

Volume 14, 01 October 2014

Publisher: Igitur publishing

URL: <http://www.ijic.org>

Cite this as: Int J Integr Care 2014; Annual Conf Suppl; [URN:NBN:NL:UI:10-1-116156](https://nbn-resolving.org/urn:nbn:nl:ui-10-1-116156)

Copyright: 

---

Conference Abstract

## Virtual community ward in a semi-rural area of Catalonia: improving efficiency through health and social care service integration

*Mrs. Àngela Vilà, Registered Nurse, Attached to Nursing Direction for Primary Care, IAS, Girona, Spain*

*Mrs. Teresa Vilalta, RN, Director of Nursing Institut Assistència Sanitària, Spain*

*Mrs. Caridad Castillo, Manager, Consorci Benestar Social Gironès-Salt, Spain*

*Mr. Benjamí Comas, Social Worker, Technical Assessment Team CBS (Consorci Benestar Social Gironès.Salt), Spain*

Correspondence to: *Mrs. Àngela Vilà, Registered Nurse, Attached to Nursing Direction for Primary Care, IAS, Girona, Spain, Phone: , E-mail: [angela.vila@ias.scs.es](mailto:angela.vila@ias.scs.es)*

---

### Abstract

**Introduction:** The increasing of the number of patients with complex chronic conditions entails a challenge for the welfare structures. Different ways must thus be found to improve coordination between health care, long-term care and social care. The paper presents the results of a experience developed in a semi-rural area of a population of 54,000. Since March 2013, some patients (mainly complex and frail) are assigned to an integrated community platform of primary care and social services teams ("virtual ward"). 49% of these patients come from hospital continuity structures, whereas 51% come from primary care or social care professionals.

**Virtual Ward Operation:** A virtual ward is a multidisciplinary case management approach for patients identified as susceptible to unplanned hospital admissions. Patients are assessed at their homes by the nurse in charge and a coordinated intervention plan is designed. They are then visited and reviewed by the whole team at intervals daily, weekly, monthly depending on the patient's condition. Basic information about the patient, is accessible both to different healthcare services professionals (emergency department, primary care, hospital wards...)

The virtual ward offers proactive attention and preventive home visits and after a period of time, the ward staff may feel that the patient is ready to be discharged back to the care of the primary care practice.

**Aims:** The project aims at improving the quality and effectiveness of health and social services through coordinated teamwork in partnership with patients and their social networks. The main goal of the project is to assess the virtual ward's impact upon hospitalisation rates. Virtual ward aims at relieving caregivers' burden and improving patient's experience of care services.

**Results:** 95 patients have been admitted to the virtual community ward. 36.8% of those needed social resources whereas only 28.5% had unplanned hospital admissions or received emergency visits.

In the six months that the scheme has been functioning, the total rate of avoidable hospitalisations has fallen by 10.3%: 18.5% for chronic obstructive airways disease and 9.1% for congestive cardiac failure.

**Conclusion:** Integration and continuity of care appear to diminish unplanned admissions and improve the care experience for both the patient and his or her carers.

Holistic focus prevents redundant assessments (one direction point only).

Continuity of care supported by a multidisciplinary team avoids professional's isolation. Shared vision and goals make care provided more effective.

Good access to a wide range of services to meet the patient's needs should be given preference.

Clinical and social records should be accessible both to healthcare and social services professionals, but data sharing remains an issue.

## **Keywords**

**avoidable admissions, case management, integrated care**

---

## **Powerpoint presentation:**

<http://www.integratedcarefoundation.org/content/integrated-care-practice-case-management>

---