Using Virtual Remote Monitoring as an Alternative Observation Method for Suicidal Patients

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INTRO

Virtual Remote Monitoring is only beginning to gain favor among behavioral health consultants responsible for the safety and well-being of patients on suicide watch. The Joint Commission (2018) has allowed hospitals to decide on the most suitable safety surveillance method for patients at low or moderate risk for suicide, but still requires the assignment of individual sitters for patients at high risk.

AIM

The overarching aim of this project is to determine if Virtual Remote Monitoring is an acceptable alternative to the constant observation method traditionally deployed, which includes the assignment of an individual sitter to each suicidal patient until active suicide precautions are discontinued.

METHODS

1. Replication of a quality improvement project conducted by Kroll et al. (2019) at Brigham and Women's Hospital
2. Target population: Adult suicidal patients at low or moderate risk and low impulsivity residing on inpatient floors outside the inpatient psychiatric unit
3. Compared outcomes using virtual remote monitoring vs. in-person sitting

RESULTS

- There were no adverse events associated with virtual remote monitoring.
- Sixteen weeks of data collection revealed a net annual cost savings of $357,000.
- Nurses preferred in-person sitting to virtual remote monitoring.

DISCUSSION

- The sample size was small as in the original study; n = 20. 16 /36 total cases met exclusion criteria for VRM, i.e., high risk for suicide.
- Unable to extrapolate intervention to high-risk-for-suicide patient with high impulsivity.
- Sitter cost savings were hypothetical to avoid job elimination per collective bargaining agreement and included the capital investment in technology and staffing.

Virtual Remote Monitoring (VRM) is a safe and cost-effective means for providing observation for adult suicidal patients.

VRM-Associated Adverse Events
1/14/21 – 5/14/21

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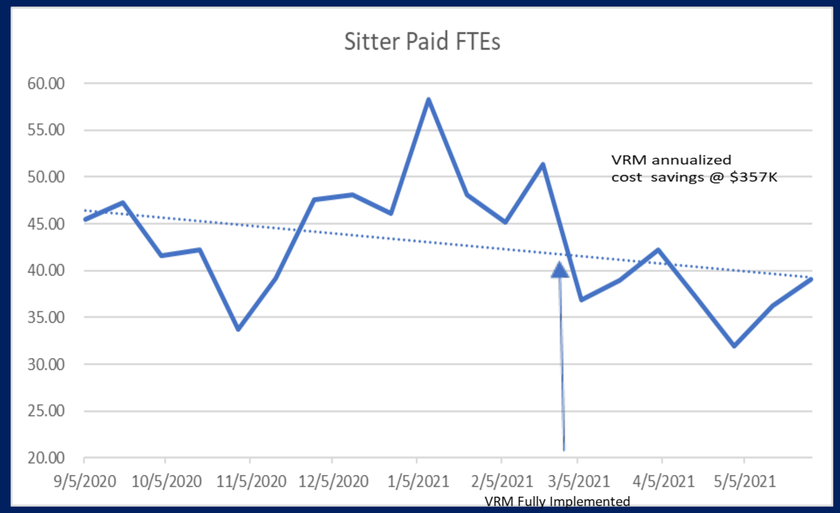

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CHANGES MADE TO ACHIEVE IMPROVEMENT IN TARGETED PROCESS

1. Established a suicide watch protocol including inclusion and exclusion criteria for VRM.
2. Incorporated the use of SafeT to stratify suicide risk following a positive Columbia Suicide Severity Rating Scale (C-SSRS).
3. Utilized the Behavioral Activity Rating Scale (BARS) to measure impulsivity as an extra criterion to assess and assure suitability for VRM.
4. Identified role and responsibilities for assessment, re-assessment, and notification of changes.
5. In addition to assigning the clinical house supervisor the gatekeeping function, established a daily 5-minute huddle to review the status on cases including outstanding assessments and/or reasons in-person sitting was selected over VRM.
6. Established a weekly meeting of key stakeholders including CNO, CNS, Medical Director of Psychiatry, Director of Logistics, nurse educator, accreditation leader, and IT.

LESSONS LEARNED

1. An automated suicide risk category was prematurely assigned to a patient based solely on the C-SSRS rather than a positive C-SSRS followed by SafeT. A request for an enterprise-wide change in the original logic in the Epic build was submitted to avoid an erroneous classification of suicide risk and the assignment of an improper observation method.
2. When in "disaster charting" mode as was the case with Covid-19 waves 1 and 2, the suicide risk assessment in all workflows was hidden. A request for an enterprise-wide change in the original logic in the Epic build was submitted to remain in compliance with The Joint Commission standard of performance for suicide risk assessment.
3. The decision to use virtual remote monitoring was best guided by criteria for use rather than nurse preference.

REFERENCES

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