Standard Operating Procedure for the Management of Telephone or Video Enabled Care Clinical Practice

A Protocol is a written plan that specifies procedures to be followed in defined situations

Is this document a:

Policy ☐ Procedure ■ Protocol ☐ Guideline ☐

Hospital Group and CHO Services

Title of PPPG Development Group:	Guideline Development Group
Approved by:	Telehealth Steering Committee
Reference Number:	
Version Number	1
Publication Date:	
Date for revision:	
Electronic Location:	https://healthservice.hse.ie/staff/procedures-guidelines/digital-health/video-enabled-care/governance-implementation-toolkit-and-templates/

Version	Date Approved	List section numbers changed	Authors
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Glossary of Terms

DPIA Data Protection Impact Assessment
GDPR General Data Protection Regulation
HSE Health Service Executive
NCLC National Clinical Leadership Centre
NMPDU Nursing and Midwiery Planning and Development Unit
ONMSD Office Of Nursing and Midwifery Service Director
TH Telehealth
SCA States Claims Agency
T/VEC Telephone/ Video Enabled Care
PPPG Policy, Proceedures, Protocols and guidelines
URL Uniform Resource Locators
VEC Video Enabled Care

Part A: Standard Operating Procedure for the Management of Telephone or Video Enabled Care Clinical Practice

1.0 Introduction

1.1 Telehealth is the "delivery of health care services, where patients and providers are separated by distance. Telehealth uses ICT for the exchange of information for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals" (WHO 2010).

1.2 Telehealth encompasses Remote Health monitoring, Video Enabled Care and Online Supports and Therapies. The purpose of this procedural document is to outline the processes and appropriate procedures to be followed when offering or delivering video enabled care (VEC) and telephone (T) consultations along with certain considerations involving access, consent, safety and governance.

1.3 For the purpose of this document, all healthcare professionals will be collectively referred to as clinicians.

1.4 For the purpose of this document the term patient will be used to indicate patients, clients and service users

1.5 Clinicians must assess the suitability of this method of consultation in partnership with each patient and offer the service with the patient preference and in accordance with assessment and evidence based clinical judgement and in compliance with this PPPG.

1.6 T/VEC are not methods of care to replace face to face interactions but to enhance the service offering and give patients and clinicians choices. It should also not be used as a last resort method of care either but to be used as a blended care approach for the patient. **Blended care** means you meet your patient in person sometimes, and by video enabled care or telephone other times.

2.0 Legislation and Compliance for Video Enabled Care

2.1 While there is no specific legislation in Ireland that directly regulates Video Enabled Care (VEC), several existing laws and guidelines must be considered when implementing VEC services. Healthcare professionals and organisations must adhere to these regulations to ensure patient safety, privacy, and high-quality care.

Below is a summary of the relevant legislation and guidelines that pertain to VEC in Ireland:

2.2 Medical Council's Guide to Professional Conduct and Ethics: Although not a legislation, the guide provides a framework for telemedicine services in Ireland. It requires healthcare providers to:

2.2.1 Implement robust security measures to protect patient information.

2.3 Obtain patient consent for telemedicine consultations and any treatments provided.

2.3.1 Ensure that information policies are transparent and accessible to users.

2.3.2 Confirm that telemedicine services are safe and suitable for patients.

2.3.3 Ensure compliance with data protection principles when transferring patient information across jurisdictions.

2.4 Health Act (2007) and its amendments: This act establishes the structure of the Irish national health system, including the Health Service Executive (HSE). The Health Information and Quality Authority (HIQA) serves as the accrediting and regulatory body for public hospitals, implementing quality assurance programs.

2.5 Professional Regulations: The following acts regulate the conduct and registration of various healthcare professionals:

2.5.1 Medical Practitioners Act (2007)

2.5.2 Nurses and Midwives Act (2011)

2.5.3 Pharmacy Act (2007)

2.5.4 Health and Social Care Professionals Act (2005)

2.6 Device Regulations: Medical devices used in VEC must comply with the following regulations:

2.6.1 European Product Safety Regulations (2004)

2.6.2 Consumer Protection Act (2007)

2.7 Data Protection: VEC services must adhere to data protection laws, including:

2.7.1 Data Protection Act (1988-2018): HSE (2019) Data Protection Policy

2.7.2 HSE National IT Policies and Standards

2.7.3 National HSE Consent Policy (HSE, 2020)

2.8 Before initiating VEC services, it is crucial for healthcare providers to assess the primary considerations outlined in these regulations and guidelines. This will ensure that VEC services are delivered in a safe, effective, and compliant manner, enhancing the patient experience and improving overall healthcare outcomes.

