children and boundaries to include safe spaces for disclosure etc. Telehealth should be seen as an addition, another way to provide healthcare (Europe Economics 2021). It should be ensured that patients understand that in-person appointments are still an option (Royal Australian College of General Practitioners 2020).

The decision to use VEC should be part of a wider system of triage (Lane and Clarke 2021; Royal College of General Practitioners NHS 2020). Assessment of appropriateness should include evaluation of clinical efficiency, quality of care, safety of care and the practicality of VEC for that episode of care (Allied Health Professionals Australia 2020). Consideration needs to be given by organisations to how non-compliance by clinicians with standards of care is addressed. There is a risk that patients may accept poorer standards of care in lieu of an earlier appointment than would otherwise be possible (Europe Economics 2021)

Adequate Preparation

Preparation advice includes determining who is responsible for and accountable for technical and business aspects of telehealth; determining what platforms will be used; setting up test platforms; considering training requirements; deciding communication strategies for patients and stakeholders; updating the organisational website and providing information on what users should expect with TH (Royal Australian College of General Practitioners, 2020) the NHS (2020) issues similar advice and includes the need to consult with HCPs and patients in the setting up process.

Consultation with and education of the people using it when setting up TH is recommended in the literature. It should involve the key stakeholders (Agency for Clinical Innovation NSW Australia 2019) including clinicians, ICT and administrative personnel (The American Medical Association 2020). In Ireland the views and experience of clinicians and services users have been elicited and recommendations developed for future progress. Individual health professional bodies, HSE Information and Communications Technology professionals (ICT) and the National Virtual Health team specifically, have also been represented on the National Telehealth Steering Group. It is suggested here that other key stakeholders in this country may include professional regulatory bodies, health education centres and Higher Education Institutes and the Health Information and Quality Authority (HIQA). Planning and resource allocation should support service delivery and goals.

Training, according to the Royal Australian College of General Practitioners (2020) should cover booking systems, virtual room set-ups and equipment but should also include ethics and data protection issues such as informed patient decisions, consent, presence of third parties and cultural awareness and sensitivity. Recommendations from the Irish VEC evaluation (Lane and Clarke 2021) include education of both clinicians and service users and improvement of computer systems and internet connectivity. The Royal Australian College of General Practitioners (2020) provides a comprehensive overview of how organisational systems should be prepared for telehealth. Systems should include efficient coordination of appointments and cancellations and clinician availability (Royal Australian College of General Practitioners 2020) and equipment should function well and should be used proficiently. Telehealth etiquette, communication protocols, practice and organisational policy regarding video recordings, patient and patient data privacy and security should all be in operation (Royal Australian College of General Practitioners 2020). Systems, their paper continues, should be put in place to prevent interruptions, the environment should be secure, and video and audio should be at the standard of in-person consultations. Access to a ‘phone should be available in case of the need to default but whether the clinician delivering care is at home or at the workplace, the system should be technically fit for the purpose of the consultation (Royal Australian College of General Practitioners 2020). Clinicians at home using their own IT equipment also need to check their security (Royal College of General Practitioners 2020). The Medical Council

of New Zealand (2020) advises clinicians to ensure devices are fit for purpose and to check that they and their patients are proficient in their operation. In terms of consultation efficacy, tools should not overshadow holistic assessments (Royal College of General Practitioners 2020). Consideration should be given to when not to use TH and examples of this are potentially serious and high risk issues needing physical examination; when a physical examination cannot be deferred; for patients with chronic disease and poor self-management; where patients' ability to communicate does not lend itself to phone or VEC or where there is any doubt about appropriateness of VEC (Royal Australian College of General Practitioners 2020). This comprehensive paper includes information on the key principles of consultation such as excellent communication, open questions, avoidance of jargon, solutions to communication problems such as cultural barriers, assistance to use home devices, establishment of patients' functional status, prior knowledge of each patient and history to reduce risk, ensuring that the patient has a support network and creating an action plan for exacerbation of symptoms. This advice is reiterated by The Medical Council of New Zealand (2020).

In terms of risk management, since the usual facilities that are available at health centres are not necessarily available at the patient's location, there should be a contingency plan for adverse events. There should be a documented plan for technical interruptions – revert to phone/easy read trouble shooting guide. Sound and vision should be good to avoid near misses/mistakes. Formal introduction of all present should be undertaken and consent assured from patient for the presence of all there (Royal Australian College of General Practitioners 2020).

Process/Guidance

A large number of the international papers reviewed included comprehensive checklists for clinicians covering preparation for most or all aspects of telehealth. Occupational Therapy Australia (2020), for example, provides a checklist which covers preparation of equipment, technical tips, audio visual tips, security, informed consent, risk management and professional indemnity.

The following is a summary of items discovered from these papers covering the themes discussed above.

1) Clinicians should prepare for TH with attention to consultation workflow design and preparation of the team including digital literacy and job allocation. Preparation should be in partnership with the patient/client and after implementation, the process should be evaluated (American Medical Association 2020)
2) The Allied health Professionals New Zealand (2020) draw attention to the choice of technology and platforms used and the organisation of technical necessities such as remote monitoring devices, screens and cameras.
3) Consent, for the purpose of this review, assumes the correct consent process for the consultation per se and refers only to consent for the use of telehealth for the consultation process. The same standards of consent and confidentiality as those held for in-person care must be upheld by those using telehealth (Royal Australian College of General Practitioners 2020). This applies to child and adult protection referral pathways and under 16 and under 18 year old patient safeguarding and chaperone policies (Royal College of General Practitioners 2020). The Royal College of General Practitioners (2020) caution that if a child is the subject of the consultation, the child him/herself should be seen. Informed consent (Occupational Therapy Australia 2020) and consent for participation by third parties (Allied

Health Professionals Australia 2020) are also widely addressed. Informed consent for consultation via telehealth is generally agreed to be necessary but inferred consent is sufficient for telehealth consultation in the same way as it is for in-person consultation (Medical council of New Zealand 2020; Agency for Clinical Innovation NSW Australia, 2019; Allied health Professionals Australia 2020; Royal College of General Practitioners 2020). The Royal College of General Practitioners (2020) suggest however, that it is good practice to confirm and record consent and the NSW Australia, Agency for Clinical Innovation (2019) add that patients should be offered the choice of all options for consultation. Allied Health Professionals Australia (2020) emphasise the need to ensure that patients understand that they have free choice whether or not to engage in telehealth.

Telehealth introduces new challenges in terms of data protection and additional risks. Patients who are not technically competent may need a relative or carer to assist them. Others may need interpretation services. It is suggested in this paper that clinicians may need to make a judgement on whether it may be better to arrange an in-person appointment in the interests of privacy. Patients, however, can be assisted by carers with implied consent and translation services should be facilitated when needed (Royal College of General Practitioners 2020)

Recording is unusual in in-person consultation but more easily manageable with telehealth. It is not standard practice but where it is used (in exceptional cases) there should be robust justification and documented patient consultation and consent (NSW Australia, Agency for Clinical Innovation 2019). Separate informed consent is required for recording (Enable New Zealand 2020). This is an issue that will be important and in Ireland, once the need for consent is understood, the National Consent Policy (HSE 2022) offers guidance on process.

4) Car et al. (2020) included patients' views in their study and provide a useful list of precautions for consideration during a TH consultation including verification of the patient's name, date of birth, location and 'phone number, this last in case of unanticipated disconnection. They advise a low threshold for transfer to in-person consultation maintaining awareness of the patient comfort with the medium and to patient sensitivities and vulnerabilities in general. They give the example of the patient's potential discomfort with guided self-examination but also with its accuracy. Colours, they caution may appear different on screen and observations need to be correct. Video enabled consultation is not advised for the first meeting say Car et al. (2020) and clinicians need to be aware of how they are perceived on screen. Rapport and trust are more important with TH so eye contact to reassure the patient of the clinician's full engagement and care with closing the session is needed (Car et al 2020). They recommend inviting the patient to say goodbye first so that they are sure it is not a mistaken disconnection. Grenhalgh (2020) agrees with the importance of appropriate eye contact and of ending the appointment overtly and adds that clinicians should summarise as the consultation goes along and at the end, and ask if clarification is needed before signing off. They should also confirm the mode of the next appointment (Grenhalgh 2020) although this may need to be reassessed nearer the time as per the principles of the National Consent Policy (HSE 2022)
5) After consultation, documentation of clinical information, who attended, who participated, consent and technical issues are important (Allied health Professionals Australia 2020) as is information storage. Storage of information is addressed in the Irish Data Protection Policy (HSE 2019). Consultations from the clinician's home, however, introduce the risk of use of a

personal device. Guidelines from the HSE memo concerning use of personal IT resources (HSE 2021) offer clarity on the use of personal devices and it is addressed by the Royal College of General Practitioners (2020) who stipulate that unless it is essential, patient information should not be stored on the clinician's devise. Irish guidelines, however, have, in some cases been issued in times of unprecedented health service disruptions and may require a review of their coverage of telehealth for the longer term. The additional risk to security created by VEC, state the Allied Health Professionals Australia (2020), necessitates additional actions to preserve privacy and security in relation to data protection including: Patient information, data storage, data access and permissions, data disclosure, interference with or loss of data and disposal or misuse of data. Policies covering these issues in Ireland should perhaps be reviewed and updated with specific reference to new risks presented by telehealth if necessary.

6) Documentation of consent for the use of telehealth, as discussed earlier, is advisable although tacit consent is acceptable. Care is required, however, with documentation of the consultation itself (NHS 2020) and should be in accordance with regulatory body codes and with standards and guidelines (Allied health Professionals Australia 2020). Standards of practice should be equivalent to in-person practice standards (The New Zealand Psychologists Board 2012).

   The importance of documentation of TH because of the need for traceability (Bensemmane, and Baeten 2019) is noted in the literature and was also an important consideration for HCPs in the Republic of Ireland evaluation. Qualitative responses to the question on documentation indicated that those who had access to electronic health records were at an advantage. The Royal Australian College of General Practitioners (2020) advise to ensure read/write access to an electronic record system and that all interactions must be documented in accordance with DPIA guidelines. Accurate, maintenance of patient record, verbal consent for this way of care, documentation of mode of consultation, clinical findings, follow up, technical malfunctions if any and establishment of secure documentation method if electronic records are not in existence are also advised (Royal Australian College of General Practitioners 2020).

   GPs should have full access to patients' records, should apply current skills and use proper boundaries as they would with in-person appointments state the Royal College of General Practitioners (2020) and this advice is generalizable to all healthcare clinicians. VEC should have contemporaneous written records (Royal College of General Practitioners 2020) and in-person standards of records should be kept (Australian Digital Health Agency 2020). Bensemmane, S. and Baeten, R. (2019) advice that HCPs should have direct access to patient data rather than having to log in to medicinal device platforms to access it and that they should be competent and aware of the ethics and legislation relating to TH.

7) Risk management and professional indemnity are also addressed in the literature. The New Zealand Psychologists Board (2012) advise risk assessment, risk mitigation and planning for crises management around TH. This theme focuses mainly on patient safety but clinical indemnity for the clinician is also advised as part of this (Occupational Therapy Australia 2020; Allied health Professionals Australia, 2020; NSW Australia, Agency for Clinical Innovation 2019). Strong governance arrangements are critical to success (NSW Australia,

Agency for Clinical Innovation 2019) and indemnity or liability should connect local to national bodies and to European and international policy (Bensemmane, and Baeten 2019).

8) The issue of standards of care in the literature reviewed, relates mainly to the stipulation that healthcare delivered via TH must be of the same standard as that which would be delivered in person. According to the Royal College of General Practitioners (2020), GPs should apply current skills and use professional boundaries as usual. Care given should be equivalent to in-person care say the Medical council of New Zealand (2020); all standards that apply to doctors in New Zealand apply to their VEC consultations with the focus on the patient's experience and quality of care and on cultural requirements (Medical council of New Zealand 2020). Similarly, GPs in the UK, according to the Royal College of General Practitioners (2020), should apply current skills and use proper boundaries in the same way as they would with in-person appointments. Tools, they caution, should not overshadow holistic assessments. Competence in the use of technology is also important and includes the clinician and the patient/client if the clinician is to ensure that the care delivered through the medium of TH is at least at the same level of quality that is expected of in-person care. Awareness of clinicians' scopes of practice, the organisational scope of capability and digital literacy and skills issues (NSW Australia, Agency for Clinical Innovation 2019) should form part of the planning for TH.
   Patient safety should not be compromised by the use of TH (Nurse Executives of New Zealand Inc. 2015). Clinicians must have knowledge and skills to provide appropriate and safe care (Nurse Executives of New Zealand Inc. 2015). In Ireland, consideration may perhaps be given to developing a standard of digital literacy which clinicians must achieve to show proof of digital competency before offering care via TH. Risk assessors should consider responsibility for ensuring appropriate, ethical and standard compliant care (Nurse Executives of New Zealand Inc. 2015). Standards should be safeguarded, risks managed, continuous quality improvement engaged in and accountability created for quality of care (Allied health Professionals Australia 2020).
9) There are other cautions in terms of standards, such as the importance of maintaining continuity of care as would be done with in-person appointments (Nurse Executives of New Zealand Inc. 2015) and maintaining cultural sensitivity and responsiveness (NSW Australia, Agency for Clinical Innovation 2019). Nurses are obliged to advocate for safe, competent, ethical systems and engage in research that informs and evaluates practice in terms of outcomes, cost, clinical effectiveness and accessibility (Nurse Executives of New Zealand Inc. 2015). Clinicians should be prepared to switch from video to phone or in-person consultation depending on technology, the patient or clinical factors and should have a low threshold for moving to an in-person appointment (Car et al. 2020).

