Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE	**Surgical Step Down to Virtual Ward**
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VERSION NUMBER	**1.0**
APPROVING COMMITTEE	**DPARG** (Divisional Policy Approval and Ratification Group)
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RATIFYING COMMITTEE	**PARG** (Policy Approval and Ratification Group)
DATE THIS VERSION RATIFIED	**August 2023**
AUTHOR(S) (JOB TITLE)	**Clinical Quality Lead (Admission Avoidance & Virtual Care)**
DIVISION/DIRECTORATE	**Community**
ASSOCIATED TO WHICH POLICY?	**N/A**
CONSULTED WITH	**Surgical Consultants Ms Mckenzie and Mr Alam , Surgical Matron, SAEC Lead**

DATES PREVIOUS VERSION(S) RATIFIED	
DATE OF NEXT REVIEW	**August 2026**
MANAGER RESPONSIBLE FOR REVIEW (Job Title)	**Clinical Quality Lead (Admission Avoidance & Virtual Care)**

The WWL Way

VERSION CONTROL

Version	Date	Amendment

1 INTRODUCTION

1.1 The purpose of this Standard Operating Procedure (SOP) is to outline the steps for the Surgical Discharging Team to be able to Step down post-operative surgical patients who are deemed suitable for Virtual Ward (VW) monitoring from an acute bed within WWL.

1.2 Virtual ward monitoring can be considered as an alternative to continuing hospital stay for suitable surgical patients who are post-operative and deemed appropriate at the discretion of the Surgical Consultant.

1.3 Patients may be suitable for Step Down to the Virtual Ward to support early discharge if they require on-going treatment and/or need close monitoring to detect early deterioration and intervention.

1.4 Patients need to be agreeable to consider care outside of a hospital environment and be willing to actively monitor their own condition, provide answers to questions about their symptoms, provide their observations daily, and agree to a daily video call with a member of the Virtual Ward Team.

1.5 Referrals will be considered on a case-by-case basis and be triaged by the coordinator. The coordinator will take key information from the referring clinician over the telephone. The coordinator will ensure that the patient is onboarded on to the Virtual Ward and will provide information about next steps i.e., a ward visit and set-up of the patient on the Current Health remote monitoring equipment. The patient will need to provide verbal consent at the time of referral and the coordinator will document this.

1.6 For all Virtual Ward Step Down enquiries including advice about whether a patient is suitable for Virtual Ward should **bleep 2665 or call 01942 778918 between 8am – 8pm daily.**

1.7 Calls will be answered by the Virtual Ward Coordinator at WWL who will take basic details. The Coordinator has 2 options:

- accept on the patient onto the Virtual Ward, or
- advise the referring clinician the patient is not appropriate for the virtual ward, explaining the reason why, and ask them to manage the patient through their normal pathways.

1.8 Virtual Ward benefits patients and clinicians through:

- Remote delivery of monitoring, avoiding hospital attendance and transmission of infections.
- Reduced potential for nosocomial transmission, hospital acquired infections, delirium, deconditioning, and pressure sores.
- Supporting rapid deployment during surges in community infection rates maintaining inpatient capacity.
- Supporting early mobilisation.
- Reducing requirement for hospital stays through Admission Avoidance.
- Reducing 30-day readmissions.
- Improved patient experience.

2 SCOPE

2.1 This SOP applies to Surgical Discharge Team working within the Surgical Division at WWL. Referrals can be taken onto the Virtual Ward from any of these clinicians.

2.2 This SOP applies to the following category of patients: Post-operative surgical patients deemed suitable by the referring Clinician. This may be expanded as new pathways for Virtual Care develop.

2.3 Surgical Discharge Team must decide whether the patient should be discharged under the Virtual Ward on oral or IV Antibiotics (if indicated).

2.4 Surgical Discharge Team must document clear care plan in the patient notes on HIS prior to discharge to the virtual ward. The surgical discharge team will also state the outcome within the plan and provide a clear discharge plan.

3 INCLUSION CRITERIA

3.1 Inclusion criteria (General)

Patient Selection and Onboarding will need to ensure the referring clinician:

- Selects patients who wish to receive ongoing care and monitoring at home.
- Enroll only patients who have a degree of social support.
- Ensures patients have technological fluency.
- Ensure patients understand the importance and benefits of vital sign monitoring and treatment adherence.
- Patient with down-trending CRP.
- Patients with no evidence of perintonitis.
- Selects non-operative patients with acute cholecystitis, acute diverticulitis, or any other condition that may require monitoring but not a stay in hospital.
- Selects post-operative patients who are deemed suitable for the virtual ward by the surgical consultant.