3.0 Clinical Governance and additional Guidance Documents (All documents updated in line with normal procedure)

Each clinician must also be familiar with the following prior to commencing Video Enabled Care consultations:

3.1 Governance, implementation toolkit and templates
3.2 Digital health Procedures and Guidelines
3.3 Professional indemnity statement from your relevant regulatory body
3.4 Guidance or instructions from the platform vendor
3.5 Health Service Executive (2014) Information Technology Acceptable Use Policy
3.6 Virtual Outpatient Consultations should be aligned to the SCA Risk Advisory Notice Providing Telehealth: Virtual Sessions
3.7 Implementing VEC into a service is a change management project - Change Guide Resources
3.8 Useful tools to support the project - Quality Improvement toolkit
3.9 Creating awareness with posters, brochures and leaflets VEC Resources & Documents
3.10 A guide to implementing and embedding VEC in your service - VEC Implementation Framework
3.11 Engaging with necessary stakeholders - Consider doing a stakeholder map
3.12 Supporting patients using VEC - **Information about Online Health Appointments**

4.0 Requirements for the use of Video Enabled Care platforms for Clinicians

4.1 Approval from the relevant professional line/service manager.
4.2 A licence and log in details for each clinician using a video enabled care platform.
4.3 For access to some video platforms the Clinician will need a managed email account e.g @hse.ie.
4.4 Access to an HSE approved device with secure internet connection and a platform appropriate to clinical needs. If there are connection issues, contact the local digital Health team or local ICT team for support.
4.5 Recent versions of Chrome or Safari Web browser or Edge Web Browser.
4.6 Headset or speakers and web camera if working with a desktop; cameras are usually built into laptops.
4.7 Extra hardware may be required in accordance with the type of interaction necessary - Equipment Catalogue.
4.8 If working from home, compliance with all guidance relating to remote working and data protection must be adhered to as per HSE remote working policy
    3.8.1 HSE Policy on Public Health Employees working from Home during COVID 19
    3.8.2 Protecting Personal Data When Working Remotely
4.9 Appropriate training must be undertaken by all clinicians prior to initiating video enabled care consultations - Guidance for Clinicans using VEC
4.10 If you are considering a different platform, consider one that addresses the patient and service need as best as possible e.g. patients with hearing difficulties or with dexterity due to coordination problems or arthritis.

5.0 Training

5.1 Some platform vendors provide training, the level of training varies with each vendor. Clinicians should undertake user training appropriate to the platform(s) they intend to use prior to initiating a video call with a patient. Training is essential - Platform training contacts

5.2 Clinician should take time to practice and familiarise themselves with the platform and supporting technology prior to undertaking a clinical consultation. This is vital as identified nationally from services who have implemented T/VEC within their service.

5.3 Run a test call with the patient at the start of their VEC journey, invest time which maybe worthwhile.

5.4 Clinician should complete the mandatory training programmes, cyber security, and GDPR training on HSEland. Other suggested telehealth training - Telehealth courses

6.0 Clinical Setting Requirements

6.1 The clinician should ensure that visual and audio information in the room background is limited and does not breach data governance guidelines or display personal material.

6.2 The clinic should run as per normal clinic management with clinicians having access to the patient referral, healthcare record and relevant results.

6.3 It is also good practice to begin by establishing who may be present in the patient's home, in the room where the consultation is taking place such as; a relative/carer/advocate/partner to allow them to introduce themselves and clarify the purpose of the consultation with them, if appropriate. They may be added to the video call if requested by the patient.

6.4 Clinicians should ask the patient where they are (they may not be in the address on their file)and advise on moving to a private location, if required.

6.5 The clinician should identify tools that they may use in the consultation, for example questionnaires, forms for completion, home monitoring devices and processes.

6.6 The clinician should inform the patient that the call will not be recorded without their permission/consent and they should not record either without the clinicans permission/consent. If recorded written consent will be required.

6.7 The methodology used to contact the patient should be noted (T/VEC) and where possible is recorded on the organisation's patient management system and the patients' healthcare record.

6.8 The consultation outcome should be recorded in writing and be retained in the patient's healthcare record in line with current process.

6.9 Normal clinic follow-up should occur e.g. letter to GP, booking forms for next visit, relevant ordering of tests.

7.0 Technical Requirements for Establishment of Video Enabled Care consultation for patients

7.1 A good connection to the internet- wired broadband or WiFi are the preferred options. Mobile data can be used but there is a cost with this.
7.2 A private, well-lit area where the patient will not be disturbed during the consultation.
7.3 Recent version of Chrome web browser on a desktop, laptop, android tablet , smartphone or Safari web browser on an Apple iMac, Macbook, iPad or iPhone.
7.4 Web-camera, speakers and microphone (may already be built into laptop or mobile devices).
7.5 Information on how to utilise the Video Enabled Care platform should be sent to the patient prior to the appointment time.
7.6 An ability to use the platform or a nominated person to assist where the patient is not technically competent. Attendance of a family member/helper must comply with the consent of the patient.
7.7 Consider setting up a process to check if the patient can use the platform.
7.8 Preparing for your online appointment

8.0 Consent - HSE National Consent policy

8.1 Informed consent should be sought before each consultation begins.
8.2 By logging into the system implicit consent is inferred.
8.3 The clinician should repeat the request for consent outlining that the link is secure, that the conversation will not be recorded, and that it carries the same rules of confidentiality as all clinical consultations.
8.4 The patient should be aware that they can withdraw from the process at any time.
8.5 For patients logging in with assistance, verbal consent must be obtained at the start of the video appointment to ensure they are happy to proceed.
8.6 Verbal consent should be documented, together with all patient communication and clinical notes relating to the video appointment, in the patients records (as is be done for face to face appointments).
8.7 **I**f the call is been recorded written permission/consent will be required.
8.8 The clinician should identify who is present in the room with them prior to proceeding with the call and ensure that their presence is appropriate, and seek consent from the patient for their presence.