Legislation and Jurisdiction Regulations

The main themes arising in the area of legal frameworks and legislation are to do with adherence to professional codes of conduct, consideration of responsibility during referrals and licencing for use of TH outside of the clinician's usual jurisdiction. General advice includes harmonising health terminology to facilitate cross border care, a stronger EU legal framework to ensure reliability, safety and effectiveness of devices and the creation of international practice standards for TH (Bensemmane and Baeten 2019). HCPs are advised to be aware of policies governing their practice

(Allied Health Professionals Australia 2020; AHPra 2020; Nurse Executives of New Zealand Inc. 2015). If there are discrepancies between TH guidelines, for example, the New Zealand Psychologists Board (2012) advises that their code of practice takes precedence along with the usual standards of competence.

Telehealth is useful where expertize is not domestically available (Bensemmane and Baeten 2019) but a robust legal process must be ensured for referrals out of jurisdiction. It is necessary to consider locus of responsibility for patient care, whether this is with the HCP referring, or the HCP referred to (Europe Economics 2021). In terms of the import and export of healthcare (Bensemmane and Baeten 2019) applicable legislation for care of the patient usually refers to the legal framework of the member state (in the EU) where the care is provided (i.e., where the patient/client is located). With TH, however, the legal framework applied is that where the healthcare provider is located (Bensemmane and Baeten 2019). They differentiate between the requesting physician who contacts a peer in the context of TH while with a patient (physically or remotely) and referring which is referral to another specialist for expertise.

In New Zealand, regardless of the patient/client's whereabouts, it is the region from where the nurse is practicing that counts in terms of registration so wherever the nurse is providing telehealth, s/he should be registered/licenced in that region and should adhere to the policies there but also needs to be aware of the standards where the patient is (Nurse Executives of New Zealand Inc. 2015). If a physician is providing care to patients based in New Zealand, they need also to be registered as a doctor in New Zealand (Medical council of New Zealand 2020). The Royal College of General Practitioners (2020) for COVID, specify that GPs are expected to have full access to patient records and to be consulting with patients in England. Doctors from outside the UK, however, are allowed to practice telemedicine with patients in the UK without registering with the GMC (Europe Economics 2021). In Australia, if the clinician is registered with their registration body in Australia but is, at the time, overseas, they can still treat patients in Australia via telehealth but must check with the authorities in the country they are in for any legal or funding implications. The clinician's Australian regulation body has the same expectations of good practice regardless of where the clinician is practicing (AHPra 2020).

A further caution is that it is possible that a clinician working on-line may not know the geographical location of the client. This is important where locus of legal responsibility is mandated (The New Zealand Psychologists Board 2012). It is suggested here that this would also present a serious problem if the clinician is not able to given geographical information to the emergency services in the event of a crisis. Equally, service users should be able to check practitioners' identity and qualifications and regulatory bodies should make this feasible (Bensemmane and Baeten 2019).

Appropriateness

Many papers address the appropriate use of TH. Not all healthcare services are TH appropriate; TH has to be appropriate for the clinical service and suitable for the patient/client (AHPra 2020). Allied Health Aotearoa (2018) specify potential challenges such as establishing rapport, conducting a physical examination, recognising emotion, cultural responsiveness and clients' concerns about privacy and security. Concerns about privacy and security, although only occasionally expressed, were identified in the recent Irish evaluation of VEC (Lane and Clarke 2021). Clinicians should check for privacy and a quiet environment and check if the patient is in an appropriate space and in a good

place to talk (Car et al. 2020). The NHS specialty guide for COVID 19 (NHS 2020) advocates triage for TH appropriateness and warns against VEC for serious/high risk issues, physical examinations, internal examinations, patients who are not technically able and those who are deaf. Special considerations should also be given to children and adolescents as neither may be as well able to communicate via this medium. The Irish evaluation (Lane and Clarke 2021) identified a number of advantages and disadvantages experienced by HCPs and parents or guardians when using VEC with children and concluded that a rigorous assessment or triage process is key to determining appropriateness of TH for children. Safeguarding patients takes precedence and alternative arrangements should be made if necessary (NHS 2020). The Australian Digital Health Agency (2020) suggests similar checklists.

Security

The possibility of clinicians at home using their own IT equipment has been addressed earlier but it is important if this does happen that they check their security and, unless it is essential, do not store patient information on their device (Royal College of General Practitioners 2020). Privacy, confidentiality and security should all be safeguarded to the same standard as they are with in-person appointments (NSW Australia, Agency for Clinical Innovation 2019). The British Medical Association (2021) provides a useful toolkit for confidentiality and there is general agreement on the importance of security, patient safety and risk management (Occupational Therapy Australia 2020; Allied health Professionals Australia 2020; Car et al. 2020; Australian Digital Health Agency 2020). The Allied health Professionals Australia (2020) advocate the development of checklists for clinicians and associates to ensure security and privacy with each VEC. In Australia, if telecom services used for VEC are provided from overseas, they may not be covered by Australian disclosure law and may potentially collect and retain patient information. Telecom provider polices, therefore, should be known and understood by all parties. (Australian Digital Health Agency 2020) and the patient's attention should be drawn to the healthcare provider's privacy policy (Australian Digital Health Agency 2020). These cautions are widely applicable. Platform provider standards need to match those of the care provider and, in Ireland, platform providers are currently vetted and approved by a national group of digital experts. Potentially, however, clinicians treating patients/clients in Ireland from abroad, may not be using platforms meeting this approval standard.

The Australian Digital Health Agency (2020) issues a detailed checklist for patient privacy and security for VEC including encryption, secure platforms, cyber-attack guidelines, updated systems, delivery from private and secure settings and having data breach action plans in place. During consultation they advise verifying personal identification, collecting only necessary information and planning for new avenues of information such as email, photographs etc. Checks must be in place for sending patient information, e.g. when sending prescriptions to chemists, and consent assured from the patient. Information should be marked as confidential and recipients should be asked to delete any information received by mistake. Default settings on VEC platforms should be checked to meet security needs, recording should be disabled, personal devices should not be used, unique log-ins should be used for each patient, cameras and microphones should be turned off when not in use and privacy should be ensured with designated VEC spaces. (Australian Digital Health Agency 2020)

Additional elements of what a typical TH policy should cover include identifying clinical risks, training and professional development, maintaining VEC Equipment, contingency plans, patient

communications prior to consultations (an issue raised by patients/clients in the Irish evaluation), patient feedback and QI mechanisms and investigation of VEC related clinical incidents (Allied health Professionals Australia 2020). AHPra (2020) advise to consider verification of identities, information to clients regarding benefits and limitations of TH and ensuring availability of interpreters or cultural representatives.

Evaluation

There is general agreement that telehealth as a practice should undergo on-going evaluation. The Allied health Professionals Australia (2020) speak to the importance of engaging in quality improvement strategies, the American Medical Association (2020) list, as measurements of success, patient flow, staff flexibility, patient convenience and equity. In terms of digital platforms, vendors should be thoroughly evaluated before they are engaged and regularly reviewed after engagement. In Ireland, as previously discussed, this has been happening since the beginning of the largescale engagement with TH in early 2020 and vendors are assessed for GDPR reliability before gaining approval for use by the Health Service Executive. Feedback should be sought from patients say the Royal College of General Practitioners (2020) and the first stage of this has already been undertaken in Ireland. In terms of on-going quality improvement it is suggested here that a national telehealth metric to which all health disciplines can align should be established to allow for regular data collection and comparison against agreed telehealth standards in tandem with regular patient surveys for feedback. The National Care Experience Programme which operates under the governance of the HSE, HIQA and the Department of Health is suggested as a potentially appropriate body to carry out on-going patient/client surveys.

Note: Individual countries and states appear to have a plethora of guidelines and policies, both multidisciplinary and discipline specific. This is also the developing case in Ireland and it may be useful to develop a digital repository to house all guidelines which meet a minimum standard of safety.

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