



Continuous Video Monitoring Implementation: Lessons Learned

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Introduction

The VA Portland Health Care System (VAPORHCS) followed the Johns Hopkins Evidence Based Practice Model to select a video monitoring product that could feasibly integrate with existing VA technologies, meet the safety needs of our Veteran population, and support clinical staff. Continuous Video Monitoring (CVM) was fully implemented in June 2023. Implementation challenges emerged and strategies were employed to improve device utilization.

Objectives

- Discuss barriers to implementation of continuous video monitoring (CVM)
- Share strategies used to address barriers and challenges
- Improve device utilization



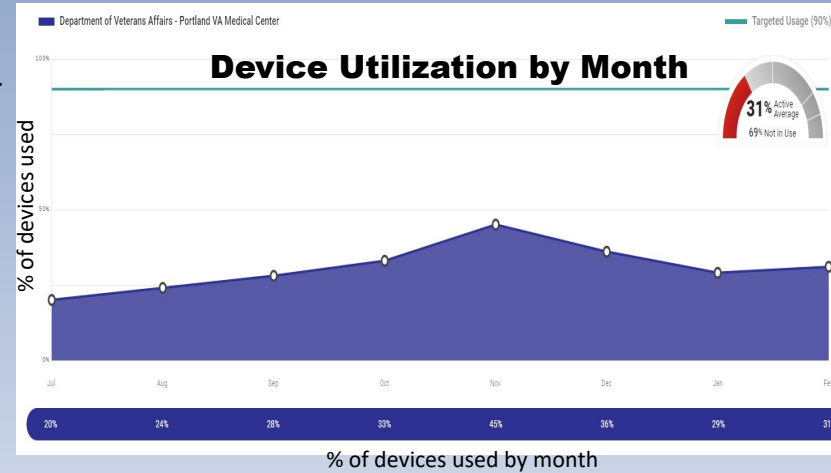
Methods

An average of 31% of available devices have been utilized since implementation. VAPORHCS targeted usage goal is 90%. Low compliance in utilization of CVM has been attributed to lack of nurse buy-in, frequent patient refusals, staff refusing to be on camera, challenges with staffing in the CVM suite, continued need for bedside sitters and lack of utilization for our intended high fall risk population.

Results

Strategies used to address barriers and challenges:

- **Lack of nurse buy-in:** Engaged unit fall champion by hosting a fall retreat, completed a nursing needs assessment and learned staff wanted more education, provided a variety of educational modalities (unit rounding, online education, visual aids, etc.). Encouraged charge nurses to trial CVM on appropriate patients and obtained leadership support by adding daily CVM census and CVM staffing review to leadership and unit huddles.
- **Patient refusals:** Provided specific patient messaging examples (i.e., “this technology is here to maintain your safety while in our care, recording is not allowed, etc.”).
- **Staff refusing to be on camera:** Encouraged utilization of privacy options during patient interactions.
- **Staffing challenges:** Utilized light duty staff personnel, posting to hire nonclinical staff, saturate staff training to cover float needs.
- **Continued need for bedside sitters:** Encouraged frequent CVM trials for patients requiring bedside sitters who do not meet specific exclusion criteria (i.e., suicide risk). Consider that some patients only need bedside sitter at night and CVM appropriate during the day.



Results (Continued)

- **Lack of utilization for our intended high fall risk population:** Developed fall risk criteria for who should be on video monitoring (Fall Risk Criteria), reported daily fall events during leadership huddles, developed a fall report for unit staff to utilize which aids in the identification of high fall risk patients according to Morse Fall Scale scores.

Fall Risk Criteria

Fall risk patients with any of the following should be placed on CVM:

- Any fall during current hospitalization
- Any fall at home in the last 30 days
- Any fracture related to fall in last 6 months



Guideline and clinical judgement:

- Consider patients on a bed alarm
- *Morse Fall Scale >45 AND osteoporosis
- *Morse Fall Scale >45 AND on anticoagulation/bleeding disorders
- *Morse Fall Scale >45 AND recent surgery of lower limb, major abdominal or thoracic surgery
- *Morse Fall Scale >65 (When trending local inpatient fall injury data from FY21-FY23, the mean Morse Fall Scale score was 69)

*The Morse Fall Scale changes frequently based on clinical picture and from shift-to-shift assessment. Please use clinical judgement to help determine CVM eligibility.

Conclusions

To improve device utilization and staff compliance with video monitoring technology, teams should place strong emphasis on obtaining staff buy-in, leading by change management, and addressing barriers to utilization in a timely manner.

*See QR code for references, acknowledgements and contact information