9.0 Procedure

9.1 Establish a suitable cohort of patients for T/VEC. Please see **Appendix 1**: Example of Inclusion & Exclusion criteria for pulmonary rehabilitation clinic.

9.2 Suitable Patients:

Each patient must be reviewed on a case by case basis. The decision to offer a T/VECover face to face consultation is based upon the following assurances:

- 9.2.1 The patient is clinically suitable
- 9.2.2 The patient is deemed competent to consent verbally to this form of consultation and have consented to it.
- 9.2.3 The patient has access to a device with web-camera, speakers and microphone, which is required to undertake video consultation.
- 9.2.4 Based on clinical judgement, the patient who the clinician (with or without MDT colleagues, as appropriate) deems likely to benefit and is suitable for T/VEC consultation.
- 9.2.5 The patient's preference, consider religious beliefs and practices.
- 9.2.6 Clinician familiarity with and access to suitable space and technology.
- 9.2.7 Patient or family member familiarity with and access to suitable technology and space required to undertake video consultation, with the correct browsers needed for the platforms.
- 9.2.8 Patient must meet inclusion criteria, and not have exclusion criteria as per **Table 1** below.
- 9.2.9 There is evidence of patient understanding that the consultation may be refused and an face to face consultation arranged if this is their preference.
- 9.2.10 Appropriateness of T/VEC consultation for clinician to assess, diagnose or treat where these are required.
- 9.2.11 Intention to maintain a low threshold for transfer to face to face consultation should the need arise.

Table 1: Example of Inclusion and Exclusion Criteria for Telehealth

Inclusion criteria

A. Clinically suitable

B. Patient Consent – agrees to participate

C. Patient and/ or nominated person comfortable with and have access to the necessary technology

D. Patient access to suitable space for video consultation

Exclusion Criteria- (Clinician deems the patient not suitable)

A. Not clinically suitable e.g.
   - I. Assessing patients with potentially serious, high-risk conditions likely to need a physical examination
   - II. When an internal examination (e.g. gynaecological, rectal) cannot be deferred
   - III. Co-morbidities affecting the patient's ability to use the technology (e.g. confusion), or serious anxieties about the technology (though note that relatives may be able to help)

B. Patient preference, does not wish to participate

C. Patient or nominated person is not comfortable with or have access to the necessary technology

D. Any condition which makes remote communication difficult e.g. Mental impairment, or any condition,

E. Some deaf and hard-of-hearing patients may find T/VEC difficult, but if they can lip read and/or use the chat function, this medium may increase accessibility

10.0 Prior to undertaking consultation

10.1 All relevant training is completed as per **section 4.0 Training.**

10.2 If the patient is deemed suitable for T/VEC consultation, this should be arranged.

10.3 Patients who choose not to use a VEC consultation should be offered the alternative of a telephone consultation (if appropriate for the care required) and an appointment time will be scheduled for this.

10.4 Face to face appointments should continue to be scheduled as far as possible where a T/VEC appointment is unacceptable.

10.5 The clinician or administrative staff will initially contact the patient to explain the rationale for T/VEC consultation. They will assess the patients willingness to use this method of consultation and assess for potential additional risks to the patient associated with video consultation as an alternative to face to face consultation.

10.6 If the patient consents to proceed with the T/VEC consultation, a suitable appointment date and time will be arranged with the patient and recorded as per the normal process. This will also be documented in the patient's record. Information specific to the platform should be sent to the patient about video call. (See **Section 7.0 Consent**)

10.7 The Clinician will inform the patient, that video calls are secure and privacy is protected. This should be specified / made explicit on the appointment correspondence also. If the patient is invited to a group rehabilitation session, then they must be informed and agree to this.

10.8 **Contingency Planning**. An alternative should be agreed with the patient before consultation begins so that the patient is not left in a vulnerable position should connectivity fail.The Clinician, should confirm the patient's phone number and provide the patient with a phone number in the event that technical issues arise at the time of the video consultation. If persistent technical issues, the consultation may be required to continue by telephone or face to face.

10.9 Information will be provided to the patient prior to the VEC appointment with instructions around the platform (See **Appendix 3**).

10.10 The URL link, the patient information leaflet and an appointment will be forwarded to the patient. The URL link will be specific to each clinic.

10.11 If an interpreter is required for the video consultation they can be invited by the Clinician (or admin support) who has the option to add 'Extra participants', who will also then be sent an invite to the Video Consultation. The interpreter must be familiar with video platform and HSE GDPR policies and be from a recognised HSE interpreter service, for example, Access Translators. Patient's consent for an interpreter to be present is obtained in the same way as it is obtained with face to face consultations.The patient will be informed that the video call will use similar data to Zoom or WhatsApp. Clinican to suggest that they use wired broadband or WiFi (preferred options) or mobile data. While the video call is free, it will incur standard costs for internet use/mobile data.

10.12 Patient records and diagnostic should be reviewed prior to the T/VEC consultation occurring.

11.0 Procedure for undertaking Telephone/ Video Enabled Care

11.1 With the patients preference in mind the clinician will determine if the patient is suitable for T/VEC. Please see Figure 1 for Telehealth clinical workflow process, see below.

Figure 1: Telehealth Clinical Workflow Process

Please see **Appendix 2:** Example of Blended Pulmonary Rehabilitation Programme Workflow

Procedural Steps

Preparation

1. Contact the patient to clearly explain T/VEC.
2. Confirm patient's understanding.
3. Confirm suitability for and consent to engage in T/VEC.
4. Inform patient of hardware and software requirements necessary to engage in T/VEC.
5. Confirm understanding.
6. Obtain patient telephone number for delivery of invitation and against the possibility of connectivity failure during consultation.
7. Forward appointment and URL link for appointment with information specific to the video consultation platform to be used. If an interpreter is required they will be invited to join the call once the clinician has joined.

Consultation

1. At consultation time the patient is requested to proceed to URL link provided.
2. *On certain platforms, patients are requested to enter their name, date of birth and telephone number. The client will then enter the waiting or consultation room.*
3. Clinician then logs in to the consultation link, clearly identifies that the correct patient/client is present and confirms consent for T/VEC.
4. At the start of each video consultation the clinician completes the Consultation Checklist (See Appendix I) which is filed in the patient's record upon completion of the video consultation.
5. At the end of the consultation the clinician summarises key points and asks the client if they have any questions. Findings from the consultation will be documented in the patient's record.
6. Further appointments scheduled if appropriate, T/VEC or face to face as appropriate.
7. To end, disconnect from the call and close web page. Ensure log out of virtual platform is completed.

12.0 **Procedure for undertaking Telephone/ Video Enabled Care**

12.1 The T/VEC consultation checklist must be completed at the beginning of each telephone/VEC consultation **(Appendix 4)** with all patients. The checklist should be filed in the patient's healthcare record.

12.2 To end the call, the clinician will allow the patient to say goodbye first to avoid misunderstanding and then disconnect from the call and ensure the web page is closed. The clinician must ensure s/he is logged out of the consultation. The patient can end the call at any stage by clicking end/leave on the screen.

12.3 No personal information should be stored by the video platform after completion of the video consultation.

12.4 HSE services are required to ensure that the video enabled care platform they use is DPIA assessed in line with their organisational policies.

12.5 For further information on telephone consultations; click hyperlink

13.0 Management Procedure for Non-Attendance

13.1 If a patient does not attend (DNA) a scheduled appointment, the patient will be managed as per the local DNA policy.

13.2 Patients who cannot attend (CNA) their appointments a decision to rearrange an appointment with the patient must be made by the clinician as per local policy.

14.0 Safeguarding

14.1 T/VEC may add a dimension of insight into the patient's place of residence that is usually absent during face to face meetings at clinics. Before all consultations notes should be checked to see if there are any safeguarding flags or alerts recorded as a file may be updated by another member of staff.

14.2 In the event that an adverse event such as an accident or dangerous or abusive behaviour occurs in the home or environment of the person with whom a video consultation is in progress, immediate action should be undertaken to ensure the safety of the individual. This may require an emergency call to the Gardaí or other emergency services. The clinician should report the event through the proper agencies or authorities to ensure the on-going safety of the patient or member of the household. The link below provides guidance on management of domestic abuse. https://www.tusla.ie/uploads/content/Domestic_Practice_Guide_on_DSG_bassed_violence.pdf

15.0 Risk Management

15.1 Management of clinical risk is the responsibility of each clinician. Low confidence in a patients capacity or ability to understand risks and make informed choices may underpin alternative clinical recommendations or decisions. All discussions, risks and decisions should be well documented.