NB: This is not a district nurse service – it is for monitoring patients after hospital discharge. Wounds and drains will not be checked.

4 EXCLUSION CRITERIA

4.1 Exclusion criteria (General)

- Acute delirium deemed unsafe for community management.
- Uncontrolled pain.
- Heavy tattooing to upper arms.
- Bilateral axillary lymph node dissection.
- Persistent atrial fibrillation (relative contraindication).
- No access to home or mobile telephone.
- At risk of domestic violence.
- Homeless or inadequate housing facility.
- Patients under the age of 16 years.

5 PROCEDURE

5.1 Patient Selection and Onboarding:

- Select patients who wish to receive their ongoing care and monitoring at home.
- Patients who have a degree of social support.
- Technological fluency sufficient to be trained to use connecting health kit.
- Onboarding should be face to face by Virtual Ward coordinator.
- The importance and benefits of vital sign monitoring and treatment adherence must be clearly explained to the patient.
- Contact should be made by the Surgical Discharge Team with Virtual Ward Band 7 on bleep 2665 or call 01942 778918 to discuss suitability and availability on VW capacity.
- Patients details and onboarding completed by coordinator, onboarding to be completed at this time.
- Nurse/CSW will put patient on kit and given an thermometer while on the ward or discharge lounge prior to discharge.
- Patient to be discharged from HIS care after full notes have been written. Ongoing care while on VW will be on HIS under care of Consultant.
- Surgical team to complete referral on HIS using drop down code ‘Referred to VW’.
- Care to be taken over by VW.
- Surgical Discharge Team to document any relevant notes onto HIS Patients notes.

5.2 Patient Reviews:

- Frequency of blood tests to be determined by the referring consultant and done by the community team.
- Patients are to have regular observations while on the virtual ward.
- Patients are to have a daily video call by the virtual ward team.
- Ward round middle grade will liaise with the VW team at the end of every ward round to be updated on the VW patients. There must be documentation on HIS to reflect this.
- Day 5 the patient will come back to the hot clinic for F2F review and probable discharge from the ward. If treatment needs to be extended on the VW, this can be arranged from the hot clinic. Further hot clinic review will need to be booked.
- Ongoing management plans arranged at that point.

5.3 Patient Discharge:

- 5 day Hot Clinic review to decide on ongoing management / discharge from VW.
- For all patients this appointment should be made prior to transfer onto virtual ward.

6 ESCALATION AND PATIENT RETURN TO SAEC

6.1 Criteria for Escalation includes:

- Up-trending WCC or CRP on 3 consecutive readings
- NEWS 3 or more
- Worsening symptoms.
- If a patient needs to be seen urgently due to any of the above, the VW nurse will contact the ward round middle grade. The patient can be brought to either SAEC or hot clinic that day.
- If it is after 5pm, the VW nurse will contact the on-call middle grade who can decide where to review the patient. Ideally, we would try and avoid using A&E but if this

route is the only one available, ask the A&E co-ordinator on extension 2429/2287 to bleep the on-call middle grade when the patient arrives.

- If the patient comes to the hot clinic at the Day 5 appointment and is unwell and needs admission, this will be arranged via the on-call team.

6.2 First step following identification of an issue should be assessment of the patient, triage, and then escalation via Band6/7 to Consultant/Registrar assigned to Virtual ward on the Surgical Ward round.

6.3 Assessment should be by review of triage/call documentation, virtual visit/ telephone call or Face to Face via SAEC/A&E.

6.4 Consultant should clearly document treatment plan, and Virtual Ward team will then arrange appropriate treatment and monitoring, liaising with Hospital@Home or other departments to arrange investigations or deliver treatments as requested and required.

6.5 The VW patient will remain under the care of the primary consultant until discharged from hot clinic.

6.6 Any ongoing management stays under that consultant, including endoscopy and repeat scans.

6.7 If the patient needs listing for a procedure that the primary consultant does not do, (eg cholecystectomy), it is their responsibility to refer to a colleague. The hot clinic doctor must inform the primary consultant that the patient is ready for listing.

