THE CARE PATHWAY

A walk through the care pathway for Vanguards Recovery at Home and Admission Avoidance shows how patient safety and experience remain a priority throughout.

Recovery at Home Service *Step down:* early supported discharge/transfer out of hospital

Step down

Patient cared for in hospital

- Whether a long-term condition, elective or an acute emergency, the patient is admitted to hospital and follows the usual care pathway.

Identify patient

- Patient is identified by acute hospital clinicians and by vanguards on-site transfer co-ordinator as suitable for homecare.

Admission Avoidance Service *Step up:* clinical support at home for patients referred onto service by GP

Step up

Patient cared for at home

- A patient with a long-term and/or ambulatory care sensitive condition is at home.

Identify patient

- Patient can self - refer or we can accepted referred to virtual ward by GP, out-of-hours services, ambulance, advanced nurse practitioner/ community matron, clinical specialist or emergency department team.

Assessments conducted

- A comprehensive assessment is conducted to ensure the patient meets the agreed referral criteria and can be safely cared for by the service.

Care plan agreed

- In consultation with the patient or the referring clinician and the virtual ward co-ordinator and a care plan is agreed.
- Consent is granted from the consultant or GP and the patient.

Treatment

- The multi-disciplinary team delivers the agreed care plan in the patient's home.
- The electronic patient record is updated after each treatment or intervention.

Monitoring

- Notes are shared with the referring clinician or organisation so that the clinical team can monitor their patients.

Completion of treatment and discharge

- When the patient completes their care plan and achieves their goals they are discharged from the service.

Video + Telephone based HealthCare Bureau available 24/7

- The HealthCare Bureau co-ordinates care, provides clinical triage and directly supports patients and local clinicians to safely manage patients in their own homes.
- It is staffed by qualified nurses and supported by a triaging tool, and can offer reassurance, initiate extra help or extra visits, signpost patients to out-of-hours services or in rare cases initiate transfers back to the referring centre.

Discharge planning in place

- All patients have an expected discharge date, which is agreed when they transfer onto a virtual ward. As this date approaches, discharge planning is finalised.
- This involves communication and co-ordination with social services, community health teams and carers where necessary.

Patient satisfaction

- Patients are sent a satisfaction survey on discharge so that experiences can be monitored and the service can learn and improve.

CLINICAL SERVICES

As technology, clinical knowledge and practice have evolved, so hospital length of stay has reduced. Clinical homecare can, enhancing the overall patient experience. Many treatments and care that can safely be carried out at home include:

- Day stay treatment for haematology, medical, oncology/cancer, neurology and surgical conditions
- Outpatient clinics, e.g. Follow-up clinics for drain/tube removals, TWOC clinics, hyperemesis, anticoagulation, bronchiectasis, physiotherapy, dietetic support, and specific conditions that require ongoing monitoring and review
- Assessment units for cancer, frail elderly and surgery can transfer patients' home for treatment following diagnosis
- IV and subcutaneous medication and therapy, monitoring and review
- Physiotherapy and occupational therapy, rehabilitation
- Complex wound care
- Drain and catheter care
- Anti-coagulation management
- Collections of specimens
- Pre and post-procedural care and discharge to assess pathways

Adherence and persistence

Pharmacists are well placed to work with patients with long-term and ambulatory care and will help us to ensure that medication plans are being adhered to. As well as the pharmacists, the nurse teams who deliver injection advice and visit patients' homes can help flag when an intervention is needed. This improves treatment concordance and clinical outcomes, for every patient on a Vanguard Pathway.

Medicines Home delivery

Delivering medication on behalf of patients is another way we help patients when receiving clinical care at home. Pharmacists prescribe and dispense the necessary medication, and a dedicated supply chain delivers it directly to the patient's door. This cuts down travel or collection time and reassures patient that the medication is being delivered in a secure and reliable manner.

VIRTUAL WARDS BRINGING THE HOSPITAL HOME

Recovery at Home and Admission Avoidance services allow patients to receive complex clinical care in their home, rather than as inpatients in a hospital. While care is provided at home by a multi-disciplinary team, the patient remains under the clinical responsibility of the hospital / or GP.

HOME

It's where you want to be

VHSI

Operating 24/7

Call: 086 021 7049

Contact: referrals@vanguardhsi.com

WHAT DO WE DO! THE VIRTUAL WARD

We provide a Recovery at Home and Admission Avoidance services to allow patients to receive complex clinical care in their home, rather than as inpatients in a hospital. While care is provided at home by a multi-disciplinary team, the patient remains under the clinically responsible specialist consultant or GP.

What is a virtual ward? It is a service that treats people in their own home or usual place of residence. This typically involves helping people leave hospital earlier or avoid hospital admission in the first place.