Part B: Stages of Developmental Cycle:

1.0 Initiation

1.1 Purpose: to offer guidance to clinicians using T/VEC for patient consultation, assessment and clinical intervention.

1.2 Scope: This procedure applies to all HSE and HSE funded clinical staff using or intending to use T/VEC for the purpose of consultation, assessment or intervention in health care

1.3 Objectives: to provide guidance on the responsibilities of clinicians to their patients when undertaking health care through a telehealth medium

1.4 Outcomes: The expected outcome is a standardised approach to T/VEC with the objective of providing patients and clients with an equal level of best, evidence based, professional clinical care to that provided in face to face consultation

1.5 PPPG Development Group: See appendix 10 for contact details of the Guideline Development Group)

1.6 PPPG Governance Group: The National Telehealth Steering Group

1.7 Supporting Evidence: See links to supporting documentation as required throughout the document. See References

1.8 Glossary of Terms T/VEC: Telephone or Video Enabled Care (referring to clinical interactions comprising assessment, remote monitoring, interventions and evaluations of patients' clinical condition)

2.0 Development of PPPG

2.1 Question: What constitutes best practice for safeguarding best, evidence based, professional clinical care in the modification of the mode of health care delivery from face to face delivery to T/VEC delivery?

2.2 Literature Search Strategy: Extensive search of international literature for national and international policies, procedures and guidelines.

2.3 Method of Appraising Evidence: Review of the available international literature followed by consultation with Nursing and Midwifery Telehealth Advisory Group and subsequently, multidisciplinary healthcare professionals through the National Telehealth Steering Group

2.4 Process Used to Formulate Recommendations:

2.4.1 Collated evidence from systematic review of policies

2.4.2 Collated evidence from national health care professional and patient / client survey on their experiences of T/VEC (November / December 2020)

3.0 Summary of Evidence from Literature

Telehealth Policy Literature Review

Introduction

The following is an overview of the results of an extensive review of international Telehealth policies and procedures. The full review is available at the following link.

Telehealth is an opportunity to integrate health and social care services (Agency for Clinical Innovation NSW Australia 2019), deploy the healthcare system to the patient and free acute care facilities to provide timely access to mental health treatment (Henriksen 2018), prevent ill health and initiate self-management in patients with chronic diseases (Henriksen 2018) and protect vulnerable patients as well as managing medical certs and prescriptions; mental health consultation/counselling and routine chronic disease check-ups (The Royal Australian College of General Practitioners 2020).

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) include all aspects of nursing care and remaining aware of the limitations of telehealth and their scope of practice 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. The New Zealand Psychologists Board (2012) caution adherence to

ethical principles (e.g., working with children, documentation, 3rd party presence) and advocate adequate assessment before offering teleconsultations so that healthcare delivery matches the patient's/client's requirements. Patients should 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). 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)

Process/Guidance

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

- 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) includes the need to consult with HCPs and patients in the setting up process and Lane and Clarke (2021) include education of both clinicians and service users and improvement of computer systems and internet connectivity. Preparation should be in partnership with the patient/client and after implementation, the process should be evaluated (American Medical Association 2020)

- The choice of technology and platforms used and the organisation of technical necessities such as remote monitoring devices, screens and cameras is important (The Allied health Professionals New Zealand 2020).

- 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, safeguarding and chaperone policies say the Royal College of General Practitioners (2020) who caution that children should themselves be seen if they are the subjects of consultations.

- Verification of the patient's contact details in case of unanticipated disconnection and a low threshold for transfer to in-person consultation maintaining awareness of the patient comfort, sensitivities and vulnerabilities in general are advised by Car et al. (2020).

- Documentation is important for traceability (Bensemmane, and Baeten 2019) including documentation of clinical information, attendance, consent and technical issues after consultation. 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. Documentation of the consultation

should be in accordance with regulatory body codes and with standards and guidelines (Allied health Professionals Australia 2020).

- Risk management and professional indemnity are also addressed and The New Zealand Psychologists Board (2012) advise risk assessment, risk mitigation and planning for crises management around TH. Clinical indemnity for the clinician is also advised (Occupational Therapy Australia 2020; Allied health Professionals Australia, 2020; NSW Australia, Agency for Clinical Innovation 2019).

- Continuity of care (Nurse Executives of New Zealand Inc. 2015) and maintaining cultural sensitivity and responsiveness (NSW Australia, Agency for Clinical Innovation 2019) are important considerations.

- 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). Telecom provider polices 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).

- 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)

- Adherence to professional codes of conduct, consideration of responsibility during referrals and licencing for use of TH outside of the clinician's usual jurisdiction are important. 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 clinicians' code of practice takes precedence along with the usual standards of competence.

- 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.

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.

4.0 Summary of recommendations from the First National Evaluation of the Use VEC in Ireland

(Lane & Clarke 2021)

4.1 Key recommendations developed from this evaluation include:

4.1.1 Co-design and implement a medium term strategy for telehealth informed by evaluation findings and a robust evidence base.