6.8 If a patient is readmitted as an emergency from VW, they will stay under the care of the primary consultant but the on call team need to review them. They will then be seen on the PTWR the following day to ensure that they are reviewed in case the primary consultant is not available or it's a weekend. They can be handed back to the primary consultant when safe to do so.

7.0 KIT AND SURVEY SELECTION

Core kit:
G2 wearable (SP02, pulse rate, resp rate, skin temp, motion)
Home Hub
Tablet

Peripherals:
Blood pressure (optional)
Pulsoximeter
Thermometer

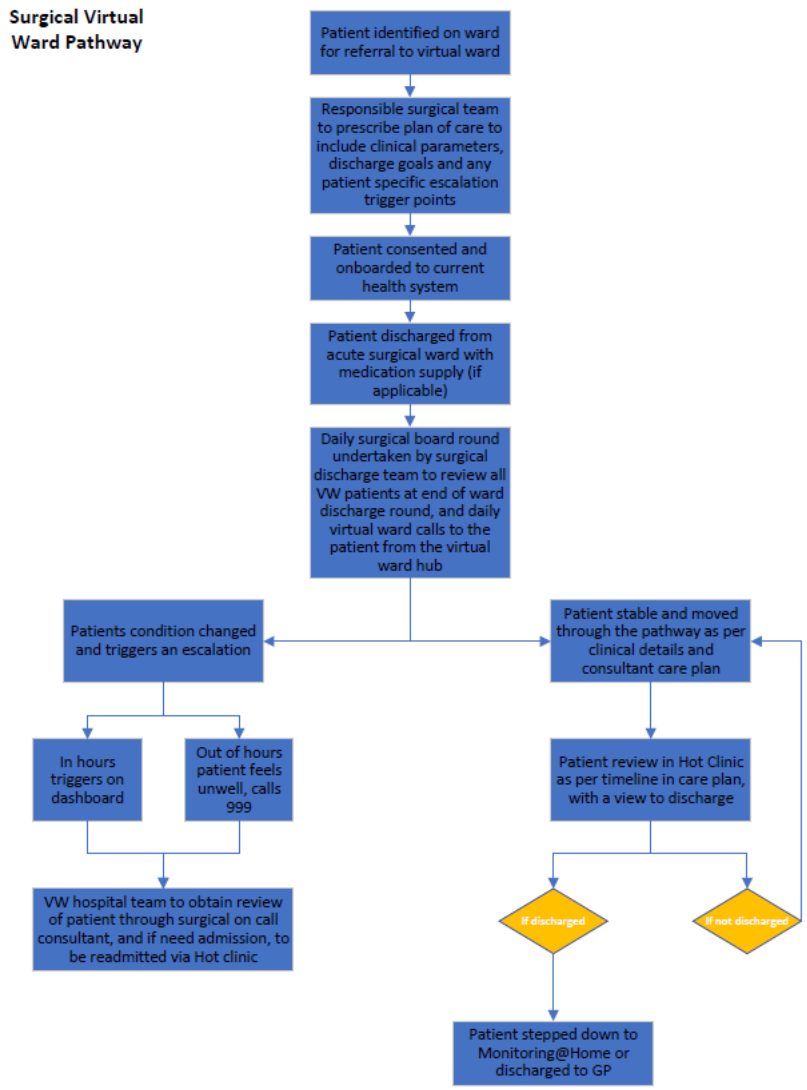
Surveys:
Tablet Survey
Symptom survey

8 ALARM SETTINGS

8.1 Standard Alarm Settings:

Alarm Name	Settings	Window
Hypertension	SBP>/=180 AND DBP >/=110	1 reading
Hypotension	SBP</=90 AND DBP</=60	1 reading
Hypoxia	Median SpO2 </=94	60 min
Tachycardia	Median Pulse >/= 120	60 min
Bradycardia	Median Pulse </=50	60 min
Tachypnea	Median Resp Rate >/=30 AND SpO2 =/<94	60 min
Bradypnea	Median Resp Rate </=8 AND SpO2 =/<94	60 min
Tachypnea_Tachycardia	Median Resp Rate >/=30 AND Median Pulse >/=100	60 min
Skin Temp	Median Temp >/=38 C	60 mi

9 VIRTUAL WARD PATIENT MANAGEMENT FLOW



10 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

11 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.
For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk