Secure Video and Audio Clinical Consultations:

Clinical Aspects

During the Emergency Measures to address Covid 19

April 2020

Contents

Background

During the Covid 19 pandemic, all efforts should be made to reduce face to face contact including working with patients in healthcare facilities. Among other aspects, Telehealth (TH) makes use of internet-based technologies to support remote consultations, providing a reasonable alternative to an office visit for many patients in all specialties.

Globally, it is well noted that there exists clear clinical advantages to the use of TH. In addition to the use of phone contact, texting, and emailing, the HSE is also introducing solutions to allow for videoconferencing for patient reviews. This should be integrated with and used within existing community and hospital resources.

Implementing any health IT solution often raises many clinical, technical, organisational, and policy questions that can be culturally and operationally challenging. With the introduction of video consultations, long established organisational, clinical and administrative processes and routines are disrupted and require some element of collaborative re-design. With the introduction of video consultations, clinicians can be concerned about technical support, clinical quality, privacy, safety and issues of accountability. It is recommended that implementation is best considered as a clinically led transformation of current practices to rapidly meet COVID-related needs enabled by IT.

Telehealth implementation may be challenging and resource intensive requiring both national and local strategic leadership with a clear vision closely aligned to local organisational COVID-19 strategic priorities in order to be successful. A framework defining clinical and operational governance will need to be clarified/established before local TH implementation begins. Local champions and subject matter experts will be required to promote adoption and develop policies and procedures, possibly with guidance from various clinical professional bodies to adapt traditional standards and clinical practice to incorporate Telehealth.

This guidance is for advice and consideration and local services will want to tailor it to meet their needs.

There will be some patients, who will not be able to use remote contacts and will require direct face to face contact. Use of personal protection measures should be included for these contacts.

All remote consulting, including phone discussions, texts, emails and video consulting should be clearly documented and documents retained for placement in the patients notes at a later date.

Key Areas for Consideration

- Consideration and individual clinical judgment will need to be given on a case-by-case basis as to whether use of TH is necessary and in several cases there will be a need to have a secure video consultation assessment/intervention with the patient. These will include patients for whom telephone delivery of services has not been possible or sufficient.
- Consideration may need to be given as to how comparable the quality and safety of the TH clinical encounter is as a substitute for a face-to-face interaction.
- Consultations, assessments and interventions delivered using TH to young children, those with disabilities, and many older adults may require further specific clinical considerations.
- Support to access technology may be required from family and/or carers, as is often the case for many individuals accessing face-to-face appointments.
- Each team is advised to develop a policy on contacting patient groups and offering them a range of contact opportunities. GPs should be informed of these opportunities.
- It is recommended that each clinical team identifies what patients would benefit from using video contact, and prior to using it, via phone, provide information on how it will work and ensure patient consent to its use. This will be verbal consent, and this should be documented.

Setting

- The clinician should be able to use the PC, laptop, tablet, or mobile device in a clinic, hospital room, or their home, ensuring privacy and confidentiality.
- What devices are best fitted with video consulting capacity is a decision for clinical end users .
- The clinician should be familiar with and competent in the use of the intended technology and device/hardware required in advance, to ensure a professional service delivery.
- Clinicians should be aware of the room background visible to the patient.
- It is important that settings used by both patient and clinician are distraction-free and quite for the duration of the video call. For example, switching off any other apps/notifications and avoidance of interruptions by others in the clinical or household environments.

Consider the room background and environment beyond your video:

- Do you look professional? Beware using the system outside an office, e.g. in a living room or bedroom. Are there photographs/books/posters visible that you would not have in a clinical room? Specifically, the clinician may need to check that there is no

information visible that may breach data governance guidelines, or if working from their home, their location or identity of other members of the household.

- Is there anyone else in the room who cannot be seen on camera (such as, a student with the clinician or a patient's relative/carer/advocate who are out of camera view)? It is good practice to begin by establishing who may be present but not visible in the room to help the clinician manage the interaction and ensure patient confidentiality. For example, allow others present to introduce themselves and clarify the purpose of the consultation with them. Ask them to move in front of the camera if they are taking part in the consultation (otherwise they may not be audible).
- Ask the patient where they are and advise on moving to a private location if required.
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- Consider the volume of loudspeakers and suggest that the patient/service user does the same, emphasising confidentiality.
- Consider the use of headphones: they can emphasise that you are taking confidentiality seriously.
- Consider the positioning of the camera to help improve eye contact.
- In the case of a child – ensure a parent or guardian is present at the start of the interview, obtain a separate phone line for the parent and ensure issues of consent and assent are addressed.

Consent

- Consent should be sought before each consultation. By logging into the system implicit consent is inferred. Consent to receiving the clinical service remotely needs to be included in addition to any routine capture of consent.
- The clinician should repeat the request for consent, outlining that the link is secure, the conversation will not be recorded and it carries the same rules of confidentiality as all clinical consultations. The patient should be aware they can withdraw from the process at any time.
- Verbal consent should be obtained and documented.
- Additional written patient information about the remote delivery of the clinical encounter, including any potential limitations associated with not completing a face-to-face appointment, may be required. This is to support all parties make informed decisions in relation to consenting to TH.

Safety

There are a number of ways to improve patient safety:

- Initial contact by phone may be used for screening and to assess for any current risks that may require any additional safety or individual care plans prior to undertaking the TH consultation. For example, some individuals may find the process of TH anxiety provoking due to a perceived lack of confidence or familiarity with technology. More specific safety planning may be required in specific clinical cohorts depending on their individual needs.
- Access notes and information from as many sources as possible prior to consultation.
- Request a second phone number, in case there is a breakdown in communication due to a dropping or lost internet signal.
- Request the contact information of a family or community member who could be called upon for support in the case of an emergency. Be aware of any change to the relevant emergency services numbers based on the location of the patient.
- Before finishing the call ensure there is a clear plan of action and a safety net in place for the person. This also applies to finishing the call in order to discuss with a senior colleague, with a view to recalling the patient.
- Ensure all Clinical contacts are captured in the Patient Administration System.

Pathway to Use

One example of a possible pathway is shown below – services can identify their own.

- Clinics/hospitals identify one person, the call coordinator, who can ensure the smooth administration of the service. This will initially involve phone or email contact with the patient – depending on the system used.
- If possible, prior to the video consultation the coordinator should ensure a copy of the most recent note/letter on the patient is sent via secure email to the clinician.
- Every patient contact, whether by e-mail, text message, telephone call or video call must be saved to the patient's clinical notes, whether as a note of the conversation or in in writing (letter, e-mail, text message), copied verbatim to the notes.
- Clinicians should use secure email to update other clinicians following assessments and interventions. A well-documented flow of work is required to ensure the clinician's practice is supported in the event of medico-legal issues.
- All video consultations should be recorded in the Patient Administration System.

Governance

Clinical Governance and Clinical Indemnity

Public health governance takes precedence during a pandemic. All clinicians are advised to remain updated on advice from public health through www.hse.ie. When using Telehealth clinical governance practices are the same as for other modes of clinical practices. All clinicians conducting remote consulting must be registered with their Irish professional body.

All reasons for using remote consulting, all information from the patient, and all decisions and advice given should be **clearly documented.**

The States Claims Agency has stated –

> **Scope of Practice -** Some doctors, nurses and allied healthcare professionals may be asked to act outside of their scope of practice/area of competence to assist with the Covid 19 response. For the avoidance of any doubt, and apart from any regulatory body implications, Clinical Indemnity Scheme cover will apply to these doctors where they are re-deployed outside their areas of competence.
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> **Also specifically on use of Video Consultations:**
> Telemedicine and remote consultations by clinical staff, during the COVID-19 emergency, are covered by the Clinical Indemnity Scheme.

A Well-documented flow of work is required for medico-legal purposes.
(See advice from the Medical Protection Society in Appendix 1)

Risks identified in using HSE provided Video Consulting

- Need for flexibility in use, both person and site. Licence will be required for multi clinician use.
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decisions.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In rare cases, lack of access to medical records may result in drug interactions, allergic reactions or other judgment errors.
- New system, ensuring HSE IT can monitor the security and quality of the system.
- Need for flexibility in use, both person and site. License will be required for multi clinician use.

Prescribing during Covid 19

The Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2020 has facilitated a change in how prescription only medicines, including controlled drugs, can be supplied to patients by pharmacists during the COVID-19 pandemic to ensure continued care and treatment for patients.

The changes amend the Medicinal Products (Prescription and Control of Supply) Regulations 2003 (as amended) and the Misuse of Drugs Regulations 2017 (as amended). The purpose of these changes is to ensure continuity of care and access to treatment for patients during the Covid-19 pandemic and to reduce some of the burden on prescribers and the broader healthcare system.

Joint Guidance

To assist pharmacists and prescribers, the PSI, Medical Council and HSE have published joint guidance setting out the amendments to the legislation for supply of prescription-only medicines during the Covid-19 pandemic.

Key Changes

- National electronic prescription transfer: The electronic transfer of a prescription between the prescriber and pharmacy is provided for through the use of the HSE Healthmail® system. This will remove the requirement for paper copy of a prescription to be forwarded to a pharmacy once this closed-system electronic service is used.

- **Maximum validity of prescriptions**: This has increased temporarily from 6 months to 9 months from the date specified on the prescription (some restrictions continue to apply around the dispensing of Controlled Drugs); only where in the pharmacist's professional judgement, after consultation with the patient, and if needs be the prescriber, continued treatment is required and it is safe and appropriate to do so.

- Repeating prescriptions: The number of repeats which may be supplied for both S1A and S1B medicinal products has been increased temporarily to enable pharmacists' continuity of patient care without necessarily requiring a new prescription.

- **Emergency supply provisions:**

- A pharmacist can dispense up to 10 days' emergency supply of a prescription only medicinal product at the request of a patient, including the Schedule 4 Part 1 Controlled Drugs: midazolam, clobazam and clonazepam for the treatment of epilepsy.
- A pharmacist can dispense up to five days' emergency supply of a Schedule 2, 3 or 4 Controlled Drug in defined circumstances, at the request of a prescriber or a patient.
- In addition to the existing provisions for emergency supply at the request of a prescriber, a prescriber can also request an emergency supply of the Schedule 4 Part 1 Controlled Drugs - midazolam, clobazam and clonazepam for the treatment of epilepsy.

Information Governance

Sharing information with other health professionals is key to clinical practice. In the current circumstances it could be more harmful not to share health and care information than to share it. We will need to work in different ways from usual and the focus should be **what** information you share and **who** you share it with, rather than **how** you share it.

It is essential that during the Covid-19 outbreak health and social care professionals are able to talk to each other. You will need to share appropriate information about the people in your care where possible using secure mail. Where these tools are not available, you should use this guidance to suggest ways that you can speak to your colleagues in social care.

- It is absolutely fine to use mobile messaging to communicate with colleagues and patients/service users as needed. Following recent changes, the use of WhatsApp where there is no practical alternative and the benefits outweigh the risk is allowable. The important thing, as always, is to consider what type of information you are sharing and with whom. And *as much as possible* limit the use of personal/confidential patient information.
- The HSE is making every effort to provide secure, encrypted video consulting systems to carry out consultations, and the ideal is for clinicians to use these systems when available. While waiting to gain access, and as last resort, clinicians may find WhatsApp adequate. This should only be used where there is no practical alternative and the benefit outweighs the risks. Clearly document the reasons for using these systems.
- You may well need to work from home - for example, when self-isolating without symptoms. If you are working from home and using your own equipment you should check that your internet access is secure (e.g. use a Virtual Private Network and/or if possible avoid public Wi-Fi) and that any security features are in use.
- If you are taking any physical documents home with you that contain personal/confidential patient information, you should also ensure the security of these documents at your home and when travelling.
- Information should be safely transferred to the appropriate health and care record as soon as it is practical to do so.

General Data Protection Regulation (GDPR)

The GDPR allows information to be shared for individual care, planning and research. Where health and care information (which would be classed as special category data) is shared for either individual care or to help tackle the disease through research and planning then the relevant Article 6 conditions (official authority, compliance with a legal obligation, public interest and on occasions vital interests) and Article 9 conditions (substantial public interest, the delivery of health and care, vital interests or for public health purposes and scientific research) should be relied on as applicable to the situation.

The Data Commissioner states: - Data protection law does not stand in the way of the provision of healthcare and the management of public health issues; nevertheless there are important considerations which should be taken into account when handling personal data in these contexts, particularly health and other sensitive data.

Measures taken in response to Coronavirus involving the use of personal data, including health data, should be necessary and proportionate. Decisions in this regard should be informed by the guidance and/or directions of public health authorities, or other relevant authorities.

Controllers should also ensure they document any decision-making process regarding measures implemented to manage COVID-19, which involve the processing of personal data. (http://dataprotection.ie)

In using commercial systems for data processing each service should ensure a Data Privacy Impact Assessment is completed.

Appendix 1: Medico-Legal Aspects of using Telemedicine.

Telemedicine during Covid19 outbreak. This applies to all consultations that do not include face to face contact. (Phone, text, email and video consulting).

Based on MPS webinar re: Remote Consulting https://prism.medicalprotection.org/mod/resource/view.php?id=9455 (You need MPS membership to access)

1. Ensure the non- Face to Face (F2F) technology (Phone/ Smart phone/ PC/ Tablet) is available and working.
2. Ensure patient expects the call (i.e. pre-arrange). Document this.
3. Endeavour to review their clinical notes, and document whether or not you have had access to them. Consider alternatives if you don't have access. Consider collateral from MDT.
4. Introduce yourself clearly.
5. Confirm their identity (You could ask them their DOB and Address).
6. Explain to the patient why the consultation is not F2F, and document the reason why.
7. Document if you know the patient or not (and the circumstances if not).
8. Consent: Ensure they know the nature and limitations of non F2F consultation and that they consent to this. Document this. (The link also asks for consent before the patient connects.)
9. Document the consultation, the treatment plan including medications, and referral or supports arranged.
10. Communicate and document the follow up plan and advice, including any "Safety netting" with clear plans for any deterioration.
11. Ask the patient to repeat the plan back to you.
12. If you decide that the patient requires a F2F consult then arrange it and document why.
13. Other considerations:
    - Telemedicine should be undertaken when the clinician decides it is reasonable to undertake to ensure the best interests of the patient are met and ensuring the safety of staff.
    - If the patients requires F2F **document clearly** who is the most appropriate clinician, how urgent is the consultation, why the F2F is needed, how they will access the required clinician and advice on what they should do while awaiting F2F.
    - A well-documented flow of work provides support for the doctor.
    - Adhere to Irish Medical Council guidelines. (See below).

Appendix 2: Irish Medical Council: Professional Conduct and Ethics.

Telemedicine describes the delivery of health care services through information and communication technologies to promote the health of individuals and their communities. It involves the exchange of information between doctors and patients, or between doctors and professional colleagues, for the diagnosis, treatment and prevention of disease and injuries, and for research, evaluation and continuing education.

43.2 If you provide telemedicine services to patients within the State, you should be registered with the Medical Council. This is to maintain public confidence in telemedicine.

43.3 You must follow the standards of good practice set out in this guide, whether you provide services using telemedicine or traditional means. In particular, you should

- Make sure that patients have given their consent to conduct the consultation through telemedicine and consent to any treatment provided.
- protect patients' privacy by following the guidance on confidentiality and medical records and explain your information policies to users;
- comply with data protection principles if you transfer any personal patient information to other jurisdictions and inform the patient's general practitioner of the consultation
- You must satisfy yourself that the services you provide through telemedicine are safe and suitable for patients.
- You should explain to patients that there are aspects of telemedicine that are different to traditional medical practice – for example, a consultation through telemedicine does not involve a physical examination and any additional risks that may arise as a result. (http://irishmedicalcouncil.ie)