4.1.2 Develop national policy to support safe, appropriate use of telehealth

4.1.3 Develop digital infrastructure and functionality to ensure timely, reliable and equitable access to healthcare for health service users and providers

4.1.4 Strengthen digital capacity amongst health service users and providers

5.0 Resources Necessary for the Implementation of the Procedure: Communication resources to enable efficient and equitable distribution of guideline to all appropriate HSE staff

6.0 Outline of Procedure recommendations:

6.1 The recommendations are fully discussed in Part B of this document. Key issues are:

- 6.1.1 Patient/client consent for the use of T/VEC as a substitute for face to face care
- 6.1.2 Preparation of the patient/client for engagement with care provided through a digital or telephone medium
- 6.1.3 Assessment of patient/clients' understanding of T/VEC and remote monitoring
- 6.1.4 Hardware and software requirements for the successful use of T/VEC
- 6.1.5 Appropriate settings for the safe and effective use of T/VEC
- 6.1.6 Appropriate actions in the event of VEC failure
- 6.1.7 Appropriate actions in the care of adverse events
- 6.1.8 Preparation of workflow and engagement in training for T/VEC

7.0 Governance and Approval

7.1 Formal Governance Arrangements

- 7.1.1 Telehealth Steering Group Review
- 7.1.2 Individual Health and Social Care Disciplines consultation
- 7.1.3 Telehealth Steering Group Approval

7.1.4 Biennial audit and review

7.1.5 Regional and Local governance in line with governance of clinical care

7.2 Methods of Assessing Adherence to PPPG Framework Development:

7.2.1 Telehealth Steering Group Review

7.3 Copyright: N/A

7.4 PPPG Checklist: See Page 50 in the link below

7.4.1 https://www.hse.ie/eng/about/who/qid/use-of-improvement-methods/nationalframeworkdevelopingpolicies/hse-national-framework-for-developing-policies-procedures-protocols-and-guidelines-pppgs-2016.pdf

8.0 Communication and Dissemination Plan:

8.1 From Telehealth Steering group via representatives of all health and social care profession through national, regional and local leads and via targeted groups known to be engaged in this form of health care

9.0 Implementation Plan:

9.1 Each health professional will be responsible for the implementation of these guidelines within their clinical practice. Governance will be incorporated into usual governance of clinical care. T/VEC is a variation of the medium through which to deliver the same standard of evidenced based health care as that delivered with evidence based face to face healthcare.

10.0 Monitoring, Audit and Evaluation

10.1 These governance strategies are the same for T/VEC as they are for face to face health care and are monitored, audited and evaluated under the same structures

11.0 Revision / Update:

11.1 Update Procedure: This will be initiated by the Telehealth Steering Committee after 2 years unless otherwise indicated and carried out by the person or group designated by the committee.

11.2 Method of Amendment: A systematic review of international telehealth procedure will be undertaken and the procedure amended in accordance with best evidence either biennially or when new evidence emerges.

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Appendices

Appendix 1: Example of Inclusion & Exclusion criteria for pulmonary rehabilitation clinic

➢ **Eligibility criteria**

The target client group for pulmonary rehabilitation is adults (over 18 years old) with a chronic lung condition such as COPD or asthma, who meet the inclusion and exclusion criteria (NCP Respiratory, 2020; British Thoracic Society PR Guidelines, 2013).

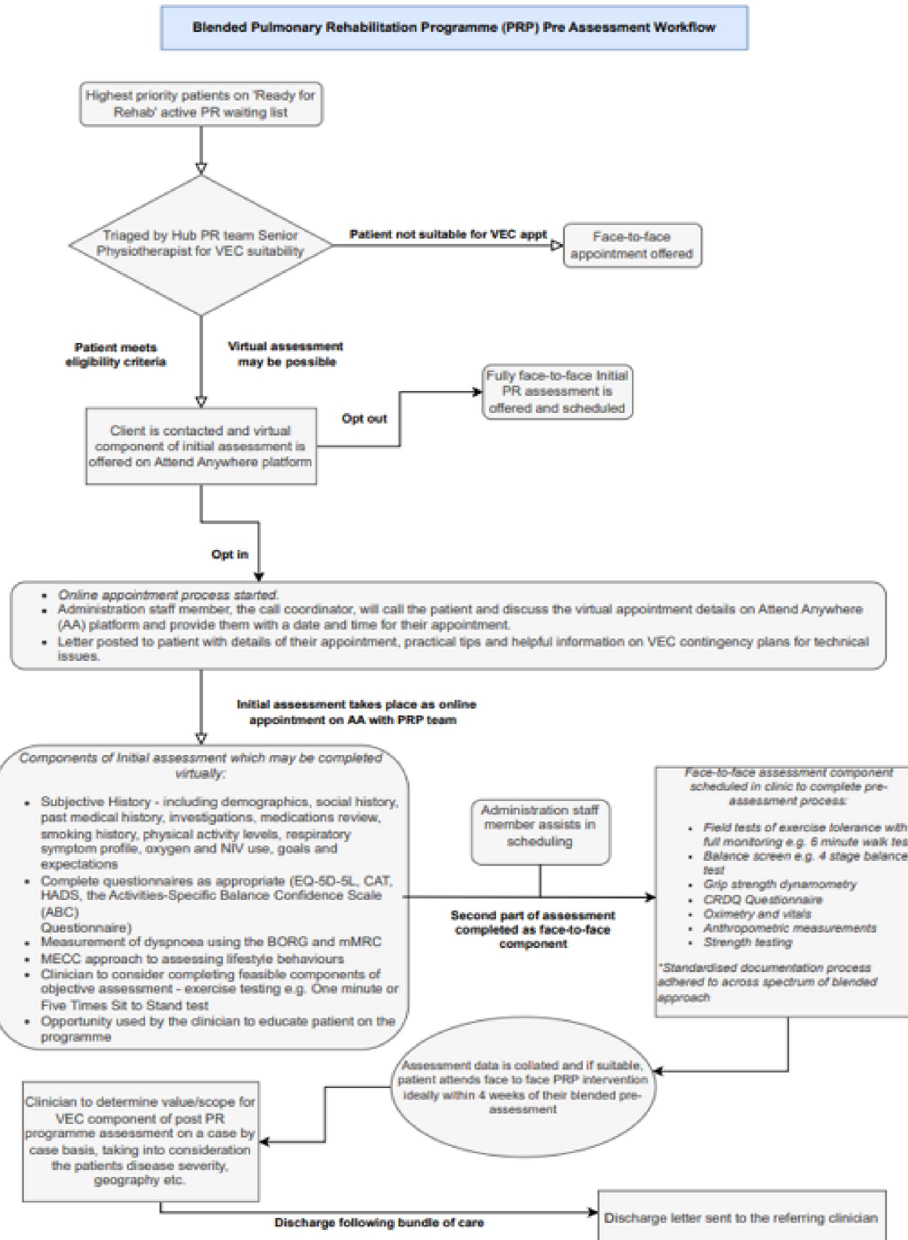
All patients who have who have access to the required patient resources

