**A picture containing screenshot, tree

Description automatically generatedPatient Journey – Virtual (Frailty) Ward**

**Day 4**

Repeat blood samples were obtained and transported by the VW team to the pathology labs at Scarborough hospital. A discussion was carried out with the pathology lab regarding 1 hour reporting of results to the consultant, to provide responsive and safe care for “Bob”.

The consultant obtained the results which required a change to the treatment plan. An outpatient visit was arranged for the following day for a blood transfusion; patient transport was arranged by the CCM, the blood was arranged by the consultant. Vitamin K was prescribed by the Locality Matron following a discussion with the consultant, the pharmacist then obtained it from a local pharmacy dispensary and took it to the house. The carers were informed regarding this medication change. “Bob” remained safe over the weekend, with additional calls from the community nursing team to record observations and ensure new medications had been administered.

**Day 5**

“Bob” attended the Acute Trust via patient transport, a successful blood transfusion was carried out, and he returned home the same day. New medications were prescribed by the Locality Matron and were obtained via a community pharmacy. Conversations were had between the VW pharmacist and “Bob’s” carers regarding drug administration.

**Day 3**

A general review was carried out by the CCM, and observations were recorded. “Bob” remained stable and happy to continue to be cared for on the VW. Documentation was completed within SystmOne which allowed the district nursing team to view current care provision from the VW team, as they were still involved in this “Bob’s” care. All teams worked together to provide care at home for “Bob”.

**Day 2**

A full review was carried out with “Bob”, the carer, and the family friend. The daily board round was carried out with the Complex Case Manager (CCM), Locality Matron (LM), consultant geriatrician and pharmacist. Decisions were made regarding increasing of a diuretic. Medication optimisation was carried out with medication being obtained from a community pharmacy.

**Day 6 – Discharge**

Repeat bloods were found to be within the normal range and the medications were reviewed again. A clinical discussion was had regarding discontinuing anticoagulation medication as this was causing the drop in Hb.

A clinical discussion took place with “Bob” regarding his advance care plan including his wishes for the future. Risks were identified with the change of medication; these risks were accepted by “Bob” and the change was made. Appropriate staff involved in his care were made aware of the changes made. Onward referrals were made to the appropriate teams, and a discharge letter was completed and sent to the GP surgery. “Bob” was discharged onto the Complex Case Manager case load and remained with the District Nurse team.

An admission to the acute hospital was avoided. The care package “Bob” had at home remained in place, and there were no delays with his discharge from the Virtual ward.

The friends and family verbal review of the service was very positive, “Very friendly and helpful. A reassuring team.”

**Day 1 - Admittance**

“Bob” a 93 year old gentleman was identified within A&E – he had been waiting there for 12 hours following a 999 call from carers regarding haematuria-blood in his urine.

Virtual Ward (VW) staff liaised with the A&E medics. “Bob” required a change in his medication and close monitoring of his fluid input/output due to his existing long term heart conditions. “Bob” did not want to be admitted to hospital and he consented to be cared for at home on the VW.