Health & Social Care Professions: Telehealth Practice Examples in Clinical Services

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Health & Social Care Professions

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Welcome

Telehealth is a key enabler of the clinical change and transformation needed to realise the quadruple aims of Sláintecare; improving patient/client experience, improving clinician experience, lowering costs and achieving better outcomes. COVID-19 has demonstrated that our health system can adapt and change quickly with the acceleration of telehealth service implementation. As the second largest clinical workforce group in Ireland, HSCP should be proud of their response to the challenges faced. The radical changes to practice in such a short period of time are testament to the leadership, teamwork and innovation of this workforce.

As the focus shifts towards sustaining new ways of working, it is time to start documenting the service improvements HSCP have undertaken. Telehealth complements and offers alternatives to traditional healthcare, resulting in clear opportunities for HSCP to adapt their clinical service. This document, *HSCP Telehealth Practice Examples in Clinical Services*, is a collection of practice examples that have emerged from HSCP services in different healthcare settings and has been developed to share experiences in telehealth amongst HSCP.

Going forward, it is important to measure the outcomes and impacts of any changes that are being implemented. To support this process, this document should be used in conjunction with its sister document, *HSCP Telehealth Toolkit*. Whilst *HSCP Telehealth Practice Examples in Clinical Services* describes the lived experience of HSCP introducing telehealth in their workplace, the *HSCP Telehealth Toolkit* provides a framework to guide adoption, implementation and evaluation of telehealth. These documents have been developed specifically to:

1. **Contextualise new ways** of delivering clinical services
2. Assist and support **HSCP to realise telehealth solutions** in order to improve patient/client quality of life and quality of care
3. Share **documentation and a blue print for the use of telehealth solutions** in HSCP services across hospital and community care
4. **Identify and share operational examples and practice changes** which are enabling or improving care.
5. Support an **ecosystem of shared learning**

HSCP Telehealth Practice Examples in Clinical Services has been developed with input from many HSCP in Ireland, across multiple settings and I thank them for sharing their experience to the benefit of colleagues and those who use the health services. We hope this sharing of practice will inspire others to start their digital journey to ensure the opportunities to assist restoration and recovery, presented by digital practice, will not be missed. We would also really welcome your interaction and engagement with this resource as well as its sister document, *HSCP Telehealth Toolkit.* This is only a starting point and we hope to expand this resource as others advance their practice in this area.

Jackie Reed
HSE National HSCP Lead
National HSCP Office

How to Use this Document

The practice examples presented in *HSCP Telehealth Practice Examples in Clinical Services* have been ordered alphabetically by title. The summary of each example provides details of the problem, what improvement initiative was undertaken, how the initiative has been evaluated and learning from the experience. At the end of each practice example, you can find contact information for the lead HSCP. In order to facilitate the search for good practice examples, an annex is provided at the end of this document.

HSCP: Telehealth Practice Examples in Clinical Services

Cochlear Implant Speech and Language Therapy Service

Beaumont Hospital

Understanding the Problem

The National Hearing Implant and Viani Research Centre (NIHVRC) was established in 1995 and since then, almost 800 children with cochlear implants have received services at the centre. We provide a service to children living all over Ireland, with a significant commitment to attend appointments, particularly in the first 5 years post implant. This gives rise to considerable challenges for families, particularly for those living far from the centre and for those children with complex medical or developmental needs. During the COVID-19 pandemic, the parents of a profoundly deaf 14 month old child were very anxious about attending for a consult while there were active COVID-19 cases in the hospital. The Speech and Language Therapist (SLT) and Audiologist established a virtual assessment pathway to manage this child's pre-operative care.

Improvement Initiative

In May 2018, a teleconferencing service was set up using WebEx. Teleconferencing is an effective tool for providing SLT support to children and families attending the NIHVRC. Although teleconferencing is of huge benefit to families living a distance from the NIHVRC, it is not suitable for all families and a clinical judgement needs to be made regarding when to use teleconferencing.

In the context of the pandemic, teleconferencing was used to facilitate a pre-operative joint session for the parents of this 14 month old boy. The SLT and Audiologist were located in two separate rooms in the hospital while the parents used their phone at home for this telehealth consultation. Assessment findings were discussed as well as the recommendation to proceed with bilateral cochlear implantation. The parents' concerns were discussed at length as well as possible outcomes from implantation.

Initial Evaluation

Evaluation of the teleconferencing service has indicated certain benefits and challenges. Benefits include: less travelling, reduced (or no) cost to family, less time off work/school, facilitates joint sessions with visiting teacher for children who are deaf/hard of hearing (VToD) or other local professional, the child is more relaxed in own home, thereby providing a more representative language sample, reduced fatigue, is ideal for children with immunosuppression and is suitable for children with infections but who are 'well'. Challenges include: increased difficulty holding the child's attention (especially for parents), more difficult to gauge responses (especially for early listening work) and variable picture quality during some sessions. Additionally, a small number of families did not have adequate broadband connectivity. Some families declined the offer of WebEx, preferring face to face sessions while others struggled with the technology. During COVID-19, it was found that telehealth provides a safe alternative in pre-operative care to face to face consultation where remote intervention is appropriate.

Lessons Learned

Teleconferencing supplements but does not replace traditional face-to-face SLT sessions. In the case of this 14 month old child, the family was an Urdu speaking family but an interpreter could not be organised remotely. Staff had some proficiency in Urdu which made this consultation possible but interpretation services are an important requirement for some patients. Clinical space is a consideration if more than one team member is required.

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Community Virtual Ward

Beaumont Hospital / CHO 9

Understanding the Problem

Individuals living with respiratory conditions are a group particularly vulnerable to COVID-19. An indirect effect of the COVID-19 pandemic is that some patients who need to attend the Emergency Department avoid it and their condition may deteriorate so far that outcomes are poor or they have an extended Length of Stay in the acute hospital system.

Dr. Clare Lewis (Deputy Chief Nursing Officer at the Department of Health), in collaboration with the HSE's Office of Nursing and Midwifery Services Directorate (ONMSD), identified the need and opportunity to test the viability of using remote patient monitoring with an appropriate communications platform to manage certain patients in the community. Identified patients might otherwise have attended the Emergency Department and possibly been admitted.

Dr. Lewis, in colloaboration with Chief Nurse DoH, Rachel Kenna and supported by the ONMSD, designed a Proof of Concept study. They worked with clinical teams in Beaumont Hospital and in Community Health Care Organisation Area 9 DNCC to implement a Community Virtual Ward for COPD/Asthma patients with a view to early intervention arising from disease exacerbation and to support early recovery as well as Emergency Department and Admission Avoidance.

Improvement Initiative

A Community Virtual Ward was implemented as a proof of concept using PatientMPower platform with Spirometry for COPD/asthma patients. This was a nursing initiative with Clinical Engineering acting in a technical advisory role regarding devices and processes. The initiative involved the Respiratory team – Advanced Nurse Practitioner (ANP), supported by a Respiratory Consultant, Respiratory Nurses, and Community Nurses, GP and Operational leads to develop pathways and programme of care delivery. The Clinical Governance group met weekly or fortnightly as required. Meetings ensured project milestones were met, feedback was provided to PatientMPower and necessary changes were made to their platform, and pathways and processes were documented and finalised.

The PatientMPower platform allows the integration of data from medical devices (e.g. spirometers, thermometers and pulse oximeters) with a patient portal where physiological data can be reviewed. The platform also allows for communications between the community and acute hospital teams.

Initial Evaluation

This proof of concept is pending a final report. However, initial outcomes indicate that from a patient perspective, this was well-received and several hospital admissions were avoided. Furthermore, the integration between the ANP and Community Nursing Team, providing a blended approach with expert specialists from the acute hospital sector and specialist generalists from the community has improved patient outcomes, satisfaction, knowledge and skills with upskilling of nursing staff. A key technical ingredient for success was the ability to share (and edit) patient notes between the acute and community team.

Lessons Learned

Senior support has been an important enabler for this project, both from DOH Deputy Chief Nursing Officer and Respiratory Consultants. Shared pathways of care were essential to the success of the model delivery. Good working relationships between clinicians in acute and community also created readiness for this service implementation. Ipads/tablets with cellular functionality are a likely future requirement for the community team. In the case of patients, some did not have a smart device so a simpler spirometer may be a better option for these patients. The Community Virtual Ward – Proof of Concept is informing policy development with proposals for wider testing of the model under the direction of the Chief Nursing Office.

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Cystic Fibrosis Service

Beaumont Hospital Medical Physics and Clinical Engineering Department / CHO 9

Understanding the Problem

CF patients may be particularly vulnerable to COVID-19; these patients will want to avoid the acute hospital environment and any unnecessary travel. In line with the recommendations of the National Clinical Care Programme for Cystic Fibrosis, our CF service considered the implementation of remote patient monitoring. University College Hospital Galway had already implemented remote patient monitoring for CF patients and early feedback was positive. We commenced a project to roll out remote patient monitoring to appropriate CF patients.

Improvement Initiative

Building on the experience of University College Hospital Galway, which was freely shared, we set out to implement PatientMPower platform with Spirometry, weighing scales, pulse oximetry and thermometer for CF patients. Appropriate patients were assigned these devices and given instructions on how and when to use them. This platform includes a patient portal which can be accessed by the CF team in the hospital where measurements from the various devices assigned to the patients can be reviewed remotely to facilitate medication changes or prioritisation of phone, video and face-to-face appointments.

In the design phase, the clinical team linked with PatientMPower and engaged in multiple WebEx demonstrations and team discussions around workflow, devices and platform. With significant liaison with PatientMPower and advisory input from Clinical Engineering, workflows were developed to support this initiative. Clinical Engineering also worked with the Finance Department to manage the financial aspects of this project.

Initial Evaluation

The introduction of this service allows for early intervention in the event of exacerbation and prevents unnecessary travel and attendance in an acute hospital when it can be avoided. From the clinician perspective, this development facilitates rapid insight into physiological parameters in the event of patient exacerbation. While in its early days, it is planned to extend this service to 50 patients. UCHG are already monitoring 40 patients.

Lessons Learned

Important enablers in this development include financial support from HSE Digital Transformation Office, Hospital Finance Department support, openness to innovative approaches by the Respiratory Consultant and peer support from the team in UCHG. Of note, the spirometry device uses different measurements to Pulmonary Function.

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Delivering CPD Remotely in Response to the COVID-19 Pandemic

Beaumont Hospital Physiotherapy Department

Understanding the Problem

Continuous Professional Development (CPD) is the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional career (CORU 2013). Formal CPD provision within the physiotherapy department in Beaumont Hospital consists primarily of scheduled in-service training, journal clubs and clinical reasoning sessions which are all facilitated in a group-based setting. In light of the COVID-19 restrictions on gatherings and social distancing, alternate methods for the delivery of formal CPD opportunities had to be explored.

Improvement Initiative

The introduction of telehealth as a medium for providing outpatient services across the department provided access to a virtual platform which could be utilised to facilitate remote CPD training. A policy was developed for the use of the Cisco WebEx virtual system to facilitate the delivery of CPD across the department in compliance with COVID-19 restrictions. The policy was created to provide clarity and guidance for all Physiotherapy staff engaging in remote meetings, with consideration given to the EU General Data Protection Regulation (GDPR) and general data security responsibilities for staff conducting such sessions. The usual proceedings for CPD events were reviewed and discussed amongst relevant staff. Procedures were adapted and documented to meet the needs of the virtual platform with consideration to the professional expectations for this mode of CPD delivery.

Training staff to use the platform was initially a challenge. A one hour training event was organised for all staff. However, staff reported ongoing difficulty applying the theory to practice. In order to address this, a buddy system for training was implemented. Staff members completing a virtual CPD event were buddied to another staff member who took responsibility for managing the technical requirements of the event. The additional support staff member was deemed the "Technical Support buddy". A rota was created identifying CPD hosts and technical support buddies for a set timeframe. The technical support buddy trained the next technical support buddy on the rota to take this role for the following event. This allowed for a 'relay effect' of information sharing whereby technical training for use of the platform was filtered through the department by peer to peer training with direct hands on experience of the platform.

Initial Evaluation

Education and learning opportunities are highly valued throughout the Physiotherapy Department at Beaumont Hospital. Moving CPD to a remote platform has provided an additional medium for the delivery of CPD going forward. The introduction of a policy for delivering formal CPD remotely signals the willingness to adapt practice. The development of a local policy ensures high professional standards and practice are maintained in this transition. Prior to implementation, feedback from staff users was obtained and the policy was altered to meet the needs of the department in line with local GDPR requirements.

Lessons Learned

The use of a virtual platform to facilitate remote attendance for CPD events represents a significant change in standard practice in the physiotherapy department. Creating a policy for its use was vital to ensure a standardised approach, clearly outlining responsibilities of all staff members. The virtual platform allows recording of training making more efficient use of therapist time with induction training. Under usual circumstances, induction training is repeated for staff rotating into a new area every quarter. The virtual platform enables easy unlimited access to training material and practical videos which supports staff on an ongoing basis for example in maintaining their 'on call competencies'. This feature allows staff to access information in their own time as they identify the need for training to meet their own personal CPD goals.

Staff reported increased confidence with this format of training and it is continued in the department. In addition, this method eliminates the burden of the technical component of hosting a virtual event from the staff member acting as host.

As a result of this transition, staff engagement in CPD activities has increased with the option for staff to attend remotely from different sites and their homes. Furthermore, the introduction of virtual events has facilitated physiotherapists from external hospitals and community organisations to attend CPD events hosted by Beaumont Hospital Physiotherapy Department.

Staff feedback has acknowledged that the face to face component of CPD training remains beneficial due to the nature of physiotherapy work, however; with recent updates on the platform including a "break out group" feature, smaller group discussion is better facilitated compared to initial implementation of the platform. Currently, with respect to the "hands on" nature of the profession and skills required for physiotherapy CPD, remote CPD complements events where possible but does not fully replace face to face CPD events.

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Early Intervention Disability Team, Speech and Language Therapy Services
CHO 7

Understanding the Problem

During the COVID-19 pandemic, face-to-face appointments were reserved for urgent cases only in line with National Public Health recommendations. In order to maintain service delivery, remote sessions were carried out via the Zoom video conferencing platform and/or phone reviews. Video and phone were utilised to:

- Support families in carrying out ongoing speech and language therapy interventions to support their child's speech, language, communication and/or feeding, eating, drinking, swallowing (FEDS) skills.
- Carry out informal assessment of a child's speech, language, communication and/or FEDS skills.
- Facilitate parent discussion around application of current recommendations/new issues arising, individually or as part of a clinical team, based on needs of parent/child.
- Support children's transition from preschool (special education/mainstream/combined) to mainstream primary school.
- Liaise with other relevant educators and healthcare professionals (within and outside of the service) involved with the child/family to facilitate shared understanding of child/family needs and goals as part of provision of co-ordinated care.

Improvement Initiative

Video and audio calls were carried out remotely with children, parents, siblings and educators as appropriate. Depending on the child's needs, multiple team members may have been present for joint remote sessions. Strategies used to support remote sessions, dependant on child's presentation and needs, included but were not limited to the following:

- Pre-appointment questionnaire, where relevant, sent by email to gather information on child's progress and current skills (communication/FEDS) to plan for session goals and activities and enable all attention to be directed to facilitating child's participation during session.
- In advance of the session, communicating session goals, activities and materials (picture/object) for the session
- Communicating ideal location and environmental factors for session
- Posting hard copies of materials required in advance of session
- Sharing screen using feature on Zoom so parent/child and therapist can attend to shared activity
- Use of blackboard feature on Zoom to facilitate activities
- Continued use of child's motivators and preferred activities within session so activities are inherently motivating
- Scheduling sessions at times that suited family's schedule, in a location chosen by family
- Parent coaching – online observation of parents using strategies in real time, in child's natural environment, with live SLT feedback
- Creation and use of remote assessment forms to guide virtual assessments for children preparing for key transition stages
- Follow-up written summary provided by email/post to family with recommendations and plan following appointment to support carryover
- Phone reviews between or in advance of sessions to discuss child progress, any parent updates/concerns so full attention can be maintained on facilitating child's engagement in activities when child present.

The following resources were used to inform change to service delivery:

- Irish Association of Speech and Language Therapists (IASLT) guidelines on telepractice
- Royal College of Speech and Language Therapists (RCSLT) guidelines on telepractice
- Speech Pathology Australia (SPA) guidelines on telepractice
- Telepractice: A practical guide for children's disability (HSE, June 2020), available at: https://www.hse.ie/eng/services/list/4/disability/progressing-disability/pds-programme/documents/telepractice-guide-for-children-s-disability-teams.pdf
- Articles published on telepractice with specific client populations internationally

Initial Evaluation

Parents reported increased confidence in use of strategies due to the requirement to lead activities (i.e. due to physical parameters) with the support of the therapist who provided live coaching and feedback. Parents reported surprise at their child's engagement with online materials. From the clinician's perspective, telehealth afforded a more natural environment leading to more accurate representation of the child's skills and abilities in their typical context. It also supported an equalling of responsibility with physical parameters more conducive to empowering parents to lead activities with SLT coaching. Clinicians experienced enhanced communication with parents regarding anticipating session activities and increased opportunity to involve siblings in sessions.

From a service perspective, telehealth enabled enhanced use of clinical resources (i.e. no time required to travel to home/community sessions; no time required to physically prepare therapy space) and it was easier to co-ordinate multiple team members to be available for joint appointments.

Lessons Learned

In order to facilitate successful telehealth, the following factors were important: parent and clinician access to computer/internet, parent/therapist computer skills level, appropriate physical space for parent/therapist as well as parent's previous experience in use of recommended strategies. The influence of a pre-existing relationship with clinician and child/parents is a possible enabler. Specific barriers included internet/computer access and negative parent/clinician attitudes towards telepractice.

In order to develop and sustain this service, further empirical research regarding parents' feedback on use of telepractice is important. Additionally, increased clinician training regarding use of the chosen video conferencing platform is required to ensure equitable service delivery using this medium within and across services. Finally, promoting availability of accurate, accessible, information regarding findings of telepractice use is essential. Potential positive/negative outcomes for parents and clinicians should be documented in order to circumvent identified challenges and support all party engagement and positive attitudes towards the process.

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Early Intervention Disability Team, Speech and Language Therapy Services

CHO 8

Understanding the Problem

When the COVID-19 pandemic struck at the start of 2020, there was an urgent need to explore other new and innovative ways to support families in Louth Early Intervention and Children's Disability Services. Six months on, with great support from management, the National Virtual Health team, the Office of the Chief Information Officer and IT, we have access to all the equipment needed to provide telepractice as a service delivery medium for our families. The use of telepractice aims to reduce the exposure and risk of transmission of COVID-19 while maintaining access to therapeutic services. As a Speech and Language Therapist on the Early Intervention Team, we understand that this is a service families cannot do without, particularly during challenging times. Evidence indicates that telepractice can support family-centred approaches consistent with best practice. Telepractice enabled assessment and intervention to be carried out in the child's natural environment, empowering parents to take the lead with their child from the comfort of their own home.

Improvement Initiative

In June, 2020, following a successful application, Louth Early Intervention and Children's Disability Services were approved to become one of the pilot sites for the roll-out of telehealth using Attend Anywhere. With the support of the National Telehealth Steering Committee and the regional telehealth working group, we developed a guideline for the use of telepractice within North and South Louth Early Intervention and Children's Disability Services. This involved coordinating staff training and support sessions on the use of online platforms, compiling consent forms, creating information leaflets for families and clinicians in relation to telepractice, the use of Attend Anywhere and Cisco WebEx, and drafting the necessary file documentation checklists and forms relevant to telepractice. Whilst this was an extensive, time-consuming piece of work, liaising with other services who had already embarked on the telehealth journey as well as utilising the support and resources compiled by the National Virtual Health team and eHealth Ireland made it a seamless process.

Initial Evaluation

Although telepractice in our service is still in its infancy and is in the early stages of the evaluation process, many benefits and positive outcomes have been identified. Having telepractice as a service delivery option has meant our service can offer many different approaches to supporting children and families. We provided a virtual 'Get Set for School' workshop over the summer to support families in preparing for starting school. We can return to providing discipline specific and multidisciplinary assessments which are reducing waiting list times and can provide intervention options to families, including individual therapy support, parent trainings, information sessions, webinars and sibling support groups amongst others. This enables us to continue to support children and families to make progress through these challenging times. It has also opened new 'virtual' doors for collaborating with other professionals such as teachers and clinicians, enabling us to provide and attend professional development opportunities with greater ease, reducing the risk of COVID-19 transmission and reducing travel times.

Lessons Learned

As with any new medium, telepractice is not a 'one size fits all' approach and brings with it some limitations. There will always be occasions where face to face contact with the children and families we work with is essential. Telepractice is not an option for some families due to technical problems such as poor internet connection, lack of a suitable device or lack of technology skills. Additionally, the clinician may not achieve everything that is required as part of an assessment or intervention via telepractice, and therefore a face-to-face consultation may be necessary to ensure best practice. Telepractice has brought about more efficient and accessible ways of working with our families and we envisage telepractice as part of a blended model of service delivery in the future.

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Head and Neck Oncology Speech and Language Therapy Services

South Infirmary Victoria University Hospital

Understanding the Problem

The COVID-19 pandemic placed significant strain on healthcare systems worldwide with delay or cancellation of service provision across many healthcare settings (Emmanuel et al., 2020). In order to continue with effective service provision, speech and language therapists needed to consider alternative forms of treatment delivery (Forner et al., 2020); telehealth is considered essential in situations where the availability of a face to face session with a qualified professional is limited (Reynolds, 2009). According to Molini-Avejonas et al. (2015), telehealth consults are advantageous in 91.1% of cases.

Improvement Initiative

During COVID-19, it was necessary to transition the entire speech and language therapy outpatient service to telehealth. Using Zoom, telehealth intervention was provided for two patient cohorts:

- Voice – initial assessment and follow up therapy provided
- Head and neck oncology – follow up management service post radiotherapy treatment/surgery

The telehealth service was led by two Speech and Language Therapists (SLT) working remotely and using Zoom initially. Patients were contacted to obtain email addresses while appropriate documentation was developed for department use to record outcomes and frequency of reviews. Outcome documentation was subsequently logged in the patients' medical charts. More recently, the service is provided on site with virtual consultations being held during dedicated weekly time slots using the T-PRO programme. Scheduling and telehealth interventions are arranged by the relevant SLT by email or phone consult with the patient.

Initial Evaluation

Telehealth enabled the continuation of goal focused therapy and multidisciplinary care, providing essential services to highly vulnerable groups. Patients who were anxious about on-site attendance or who lived a considerable distance from the hospital had their treatment needs met safely during this period. In some cases, if wished, patients' family members could be present by logging in remotely. Telehealth also enabled more vulnerable members of staff to continue working and fostered the development of new skills in telehealth. This experience led the team to identify certain patient groups for whom telehealth is suitable in the future in the interests of business continuity planning.

Lessons Learned

Stable Wi-Fi onsite in the hospital and approved platforms across sites are essential enablers to effective telehealth services. Acoustic measures were difficult to capture in voice assessment due to quality issues across sites. Adequately assessing oromotor functioning or conducting a visual oromotor exam can be challenging due to poor quality visuals. For some groups including those without internet access or patients who are unfamiliar with the use of IT, telehealth is not suitable. Additionally, unchecked emails can lead to non-attendance.

For more information, please contact:

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Home Based Virtual Pulmonary Rehabilitation for COPD Patients

Respiratory Physiotherapy Service, Our Lady of Lourdes Hospital

Understanding the Problem

Pulmonary rehabilitation (PR) has established itself as a key management approach in the treatment of chronic respiratory disease and has been shown to reduce hospital admission rates particularly for people with Chronic Obstructive Pulmonary Disease. Despite the proven benefits of PR referral, uptake and adherence remains universally low. Travel and transport are consistently identified as barriers to both participation and completion.

Improvement Initiative

This initiative began with collaboration between the HSE and the European-funded Interreg Project mPower. The aim was to enable patients, over 65 years and with chronic conditions, to take control of their health at home by using technology. By maximising this collaborative opportunity and expert support, leveraging existing technology and integrating resources into primary and secondary care settings, virtual PR enables patients to receive the right care, in the right place, at the right time, by the right team in line with the goals of Sláintecare.

Alternative models of PR have demonstrated non-inferior clinical outcomes and safety when compared to traditional face-to-face classes. Remote delivery of PR is an innovative model improving equity of access, particularly for those in rural areas and negating the inconvenience and cost of travel. Furthermore, remote PR prevents service interruption caused by COVID-19 restrictions. Traditional PR best practice guidelines form the basis for virtual PR. Video conferencing equipment is used to deliver live physiotherapist-led interactive group exercise classes for patients while they remain in the comfort of their homes. It includes all components of a traditional PR programme and supports inter-professional collaborative practice through the provision of MDT education for patients. The programme has adapted and evolved in part due to the restrictions and risks pertaining to COVID-19. For example, validated outcome measures appropriate for telehealth usage have been selected to avoid the need for this high-risk cohort to attend the acute hospital setting.

Initial Evaluation

Virtual PR has enabled patients to continue to access a safe and effective exercise programme during the COVID-19 pandemic, supporting self-efficacy while alleviating strain on acute service resources. Preliminary results from two completed groups have been positive, demonstrating 100% completion rates with significant clinical improvements in both exercise capacity and quality of life status comparable to a traditional PR programme. Additional benefits include 3436 km travel saved with reduced carbon emissions, 72 hours travel time saved and savings on fuel and parking. In addition, remotely delivered PR has the potential to be provided with 50% fewer staff.

Lessons Learned

Stakeholder collaboration has been an important component of the innovation and development of the programme. Continuous evaluation of the programme through patient feedback and service review leads to modifications resulting in enhanced service user experience. Ongoing collaboration with academic institutions in evaluating telehealth will allow for measurable improvements ensuring an effective service with high patient acceptability. Collaboration with the National Clinical Programme Respiratory has allowed virtual PR to become a valuable resource for colleagues nationally in navigating PR services during the COVID-19 pandemic.

Further specific detail on the programme can be accessed at:

https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/ncp-respiratory-guidance-on-setting-up-virtual-pulmonary-rehabilitation-for-asthma-and-copd.pdf

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Interuniversity Collaborative Development of a Telehealth Module for Physiotherapy Students on Practice Placement

**School of Physiotherapy, RCSI University of Medicine and Health Sciences,
Royal College of Surgeons in Ireland**

Discipline of Physiotherapy, Trinity Centre for Health Sciences, St James's Hospital

Understanding the Problem

Experiencing service changes is an important feature of practice placement that prepares students for the demands of the clinical environment on qualification (Smith et al, 2020). A seismic transformation in healthcare delivery, triggered by the COVID-19 pandemic, has lowered the barriers to adoption of digital technologies (Ohannessian et al. 2020). Telehealth reduces face-to-face contacts, while preserving patient access to vital services (Hoffman, 2020). Practice placements should encompass all modes of service delivery, and as such, telehealth is recognised as an acceptable placement model (Twogood et al. 2020, McMahon et al. 2020). In the early stages of the pandemic, the curtailment of in-person outpatient services prompted educators to prepare for placements delivered exclusively using telehealth. However, as students have returned to clinical sites, it is clear that a blended approach to placements has become the norm, with telehealth as a feature for most practice placements.

Physiotherapy practice education teams recognised that Telehealth was not a significant component in the academic curriculum, and that there was a gap in terms of students' knowledge and skills. The Schools of Physiotherapy in RCSI and TCD collaborated to develop a Telehealth module to be delivered remotely as a component of practice placement. The aim of the module was to equip students with the knowledge and skills to engage with telehealth activities on practice placement and in their future career.

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Improvement Initiative

A two-day Telehealth module was developed, to equip students with the knowledge and skills needed for both individual and group telehealth consultations. The module content was a blend of didactic and interactive practical workshops, facilitated by the practice education teams, lecturers and expert clinicians. Learning outcomes for the module were mapped against the learning outcomes for practice placement. Students were provided with a module workbook that detailed the programme learning outcomes and assignments.

Lectures were recorded, and students accessed the learning materials though their university learning platforms. Final year students from TCD and RCSI participated in the module as part of their first placement after lockdown. In Oct 2020, a second year cohort of RCSI students completed an adapted version of the module as part of their first practice placement. This module was adapted in response to the feedback from the first iteration of the module.

Initial Evaluation

Students evaluated the Telehealth module using an online survey. There was a good response rate to the survey (69%). Results indicated that all students felt that the module advanced their telehealth knowledge and skills. Ninety percent of respondents would recommend the module to other students, while 95% felt the module met the placement learning outcomes. Constructive feedback allowed for a student centred and iterative approach to development of the structure and content of the module.

Lessons Learned

Students demonstrated they are technologically proficient and can help services in the adoption and implementation of telehealth. Most learning outcomes detailed in the national clinical assessment tool can be achieved by a telehealth placement. We look forward to a growth in telehealth placements and the opportunity for students to demonstrate their value in clinical practice.

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Medical Social Work Service

Mater Misericordiae University Hospital

Understanding the Problem

Part of my role is completing a specialised assessment of psychosocial issues and social supports when patients are being assessed for suitability for lung transplant. As the Mater Misericordiae University Hospital is the only lung transplant unit in the country, service is provided to a national cohort of patients. Prior to the pandemic, I reviewed the patients in person, and then held a family meeting to assess social support in addition to liaising with other multi-disciplinary team members and community services. This process is quite structured and all patients undergo social work review as part of their transplant assessment.

As a result of the COVID-19 pandemic, recognising that this population is in the high risk category and that in-patient beds were limited, practice changes were introduced. These included significantly increased use of phone calls, emails and online platforms to conduct assessments and my work has become increasingly out-patient focused as a result.

Improvement Initiative

Developing these practice changes has been an iterative process with Plan, Do, Study, Act (PDSA) cycles used to inform and refine processes – looking at what works and changing what does not add value, based on practice, patient need and feedback. I upskilled in how to use various online platforms, accessing information or support from the organisation. Team and clinical meetings rapidly moved online which was helpful learning in the early days. This population, who experience respiratory conditions, have a good understanding of the need to move to a different way of working. As required, face-to-face meetings are still offered in line with public health and organisation guidelines, and informed by patient need.

Initial Evaluation

Assessing and engaging with patients and families now requires more time, particularly for education, making the necessary changes to service provision and supporting patients/families. Feedback from patients/families has been positive in relation to reducing risk and improving equity and ease of access for transplant patients, many of whom are on high levels of oxygen and many of whom live outside Dublin.

From a teamwork perspective, the move to a virtual and largely out-patient model has made timely information transfer more challenging. Greater use of emails amongst team members and good communications amongst the multi-disciplinary team has helped mitigate this difficulty. There is also less time spent on the ward and engaging in face to face interactions and as a social worker, I recognise that this can impact on one's ability to build relationships, rapport and trust. Communicating clearly about changes in working practices within the team has been important.

Lessons Learned

Some patients are not IT literate and/or can experience mental, physical or cognitive challenges engaging with this new medium. Clinical experience, adaptability and flexibility about multiple ways of engaging with clients and a client-centred approach – being able to meet patients from where they are – are key skills for professionals. In my specialised and unique area of practice, telehealth has worked well but this may not be the case in all areas of social work. Further opportunities for telehealth developments include providing client education, professional training and sharing of knowledge, adequate access to IT resources, hardware and software or IT support to assist with any IT issues and provide support/training is essential. Other enablers for success include: management support and a culture open to new ways of working; patient and family engagement and openness to change; technological literacy; social worker skills; supervision to reflect on practice and an open attitude to change.

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MS Ireland Physiotherapy Service

MS Ireland

Understanding the Problem

Public health restrictions during the COVID-19 pandemic meant that in-person classes could not be delivered. Moving existing MS Ireland classes online and later, new classes for people with mixed neurological conditions in the Mid-West (Active Neuro), has overcome this situation. This has been achieved by developing, piloting and implementing exercise classes through Zoom for Healthcare.

Improvement Initiative

The first step was to set up a community of practice on Microsoft Teams, bringing together the independent contractors who deliver these programmes (funded by branches, Lottery and other fundraised income). The community created procedures and guidelines for delivery of online programmes and these continue to be living documents. To test virtual pathways, a pilot programme was implemented in the mid-west and this has informed the proformas and other supporting documents.

Rapid implementation was led by a staff member with previous experience of telehealth, its evidence base and clinical guidelines. The physiotherapy team performed risk assessments, applied international guidelines and developed, piloted and implemented the systems, enabling delivery of online classes nationally within five weeks. Safety was optimised through individual audio and video calls which involved medical, environmental, balance and mobility assessment, enabling allocation of appropriate exercises and to groups of similar level. Data security was researched, clarified and optimised by a health-ready system, with additional security at individual class level. Digital literacy and participant usability were considered by trialling several platforms before deciding upon Zoom for Healthcare.

The online community of practice for independent contractors facilitated implementation across regions. Policy, procedure, protocol and guidance documentation and forms were shared with regular communication and a series of training and Q&A webinars. Outcome measures were collected online in addition to objective measures of balance and strength through telehealth.

Initial Evaluation

The exercise classes have enabled people with mobility limitations to adhere to existing public health guidance on exercise and physical activity, reducing symptom severity and preventing secondary health complications. Continuing these group classes was of utmost importance to maintain their function and to reduce the load on the already stretched health system. By rapidly moving the regional programmes (and the Sláintecare funded Active Neuro programme in the mid-west region) online, MS Ireland provided health promoting physical activity to people in their own homes. As public health guidance changed the emphasis from social to physical distancing, classes provided a social outlet for people vulnerable due to isolation, and who still experience vulnerability as they cocoon months later, with residual fear and anxiety about leaving their own homes.

To date, over 100 programmes have taken place nationally enabling 2055 people to take part in classes between March and July, 2020. Perceived obstacles of digital literacy and lack of interest in taking part were quickly dispelled. Uptake was high and referrals for Active Neuro doubled in response to notification of online programmes. As a result, a new challenge was the supply of physiotherapists to run classes and referrals to Active Neuro exceeded the capacity of a 0.5WTE physiotherapy post. A partnership with UL to enabled student-led groups, supervised by tutors, provided a solution to this challenge. The COVID-19 restrictions led to significant issues of isolation and poor mental health but the conversation before, during and after classes provided social connection and peer support. Participants reporting it was "something to look forward to each week". The physical inactivity pandemic was reduced by keeping this group at high risk of hospitalisation active and supported.

Outcomes data is due to be analysed for both the MS Ireland and Active Neuro services. Satisfaction survey data is extremely positive and supports both physical and mental health benefits, in addition to social and peer support and connectedness.

Lessons Learned

Piloting of online programmes began two weeks post lock down with systems and programmes developing in tandem in response to frequent feedback. National rollout occurred just 5 weeks after the restrictions began. The creation, early on, of a community of practice enabled stakeholders to participate in decision-making and the development of policy/procedure documents and the systems that underpinned the safe delivery of online exercise classes.

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Occupational Therapy and Physiotherapy Hand Trauma Service

University College Hospital Galway

Understanding the Problem

COVID-19 restrictions implemented in March 2020 hugely impacted care of trauma patients at UCHG. While their injuries are life altering, they are not life threatening and as a result, the hand trauma service was largely suspended in line with the hospital decision to cease outpatient attendances, where possible, to the hospital.

Improvement Initiative

Therapy treatment for patients attending the hand therapy service is time critical. With this in mind, telehealth solutions were deployed, at pace, to provide continuity of post-operative care and upper limb assessment and rehabilitation to trauma services. Within this newly introduced virtual pathway, patients attend the outpatient department for immediate post-operative care with the multi-disciplinary team comprising Consultant, Nurse, Physiotherapist and Occupational Therapist. On assessment, a decision is made on the patient's suitability to use telehealth as an alternative to face to face treatment. Most patients have engaged in 100% virtual treatment following this assessment. This limits social contacts and reduces contact risks for patients and staff while enabling the provision of acute post-operative care to our patients.

Initial Evaluation

Patients report that telehealth is very accessible and indicate that they are satisfied to engage in virtual therapy as an alternative to face to face consultations. It is considered time efficient, thereby reducing the need to take time off work and lessening the financial burden. Patients also feel reassured that they have received the necessary connection and follow up with therapists despite COVID-19 restrictions. Based on a recent patient satisfaction study, the majority of patients would utilise telehealth as an option for future health needs. From a service perspective, it has been possible to continue to provide critical post-operative therapy and support patient recovery without compromising patient outcomes. The virtual pathway is user friendly and can accommodate needs of patients in a large geographical region. There have been benefits in the development of clinical reasoning skills for local therapists too. A challenge experienced is the knock-on effect on administration time. This increased demand places pressure on therapists' capacity which is already maximised with clinical service demands.

Lessons Learned

Some patients are not familiar with using IT but do not assume a patient's age is reflective of his/her IT literacy skills. Often, support is available from family to assist with set-up. The internet connection can be a barrier in some cases. It is important to message clearly the benefits of telehealth so as to avoid the potential for patients to view this as a less than optimal option. The requirement for clinical space to deliver telehealth can be challenging and the delivery of care virtually can be mentally draining. However, there are clear benefits and our advice is to give it a go!

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Older Adults, Older Persons, Paediatrics and Stroke Physiotherapy Services

CHO 6

Understanding the Problem

Owing to the COVID-19 pandemic, it was necessary to reduce face to face physiotherapy assessment and intervention in the community.

Improvement Initiative

To ensure continuity of care and avoid lengthy waiting lists, virtual physiotherapy services were introduced. A phone triage service enables staff to take a subjective history from patients by phone and to schedule a time for a physical examination using a telehealth platform such as Attend Anywhere or BlueEye. Based on the outcome of the physical examination, exercises are prescribed via an exercise platform such as Physiotec, Physiotools or Salaso. Alternatively, written instructions are sent by email or post. Follow-up interventions are via Telehealth or in person as appropriate. Assessment relies on observation supported by clinical reasoning. Treatment includes tailored exercise prescription and coaching.

Initial Evaluation

Virtual therapy enables patients, particularly those at greater risk including immunocompromised patients, to access intervention while cocooning, isolating or restricting movements. Use of public transport, childcare and parking costs are all avoided. While patient feedback has been positive overall, face to face intervention remains the preference for some patients. Virtual therapy reduces COVID-19 risk amongst staff too and can be completed when staff are forced to self-isolate. Some limitations noted include the absence of hands-on assessment/intervention and loss of some visual cues. Some clinicians find the coaching method empowers patients and improves patient ownership over their health.

Lessons Learned

Some forms of assessment are more suited to telehealth than others. For example, in the adult population gait assessments are more challenging than shoulder assessments. Assessing developmental delay in infants is very manageable but screening for hip dysplasia is limited to visual examination only. Confusion can arise on Attend Anywhere when used with the paediatric population as some parents type their own name when prompted to type the name of the person the appointment is for.

For older persons, utilising the technology can be challenging but having a carer, family member or friend present to hold the phone or device and aim the camera at the patient, assists greatly. This way the clinician can easily see the patient's movement. There is an advantage in assessing the home environment in person and being able to tailor exercises to the home so home visits are more suitable for some older persons. In the paediatric population, children are often more comfortable in their own environment and using telehealth, it is possible to observe how they interact in their own environment for example, how they navigate stairs, where they play.

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Orthopaedic Physiotherapy Service

Tallaght University Hospital

Understanding the Problem

Knee osteoarthritis (OA) is a common disorder and accounts for the greatest number of General Practitioner referrals to the Orthopaedic Service in Tallaght University Hospital (TUH). On average, TUH receives 1795 new referrals to the MSK Triage service per year of which 27% (n=485) are referred for elective Knee disorders. Owing to the COVID-19 pandemic, elective services were paused with the result that 40–60 patient intervention slots were unused each week. MSK Triage clinical specialist physiotherapists were re-deployed in this period.

Improvement Initiative

On reviewing the 363 patients on the Knee MSK Triage waiting list, it was hypothesised that 65% (n=236) of these knee referrals waiting would be suitable for a virtual knee consultation and were identified for this clinic. Prior to the clinic appointment, patients were requested to get an updated Knee Weight-bearing x-ray that was ordered via the orthopaedic department. The report for this x-ray was available during the virtual knee consultation. The consultation involved knee specific screening questions, including red flag screening. The Oxford Knee Score was also completed using an online platform. At each consultation, a decision was taken to a) discharge the patient from Orthopaedics and refer for physiotherapy, b) with written advice, c) refer for a face-to-face MSK Triage consultation, c) book the patient in for an injection in MSK Triage or d) discuss the patient with an orthopaedic surgeon and list for a Total Knee Replacement.

Initial Evaluation

Over a three-month period, 86 patients were reviewed in the virtual elective knee clinic. In total, 19 (18%) patients did not attend, 35% were male, while mean age was 66 years (±10). Mean active treatment time was 17 minutes (±5). Mean Oxford Knee Score was 31 (±9). Altogether, 52 (60%) were discharged back to the care of their GP following the consultation. Follow-up care included: 31 (36%) referred for physiotherapy management; 21 (24%) given advice and education; 8 (9%) booked for a physical examination to ascertain diagnosis; 12 (14%) booked directly for a knee injection; consultant orthopaedic surgical opinion was sought in 14 (16%).

Lessons Learned

Many of these patients were in the high-risk category for contracting COVID-19 and this project enabled their virtual assessment and management during the COVID-19 pandemic. Avoiding lengthy waiting times for diagnosis and appropriate management advice can prevent the chronicity of symptoms and deconditioning for this patient population. This is the first such Virtual Elective Orthopaedic Clinic nationally and has demonstrated that a cohort of elective orthopaedic patients can be safely managed virtually.

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Paediatric Virtual Orthoptic/Vision Therapy

Pembroke Eye Clinic

Understanding the Problem

Owing to the COVID-19 pandemic, there was a need to consider alternatives to face to face therapy. This led to the introduction of Virtual Orthoptic/Vision Therapy to treat convergence and accommodative disorder in a paediatric population.

Improvement Initiative

This initiative was developed during lockdown between the months of March and June 2020 at two or three week intervals. An equipment pack was prepared in advance of therapy which was collected by the parent or posted out if necessary. A series of power point slides of exercises were prepared for parents as well as information on the set up of Zoom meetings. During sessions, I explained each exercise outlined on the slides, focusing on how to perform them and what the child should expect. The parent was observed carrying out each set of exercises with the child to ensure safe and correct practice. On each Zoom session, the child's progress was evaluated using a series of questions, exercise performance was observed and a next set of exercises was prescribed as appropriate.

Initial Evaluation

The virtual therapy pathway has enabled the continued delivery of the service, without children experiencing treatment delays. Children are typically more relaxed as they are being treated in their own homes. I had some concern about parents' ability to follow therapy directions but this treatment medium has shown effective outcomes with the potential to be scaled and spread. Some parents have expressed concern about being able to follow directions correctly and indicated a preference for face to face intervention.

Lessons Learned

Despite initial concerns, this medium has been effective in the delivery of care. Discharge evaluation are better completed face to face. A poor broadband connection can cause a lag and drop out can make some sessions challenging. It can also be difficult to manage a child's behaviour and attention when working remotely. In terms of assessment, it can be more difficult to evaluate posture and the 3D aspect of face to face sessions was missed. This medium relies on the parent's ability and facilitate the session from home.

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Podiatry for the At Risk Foot, Diabetes

Community Healthcare East CHO 6 and St Columcille's Hospital

Understanding the Problem

As a result of the COVID-19 pandemic, and as this population is at risk of ulceration and amputations often related to diabetes, it was necessary to review our work practices and identify innovative solutions to triage patients appropriateness for virtual consultation or for urgent rapid access to face to face assessment with a Podiatrist on the foot protection team.

Improvement Initiative

We set up a work flow process for triaging patients for virtual assessment or face to face assessment according to need. Patients received a phone call from a Podiatrist from the Community Healthcare East Foot Protection Project team if they were known to be at risk of ulceration or amputation. These clients had a virtual consultation regarding their foot health and care needs. Through this process, if patients were found to be in need of face to face physical assessment for a priority one urgent foot health concern, they were followed up through rapid access clinics. We reviewed the literature of international guidelines for managing the diabetic foot through COVID-19 as well as the current National Model of Care for the Diabetic Foot (2011). We also engaged with international colleagues (UK) for an update on diabetic foot services in their areas.

I engaged with my fellow Sláintecare foot project lead in CHO3 to co-ordinate our foot protection services in Clare and Wicklow and South Dublin. I then worked nationally with my Podiatry colleagues across CHO3, 5 and 9 and St. Vincent's University hospital along with our Consultant Endocrinologist and Clinical Lead to design an evidence based work flow process which podiatry teams could utilise to triage and safely manage patients in danger of ulceration or amputations through COVID-19.

Initial Evaluation

Patients were able to have their consultation at home and receive self-management support from their clinician to help keep them safe and mobile. Patients were also advised on how to contact the Foot Protection Service should they require urgent podiatry assessment of a wound. This proved very effective as many private podiatry practices had closed during the initial stages of the pandemic leading to deteriorating foot health for many patients. Clinicians had an effective triage process in place through COVID-19 to inform clinical decision making on whether a patient required face to face physical foot assessment or could be managed virtually. Benefits of this initiative included the ability to keep patients safely at home where possible through COVID-19 with all podiatrists being able to work from a structured evidence-based triaging process and freeing up clinical space and appointments in both the hospital and the community for priority one patients to be seen face to face rapidly as required.

Lessons Learned

Support from National colleagues and willingness to coordinate on designing a work flow process at speed enabled the process to work smoothly. Support from St Columcille's Hospital to use a media company to help make the form interactive and easy for clinicians to use was hugely beneficial. Having WhatsApp on clinicians' work mobiles has given the option to engage in a video call with patients if necessary; however, the team has not reported the need to use this to date.

The absence of a patient record management system has made managing patient records, audit returns, clinic bookings and appointments very time consuming. This is a barrier to the project team having the space to embrace further video platforms such as Attend Anywhere which the HSE has adopted.

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Practice Education in Speech and Language Therapy

National University of Ireland, Galway

Understanding the Problem

Speech and Language Therapists (SLT) work with children and adults who have communication and swallowing disorders. To become a Speech and Language Therapist, students are required to complete their practice education training through clinical placements in hospitals and healthcare facilities where they acquire and develop these skills. As a consequence of COVID-19, fewer clinical placements were available for speech and language therapy students owing to increased measures of infection control and the redeployment of therapists to COVID-19-related duties.

Improvement Initiative

In response to this situation, SLT in NUIG turned to telehealth. This is the first such practice education initiative in SLT and this virtual clinical placement is delivered in collaboration with SLTs from the HSE West, HSE Donegal and Voices for Down Syndrome, Galway.

Each week, under supervision, 27 fourth year SLT students offer approximately 30 telehealth appointments daily. To support the delivery of this service, SLT students are creating a bank of video podcasts to demonstrate activities being addressed in therapy. This is intended to ensure that families have support material to review between sessions.

Initial Evaluation

This virtual clinical placement model has enabled clients both young and old to receive much valued and needed Speech and Language Therapy intervention. Also, since many of the students have completed their Higher Diploma in Irish at NUI Galway, therapy has been offered as Gaeilge as required. Clients value that SLT has resumed and that they are not waiting for services. Furthermore, they report satisfaction with the service being provided in the comfort and safety of their homes. Sound and picture quality using "Attend Anywhere" has been reported to be excellent and users appreciate that the service requires no travelling or expense. Telehealth has enabled us to offer a service (under supervision) to clients as far away as Co Donegal.

Student feedback is also positive; students are developing knowledge and skills and seeing the difference their input is having to the communication needs of their clients. They are learning not just from their Clinical Educators but from each other. This is definitely an advantage over traditional face-to-face clinical placements where peer support can often be lacking. With permission from parents, we have also linked with schools to provide advice to teachers and to forward much needed therapy programmes. Another unique advantage of telehealth is that we have set up appointments with clients while at school through the facilitation of the teacher. Parents have joined these calls from home or work.

It has also been possible, for the first time, to conduct clinical examinations using telehealth. The opportunity to use telehealth has meant that the examiners are linked externally and not "present" in the room as cameras and microphones are left off. Clients are made aware of their presence but quickly forget that the session is being observed as part of an examination.

Lessons Learned

Telehealth cannot replace face-to-face clinical placements in their entirety. There are certain skills that need to be acquired through these more traditional media so a blended approach may be required moving forward. Telehealth clinical placements are a way of future-proofing students for the world into which they will graduate, making them a good fit for health service requirements. Clear opportunities now exist to roll telehealth out to all cohorts of students across the academic year 2020-2021, investigate use of telehealth from a parent/teacher training perspective and investigate the use of group therapy from a telehealth perspective.

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"Prehabilitation" for "Cancer Surgery" Physiotherapy Service

St James's Hospital

Understanding the Problem

The OpFit prehabilitation programme includes the provision of daily face to face exercise classes for patients who are awaiting cancer surgery in St James's Hospital, Dublin. During the COVID-19 pandemic, all outpatient appointments and classes were cancelled with the result that the service needed to pivot towards telehealth.

Improvement Initiative

It is well established that optimising an individual's physical function before cancer surgery can result in decreased postoperative complications, reduce the length of hospital stay after surgery and decrease the rate of mortality (Cavalheri & Granger 2017). Research has shown that the use of video-based software tools is accepted and beneficial for patients (Armfield et al. 2015). As the software is generally free to use, patients experience reduced costs since they no longer need to travel to the hospital for a face to face exercise class. With a clear evidence base for considering alternative options for the continued delivery of the programme, a virtual pathway was explored. Frontline staff, the Physiotherapy Manager, Information Management Services (IT) and the Data Protection Officer led the planning and it was decided to use the platform Zoom to run the programme. Classes are currently delivered twice daily from the gym in the physiotherapy department.

References

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- Valkenet K, van de Port IG, Dronkers JJ, de Vries WR, Lindeman E, Backx FJ. The effects of preoperative exercise therapy on postoperative outcome: a systematic review. Clin Rehabil. 2011 Feb;25(2):99-111.

Initial Evaluation

Feedback from patients has been excellent and some testimonials are detailed below:

> "The online classes gave me a great daily focus and the encouragement was greatly appreciated".

> "The online zoom daily workouts worked on many levels for me and helped me physically and mentally prepare for my surgery".

Surgical multi-disciplinary teams are supportive of the programme as patients can exercise safely at home in line with pre-operative guidance from the NCCP (National Cancer Control Programme) for cancer surgery patients. Despite the closure of gym and leisure centres, patients can continue daily exercise classes to increase physiological function which can result in better outcomes. Over seven months in 2020, 251 referrals were received with 93 patients attending the online programme and a further 124 patients engaging in the home-based exercise programme with weekly follow-up phone calls from the physiotherapist.

Lessons Learned

Access to a device to engage in the online programme was a barrier for 21% of patients referred. An application has been made for 10 devices that can be provided to patients at home to address this issue. In addition, it was not possible to complete objective outcome measures prior to starting the programme, such as a 6-minute walk test. Outcome measures that were suitable for a phone based assessment such as the Duke Activity Status Index and the Clinical Frailty Scale were used instead. It was also not possible to monitor patients heart rate (HR) at home, as this previously took place during the face to face classes, using a polar HR watch. Instead, patients are guided by their shortness of breath when exercising. However, the virtual pathway has ensured safety during COVID-19, limiting social contacts by exercising at home. Furthermore, patients saved time, money and energy (especially important for cancer patients with fatigue) and patients living outside Dublin had access to the service. Less space was required to deliver this physiotherapy service as gym space is not now needed.

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Respiratory Physiotherapy Service

Tallaght University Hospital

Understanding the Problem

The COVID-19 pandemic led to the implementation of telemedicine services internationally in line with public health advice. A guidance document on the incorporation of virtual telehealth into existing oxygen clinics was published by the National Clinical Programme for Respiratory and I contributed to this guidance. Tallaght University Hospital (TUH) piloted the first Irish virtual oxygen clinic in 2020, providing continuity of care while minimising the risks associated with hypoxaemia.

National Guideline

- Murphy, D., Curtis, S., Cunneen, S., Cribbin, E. National Clinical Programme for Respiratory (COPD & Asthma) Guidance for the process of incorporating Virtual Teleheath into existing Oxygen Clinics. (2020).

Improvement Initiative

The TUH oxygen clinic closed due to COVID-19 in March 2020 and reopened in May 2020 as a virtual clinic, with 296 patients on the waiting list. A triage system was introduced and patients were phoned in order of priority and recommended for face-to-face or virtual assessment pathways. Face-to-face consultation was deemed necessary for those requiring arterial blood gas analysis or 6-minute walk tests. 'Patient mpower' monitors were funded by the HSE to enable the monitoring of patients Spo2 and heart rate remotely and patients suitable for the virtual clinic had the monitors delivered to their homes. The innovative use of the 1MSTS test instead of the 6-minute walk test reduced the need for face-to-face appointments. Effective and safe delivery was ensured by appropriate management and prioritisation of waiting lists, stratifying patients based on their virtual assessment and having access to face-to-face appointments as required.

Patients who attended virtually had access to the same wide range of services as face-to-face attendees including changes to their oxygen and inhalers, Pulmonary Rehabilitation referrals, PCCC OT/PT/PHN referrals and smoking cessation and breathlessness management advice. To date, 62 patients have attended virtually and 40 of those do not require another oxygen clinic review for a year. Of the patients who attended for a face-to-face appointment, 50% were placed on the return waiting list for a virtual assessment as their next appointment.

Initial Evaluation

Of the 128 new patient referrals on the waiting list, 22 were identified as appropriate for virtual assessment. There were 168 return patients and of these, 91 were identified as appropriate for a virtual assessment. Return patients are already established on their oxygen therapy and therefore are typically more suited to being managed virtually than new patients. Of the patients managed virtually, 76% had COPD, 16% had Pulmonary Fibrosis and 8% had other respiratory conditions. In comparison, 45% of face-to-face attendances were for patients with COPD, 37% had Pulmonary Fibrosis and 18% had other respiratory conditions. This correlates with the National Guideline advice and is due to the different disease trajectories. Patients falling within the 'other' respiratory category comprised of patients with Lung Cancer, Pulmonary Hypertension, Cardiac Disease and COVID-19.

A patient satisfaction survey was carried out over the first 6 weeks of the initiative and it identified that patients who attended virtually (n=33) reported they had no preference regarding virtual or face-to-face appointments (n=10) or that they preferred a virtual assessment (n=23). Patients preferred virtual assessments due to progressive Pulmonary Fibrosis, living outside of Dublin and COVID-19. The virtual oxygen clinic has supported hospital discharges and those requiring oxygen on discharge post COVID-19 have also been managed through this virtual clinic.

Lessons Learned

A virtual oxygen clinic enables patients to attend from the comfort of their own homes and they avoid visiting a hospital environment. Patients living outside Dublin can also easily avail of the service. There was reduced footfall in the hospital which supports social distancing measures in waiting rooms and reduces PPE costs.

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Sending Love Initiative

Older Persons Services, Royal Hospital Donnybrook

Understanding the Problem

During the COVID-19 pandemic, while visiting residential care units was not permitted under public health advice, we set out to establish a way for residents to interact with family members and friends.

Improvement Initiative

Initially led by physiotherapy, a generic email account named sendinglove@rhd.ie was set up and advertised on hospital social media accounts and websites. Local volunteer and activity groups also advertised this new initiative. To support its development, the hospital and local hospital charity organisation secured funding for tablets and Alexa devices. Once received, emails were read and pictures and video messages from family members/friends were relayed to residents using new tablets and devices. Since its introduction in May, 2020, over 300 messages have been received. To augment this initiative, the activities coordinator also set up/managed skype calls to/from residents/patients. The Alexa devices continue to be used to help communicate with patients in quarantine or isolation and when available, they are used for assessment and interventions.

Initial Evaluation

Patients, residents and family members have indicated high levels of satisfaction with the Sending Love initiative. They have found the email link vital to help them to keep in touch generally and particularly, to celebrate birthdays virtually and see their loved ones at home or abroad. In recent months, this initiative has spread to a range of other organisations including five other hospitals nationally. Alexa treatments continue to be used to help physiotherapists and the patients they treat during this pandemic.

Lessons Learned

Supportive volunteers and ward staff, a newly installed hospital Wi-Fi system, new hardware obtained locally and enthusiastic therapy staff all contributed to making this initiative happen. Some patients/residents prefer face to face contact to telehealth initiatives and for those with cognitive impairment, this method of communication can be challenging.

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St Michael's House – Hanen's "It Takes Two To Talk" via Telepractice

St Michael's House

Understanding the Problem

"It Takes Two to Talk" is a research-based course to support parents to develop their children's communication skills. It was developed by Hanen, an organisation in Canada.

In St Michael's House, the Speech and Language Therapy Department regularly run this course face-to-face with the parents and it is very well received. We had scheduled to run a course in March 2020, but due to the pandemic, this needed to be postponed. There was a great demand for the course at that time, and the pandemic continued, so we knew we needed to find another way to support the families.

Improvement Initiative

We researched running courses via telepractice. Then we contacted the Hanen centre and were able to purchase a telepractice licence to run the course. SLTs working in Early (Intervention) Services examined the contents and discussed the possibility of offering this to families. We contacted the IT department about the technology that was necessary and our manager regarding GDPR and the logistics of how to provide this course. Having a laptop that was suitable and available proved difficult, but with lots of planning we were able to organise the course. It was provided through Zoom using telepractice materials developed by Hanen.

Over 20 families were interested. Therefore two courses were offered on two different evenings in order to facilitate as many families as possible. Nearly 20 families completed the course.

Initial Evaluation

A questionnaire was circulated to the families after the course via Survey Monkey. Eleven families completed it. The feedback was very positive and the parents found the course beneficial. The majority of parents preferred the course being online and the other families would have preferred it to be face-to-face; however, they thought the telepractice version had benefits. Running the course via telepractice meant that the families did not get to meet in person and create a "group spirit". One of the benefits of parent courses is parents supporting each other, and this was lost slightly due to it not being face-to-face.

As part of the regular course, home visits are carried out to support parents with the strategies they learned. The parents are videoed and feedback is shared. Due to the pandemic, some of the feedback sessions took place via telepractice. When the restrictions eased, some were able to be carried out face-to-face.

Lessons Learned

We have learned a few lessons about providing a parent course via telepractice. The technology aspect was complicated due to not having easy access to laptops or a full Zoom licence. However, we have learned what is needed for future courses. Familiarising ourselves with how to use PowerPoint through Zoom and use Zoom's features was very important. Running a course through Zoom is different from face-to-face, so a lot more preparation was needed. However, a benefit of running the course via telepractice was greatly increased attendance, and both parents of many families were able to attend.

For more information, please contact:
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Video Enabled Cardiac Rehabilitation Occupational Therapy Service

CHO 8

Understanding the Problem

We work with clients who are particularly vulnerable to COVID-19. In this context, we initially ceased our programme but subsequently restarted by providing some telephone services to priority clients. Non-verbal communication and seeing the client to guide assessment are important parts of the work associated with this client group and therefore, a phone service was not sufficient for some clients.

Improvement Initiative

To progress to a telehealth service, an application was initially made for hardware and suitable software including a laptop under the COVID-19 Ivanti self-help request process. I also contacted the HSE programme manager for BlueEye in order to access a BlueEye licence. In tandem, I established how telehealth could be used within the service and the processes required. Without administrative support, I have learned how to facilitate appointments and BlueEye is a tool ideally suited to this. Patient information leaflets and letters have been updated or developed to include the latest telehealth guidelines. We are currently working to progress access to these letters on the iPims system.

In preparation, I attended Zoom sessions with the National Institute for Prevention and Cardiovascular Health and with the Royal College of Occupational Therapists Specialist Section for Major Health Conditions. This provided me with the opportunity to learn from other services about what works and does not work. I have also used the HSE Secure Video and Audio Clinical Consultations: Clinical Aspects During the Emergency measures to address COVID-19 (April, 2020) and A Practical Guide to Video Mental Health Consultation from https://www.mentalhealthonline.org.au to inform my practice.

Initial Evaluation

All clients treated by telehealth have agreed to follow-up using the platform. They report satisfaction in general and particularly in relation to visual access. From a clinician's perspective, telehealth has been very effective during COVID-19 and is also creating opportunities to further develop services. For our type of service, technology is a very effective tool in providing services at the same level as before.

Lessons Learned

Technical support and group conferences amongst multidisciplinary and/or professional groups has been essential in supporting me to adapt my service to a telehealth medium. Access and sharing of resources/ guidelines between areas has saved time. Barriers include patient access to technology including internet/ Wi-Fi access and devices. This is likely to reduce over time with more of our clients having access to and becoming familiar with the use of technology. I plan to expand use of telehealth to small education groups and therapy groups.

For further information, please contact:

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Video Enabled Care Hand Therapy Service

St James's Hospital

Understanding the Problem

The Out-Patient Hand Therapy Service adapted its service delivery medium in March in response to the COVID-19 pandemic and the resulting reduction in OPD appointments.

Improvement Initiative

Assessment and interventions were completed via Zoom initially and progressed to BlueEye when this service became available. These tools were used with patients who had a condition that was safe to treat out of the clinic environment. Individuals who did not have access to video were supported and treated via telephone consultation. In addition to the video-enabled care services, we used other IT tools such as increased email communication between therapists and patients to share therapy resources and increased use of internet videos to demonstrate hand exercises.

For patients who required small custom splints or pre-fabricated items, measurements were taken by the patient on screen with guidance and the necessary resources were posted to patients.

From a therapist's perspective, as we were unable to obtain objective measurements of patient progress (i.e. goniometer assessment of ROM, dynamometer assessment of strength) we used visual estimates of hand and wrist movement, visual checks of wound status and subjective outcome measures for example, pain Verbal Rating Scale (VRS), Quick DASH assessment.

Initial Evaluation

The Hand Therapy team participated in a St James's Hospital project examining the effectiveness of telehealth for Health & Social Care Professionals (HSCP). This overall HSCP evaluation demonstrated that 87% of patients were first time users of Telehealth, 89% required no help with set up and overall patients saved an average of 2.5 hours travel time. I am currently completing a service evaluation, specifically looking at the role of telehealth in the delivery of Hand Therapy.

Lessons Learned

On occasion, challenges in the use of telehealth were experienced by patients and therapists, including:

- Therapists relied on subjective information for assessment which may have limited assessment accuracy and the ability to progress treatment
- Some patients had limited access to technology
- Family member support was required for technology with some patients
- Poor image definition of camera created difficulty visualising the injury
- Therapists felt, at times, telehealth was a more time consuming process than in-clinic appointments

Where the above factors presented as a significant barrier to assessment or intervention, patients were offered a face-to-face appointment. In addition to the current service changes we have developed Hand Therapy exercise videos that patients can access online and we aim to develop and deliver patient education programmes online (these programmes were previously delivered in person, in a group format).

For further information, please contact:
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Video Enabled Care Occupational Therapy Rheumatology Service

CHO 8

Understanding the Problem

Patients attending this service are typically seen in an outpatient setting but COVD-19 restrictions meant that alternative ways to assess and manage patients needed to be identified.

Improvement Initiative

In order to guide the telehealth process for our department, a Telehealth Standard Operating Procedure (SOP) was developed. Online guidance on the use of telehealth in healthcare as well as peer supports/ networks were used to inform this SOP. I initially trialled the BlueEye platform while waiting for set-up of Attend Anywhere. A laptop, stable internet connection and a quiet environment also needed to be sourced in preparation for this new service way of working.

Attend Anywhere is now used for telehealth consultations as well as using phone calls. Face to face appointments are also provided as indicated. In order to provide choice, I offer each client the choice of platform for his/her treatment.

Initial Evaluation

Some of the client group are working, so taking time off work to attend in person sessions can be difficult. Telehealth provides a viable alternative. From a staff perspective, Attend Anywhere has been found to be intuitive and easy to use as a platform.

Lessons Learned

The application process for Attend Anywhere access can take a number of weeks. In our case, in order to continue to deliver services in this period, we used the interim alternative of a mobile network (MiFi). However, an unstable connection presented challenges during this period. While telehealth can support some aspects of service delivery, there are also some components of intervention that require to be completed in person (e.g. splinting). Some patients experience digital literacy challenges as well as unreliable Wi-Fi and this is a consideration when planning sessions. For group education sessions, there is a restriction on the number of participants that can join when using Attend Anywhere.

For further information, please contact:
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Weight Management Service – Physiotherapy, Dietetics and Psychology

St Columcille's Hospital, Loughlinstown

Understanding the Problem

The Weight Management Service in St Columcille's Hospital, Loughlinstown, Co Dublin is the national centre for obesity management in Ireland. Patients referred receive high-intensity multidisciplinary behavioural intervention of ten 1:1 appointments. Given the challenging circumstances of travel restrictions and increased risk during COVID-19, we aimed to provide alternative support to ensure continuity of care and safe access to weight management services as a priority.

Improvement Initiative

Telehealth was introduced for people attending the weight management service (WMS) using phone or video call. Each week, patients were identified and a proforma of discipline-specific and overall weight management questions was created. Sharing the caseload between the Physiotherapist, Dietitian and Psychologist, patients were called and a video call or Attend Anywhere call was organised as appropriate.

Initial Evaluation

Adapting to telehealth enabled the continued delivery of services and continuity of care for patients. Improvements were noted in relation to case management screening, weight loss medication and surgical referral. Patient feedback about the ongoing contact, care and support has been positive. Telehealth also supported a reduction in the number of appointment cancellations particularly when national travel restrictions were in place.

Although many patients appreciated the regular contact with the service, many reported that face to face interaction is more effective than the alternative of an intervention by phone. A limitation of this initiative is that initially patients did not have access to the multi-disciplinary team of three professions at each session as the caseload was shared between all three professions.

Lessons Learned

Some patients and staff experienced difficulty accessing the required technology for telehealth. In addition, while most patients were familiar with the technology, some experienced technical difficulties which made it challenging for them to use Attend Anywhere.

For further information, please contact:

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Annex

Example of Practice	HSCP Lead	Contact Details
Cochlear Implant Speech and Language Therapy Service	Antonia Hussey, Speech and Language Therapy	antoniahussey@beaumont.ie
Community Virtual Ward	Meabh Smith, Clinical Engineering	meabhsmith@beaumont.ie
Cystic Fibrosis Service	Meabh Smith, Clinical Engineering	meabhsmith@beaumont.ie
Delivering CPD Remotely in Response to the COVID-19 Pandemic	Niamh O'Reilly and Fiona Kinsella, Physiotherapy	niamhoreilly@beaumont.ie fionakinsella@beaumont.ie
Early Intervention Disability Team, Speech and Language Therapy Services, CHO 7	Beth Milofsky, Speech and Language Therapy	Beth.Milofsky@olchc.ie
Early Intervention Disability Team, Speech and Language Therapy Services, CHO 8	Sinéad Hanratty, Speech and Language Therapy	sinead.hanratty@hse.ie
Head and Neck Oncology Speech and Language Therapy Services	Teresa Hanevy, Speech and Language Therapy	Hanevy.teresa@sivuh.ie
Home Based Virtual Pulmonary Rehabilitation for COPD Patients	Cathy Gillen, Physiotherapy	cathy.gillen@hse.ie
Interuniversity Collaborative Development of a Telehealth Module for Physiotherapy Students on Practice Placement	Helen Heery, Physiotherapy	heheery@rcsi.com
Medical Social Work Service	Maria Love, Medical Social Work	mlove@mater.ie
MS Ireland Physiotherapy Service	Susan Coote, Physiotherapy	SusanC@ms-society.ie
Occupational Therapy and Physiotherapy Hand Trauma Service	Edel Siney, Occupational Therapy	Edel.Siney@hse.ie
Older Adults, Older Persons, Paediatrics and Stroke Services	Sophie Conroy, Physiotherapy	Sophie.conroy@hse.ie
Orthopaedic Physiotherapy Service	Aisling Brennan, Physiotherapy	aisling.brennan@tuh.ie
Paediatric Virtual Orthoptic/ Vision Therapy	Lynda McGivney-Nolan, Optometry	lyndamcgivney@gmail.com
Podiatry for the At Risk Foot, Diabetes	Anita Murray, Podiatry	Anita.murray2@hse.ie

Example of Practice	HSCP Lead	Contact Details
Practice Education in Speech and Language Therapy	Laura Loftus, Speech and Language Therapy	laura.loftus@nuigalway.ie
"Prehabilitation" for "Cancer Surgery" Physiotherapy Service	Sarah Moore, Physiotherapy	SaMoore@stjames.ie
Respiratory Physiotherapy Service	Sarah Cunneen, Physiotherapy	Sarah.cunneen@tuh.ie
Sending Love Initiative	Elaine Ross, Physiotherapy	eross@rhd.ie
St Michael's House – Hanen's "It Takes Two To Talk" via Telepractice	Anna Maguire, Speech and Language Therapy	Anna.Maguire@smh.ie
Video Enabled Cardiac Rehabilitation Occupational Therapy Service	Wendy Yell, Occupational Therapy	wendy.yell@hse.ie
Video Enabled Care Hand Therapy Service	Carmel Cooney, Occupational Therapy	cacooney@stjames.ie
Video Enabled Care Occupational Therapy Rheumatology Service	Katie McCausland, Occupational Therapy	Katie.McCausland@hse.ie
Weight Management Service – Physiotherapy, Dietetics and Psychology	Emer O'Malley, Physiotherapy	emer.omalley1@hse.ie

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