(• access to an I.T. device- smart phone, tablet or laptop • internet access • an email address) and meet the F2F programme inclusion and exclusion criteria will be offered a blended initial assessment opportunity.

Inclusion	Exclusion
• Confirmed diagnosis of chronic respiratory disease by spirometry • Functionally limited by dyspnoea despite optimal management (mMRC ≥2) • Motivated to participate and change lifestyle • Ability to exercise independently and safely • Email/IT access and phone access	• Evidence of unstable asthma • Evidence of unstable ischaemic heart disease • Evidence of decompensated/unstable heart failure • Evidence of severe or uncontrolled systemic arterial hypertension (systolic blood pressure>200mmHg +/- diastolic blood pressure> 100mmHg) • Recent cardiac event (myocardial infarction during the last 6/52) • Resting heart rate of more than 120 beats per minute after 10 minutes rest. • Significant orthopaedic, psychological or neurological conditions that reduce

	mobility or cooperation with physical training. • Suspected underlying malignancy • New COVID-19 symptoms • If patients who meet the eligibility criteria and have had a hospital admission for COVID 19 please consult with patients Consultant or GP • Cognitive Impairment (MMSE < 7) • Evidence of other disabling diseases that could preventing safe performance of PR. • Active pulmonary Tuberculosis/other infection spreadable by airborne/droplet transmission. • Resting pulse oximetry (SpO2) < 88% on room air or when breathing on prescribed level of supplemental oxygen.

Appendix 2: Example of Blended Pulmonary Rehabilitation Programme Workflow



Appendix 3: Online Health Appointments Information Leaflet Template - Click hyperlink

Include Logo

Online Health Appointments Information Leaflet

What is an online health appointment?

An online appointment allows you to talk to your healthcare professional using video technology on the internet from a computer, tablet or smartphone

Online appointments are offered, if suitable, by many hospital and community services in the HSE

This type of appointment might not be suitable for certain conditions or patients. (For example, if your healthcare professional needs to listen to your breathing or look in your ears)

Benefits/Risks

Benefits

- improves access
- less travel
- less cost
- more convenient than face to face
- Family members can join the call even if they are in a different location

Risks

- video quality may not be sufficient
- video may not provide a comprehensive assessment

Your privacy

- online appointments are safe and secure
- informed consent must be given before the call
- the call will not be recorded without your permission

Practical tips to help with your call

- Use a fully charged device
- Choose a brightly lit part of the room
- Make eye contact
- Speak in your normal voice

Helpful information

- If you have technical issues during your online appointment, your healthcare professional will understand and support you
- At the start of your online appointment, your healthcare professional will ask you if you are happy to proceed with the online call
- You may request a phone call or face-to-face appointment at any time

If you do not understand how an online appointment will work for you after talking to your healthcare professional and reading this leaflet, please talk to your healthcare professional again for more information

www2.hse.ie/services/online-health

Appendix 4: Telephone/ Video Enabled Care Consultation Checklist

Telephone or Video Enabled Care Consultation Checklist

Work Location ___________________ Date & Time of scheduled Call: _______________

Clinician Signature ___________________ Purpose of Video Consultation: _______________

Initial Consultation Yes ☐ No ☐ Follow up Review Yes ☐ No ☐

Is the patient/client known to the clinician undertaking the video consultation Yes ☐ No ☐

____

Patient/client's Name: ____________________ Date of Birth: __________________________