A patient's stay on a virtual ward should be time limited as the service provides acute care in patients' homes with care planning and monitoring by either a consultant or GP. Virtual wards support integrated care models by allowing specialist consultants and GPs to retain clinical responsibility for the patient – undertaking their care planning and monitoring – while nurse-led multi-disciplinary teams provide the care. Process and clinical pathways are designed specifically to meet the needs of the patient, while complementing existing models of service delivery.

There are two main streams of services provided under the virtual ward umbrella:

Recovery at Home: Step down

This service provides acute care to patients in their own home, enabling them to leave hospital earlier while remaining under the care of their hospital consultant.

Each specialty has a service designed with the hospital clinical teams to ensure that co-ordination happens throughout the Recovery at Home service. Patients remain under the care of the hospital consultant, who defines an acute care plan ahead of transfer to home and is responsible for monitoring patient progress and adapting the treatment plan as necessary. Monitoring can be done through the review of clinical notes, which are uploaded into hospital EPRs, or in a number of other ways including a virtual ward round, phone calls with the patient and staff, and face-to-face patient reviews in clinics.

Admission Avoidance: Step up

Under this model, patients remain under the care of their registered GP or a specialist consultant. Wherever possible, an assessment is carried out within two hours of referral, and interventions are implemented rapidly to ensure hospital attendance and admission can be avoided.

Referral into the service can come from GPs or out-of-hours GP services as well as ambulance teams, matrons and emergency department consultants if a patient can be assessed, referred and discharged within the four-hour target.

Patients typically supported by Admission Avoidance schemes are those with exacerbations of long-term conditions, people presenting with ambulatory emergency care conditions or people in care homes who may be dehydrated or have low-level infections.

What services do we provide

We provide short term nursing and specialist consultant services. More than 30 clinical pathways have been developed and treatments include: IV and subcutaneous medication and therapy, monitoring and review, physiotherapy and occupational therapy, rehabilitation, complex wound care, drain and catheter care, anti-coagulation management, collections of specimens, pre and post-procedural care and discharge to assess pathways.

EVERYONE CAN CONTACT VANGUARD'S HEALTHCARE BUREAU. CALL US TODAY AND LET US HELP!

T: 086 021 7049
E: referrals@vanguardhsi.com

Supporting both the Recovery at Home and Admission Avoidance services is a single point of access for patients and their care teams. We provide clinical and administrative support 24/7, 365 days a year including triage, care co-ordination and referrals. We provide a direct link and single point of entry for the patients and carers, hospital consultants, GPs, transfer co-ordinators, nurse teams and therapists, and is supported by a single electronic patient record.

Defining features of Vanguards virtual ward

Patients have a personalised agreed care plan before treatment starts

- Before a patient is registered onto a virtual ward, the referring clinical team, the homecare team and the patient agree a full, personalised care plan. This means the patient knows exactly what is going to happen and when.
- The Care Plan assessment is completed when a patient / Career or Clinical Professional call the Healthcare Bureau and can be undertaken virtually by video consultation.

Clinical responsibility is retained by the referring clinician or Vanguards Specialist Consultant

- All patients who are on the virtual ward are still under the clinical supervision of the referring clinician or one of Vanguards Specialist Consultants. Although the care is provided by the homecare team, the virtual review of the patient data and clinical information is by the referring clinical teams.

Patients are supported 24/7 by a dedicated HealthCare Bureau

- The HealthCare Bureau is staffed by qualified nurses and offers round- the-clock telephone support for patients, families and health professionals. It provides care co-ordination as well as clinical triage, emergency advice and the instigation of urgent care and medical advice.
- Once your clinical assessment has been completed, we will give you access to your own medical record. This can include a Smart Pad being delivered to you with some diagnostic tools to help us keep a record of your medical progress.

Care is integrated with social care and local community services

- Patients complete their acute care pathway at home and are discharged to other services as required in their discharge plan. This transition is made as seamless as possible with planning and co-ordination with other local services.

Inclusion Criteria

- Patients are deemed medically fit and suitable for discharge
- Patient is aware of diagnosis and agrees to continuation of treatment at home
- There are no risks to visiting professionals and paitents can be treated safely at home
- All patients are over 18
- Complete their acute care pathway at home and are discharged

IV antibiotics Referrals

- Patients can self-refer and will have a full clinical assessment undertaken by a specialist consultant
- The referring team or Vanguard Specialist Consultant understand and have accepted clinical governance for the client until IV treatment has completed
- When leaving hospital, the patient has had their first dose of IV antibiotics given in the hospital
- Patients are independent or have appropriate support arrangements to stay at home safely
- Patients living conditions are suitable for administration of IV Treatment
- Patients agree complete their acute care pathway at home and are discharged

Inclusion Criteria

- Services as required in their discharge plan. This transition is made as seamless as possible with planning and co-ordination with social care and other local services

VHSI

Call Our HealthCare Bureau on 086 021 7049 and we will ensure you have all of the support you need to help you recover at home.