Address: ____________________ Phone Number: ________________________

Name of Parent / Guardian if patient/client is under the age of 16 : _____________________________________

Prior to commencing the video consultation, the clinician should complete the table below

▪

Task	Yes	No	Comments
Introduce yourself & inform patient/client they are in a private room where confidentiality will be maintained at all times			
Confirm patient/clients identity by confirming their name, address, date of birth.			
Confirm patient/client's phone number which may be used to continue the consultation in the event of technical difficulties			
Inform Patient/client that, for children under 16 years of age, a parent or legal guardian must be present at all times during video consultations.			
Inform the patient/client the call will not be recorded and they or anyone present during the consultation are not permitted to record the video consultation			
Confirm with the patient/client who is present in the room during the consultation and request permission if another healthcare professional is present			
Inform the patient/client the consultation will be documented in the patient/clients record which will be stored securely within the health care facility.			
Inform the patient/client they may withdraw from the process at any stage			
Obtain verbal consent to proceed with the consultation and record verbal consent received in the patient/client's record. Implicit consent is inferred by the patient logging onto the system however verbal consent must be obtained at the start of the video consultation and documented as per HSE (2019) National Consent Policy in the patient's record.			
Before completion of the T/VEC consultation, determine whether there is a requirement for either T/VEC face to face consultation and arrange accordingly			
Document the content and duration of the T/VEC within the patient healthcare record. At the end of the consultation the Clinician should summarise key points of the consultation to ensure nothing was missed due to technical interference and will ask the patient if they have any questions.	Hours : ________ Minutes : _________		

This checklist must be filed in the patient/client record upon completion of the video consultation

Appendix 5: Checklist for Implementing Video-Enabled Consultations - HSCP Telehealth Toolkit

For each healthcare area/specialty the following elements will need to be considered as part of implementation:

▯ Approval for telehealth has been agreed with the clinical service
▯ You have a process in place to identify suitable patients/patients
▯ You have considered how to record patient/patient consent
▯ You have considered how to communicate the process to your patient/patient in a way that they will understand
▯ You have identified a process to schedule the patients/patients for telehealth appointments
▯ You can ensure that all patient/patient activity and outcomes are captured and appropriately recorded
▯ The process is aligned to local clinical and information governance policies
▯ Provision has been made for staff to be appropriately trained in the use of Telehealth
You have considered the location(s) where Video-enabled clinics will take place, taking into consideration: • A private, well-lit area where you will not be disturbed during the consultation • Ensure background of the video call is appropriate, no visibility of sensitive information e.g. whiteboard with personal data, X-rays, personal items etc. • You have the appropriate hardware in place to deliver video-enabled care

Appendix 6: Audit tool template.

Audit Questions	Yes	No	N/A
Was there documented evidence in the patient's record that the consultation was delivered via video consultation?			
Was the Video Consultation Checklist completed and filed in the patient's record?			
Was the patient's identity confirmed prior to commencing with the video consultation?			
Was verbal consent recorded within the patient's record?			
Was the patient provided with a survey to complete following receipt of video consultation?			

Appendix 7: Patient Satisfaction Survey template

Patient Satisfaction Survey VEC			
What device did you use to join the video call	**Smartphone** **Tablet** **Laptop**		
	Yes	**No**	**Comments**
1. Were you asked for consent for Consult?			
2. Do you feel your needs were addressed?			
3. Did you know what to do in case of loss of connection?			
4. Did you experience technical difficulties			
5. Were you and/or family member aware of what to do in case of an emergency?			
6. Were you satisfied with instructions given on how to join the Consult?			
7. As an alternate way of meeting your clinician, were you satisfied with this interaction?			
8. Could you hear your clinician clearly			
9. Could you see your clinician clearly			
10. Any other comments			

Appendix 8: VEC Benefits

Video appointments are comparable to face-to-face appointments in delivering safe, secure person centered care. They can offer patient/service user the convenience of an appointment in a setting similar to their home, with a virtual interaction, building rapport and permitting healthcare professionals to see and assess visual cues that cannot be assessed with a phone consultation. These elements are all vital components in provision of quality healthcare.

Some identified benefits for the service user:

- Improved accessibility
- More choice
- Reduces transport or travel difficulties
- Less time waste, travel and carbon footprint
- Less cost
- Reduces time off work, school and other responsibilities
- Reduces further burdening to physical or mental health issues i.e. less exposure to infection risk, excessive travel, pain exacerbation

Some identified benefits for healthcare providers:

- Saves time and travel attending clinics at different sites
- Allows healthcare professionals to link up with other professionals and run multidisciplinary meetings and appointments
- Enables health care professionals to work from their own home when needed, improving work-life balance

Some identified benefits for the Organisation

- Creates Virtual Capacity
- Aids Integrated Care
- Less Hospital Admissions

Appendix 9: Signature Sheet

I have read, understand and agree to adhere to this Procedure:

Print Name	Signature	Area of Work	Date

Appendix 10: Guideline Development Group

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