

Good practice principles in implementing vision based patient monitoring technology in Mental Health inpatient Settings

Introduction and background

Vision based patient monitoring (VBPM) systems are being increasingly used in Mental Health services across England. These systems are used to support patient care by providing additional information and data to NHS staff.

Following concerns raised about the potential harmful impact on patients and staff of using VBPM systems in MH inpatient settings, NHSE has developed a set of principles for organisations to consider when planning to implement such technology. One system, Oxevision by Oxehealth, has been implemented in many Mental health services and these guiding principles have largely been informed by feedback received on the use of this particular technology, but it is applicable to all VBPM systems.

This document should be used as guiding principles for implementing VBPM systems, but when procuring these technologies organisations should also ensure they carry out their own due diligence and ensure the technology fits with individual policies, procedures, cultures and values.

Due to these systems already being in place in many Mental Health settings there is a need for timely guidance on implementation, which this document aims to provide. However further work and research is needed to understand the impact of these technologies on trauma informed care practices, patient centred care and other therapeutic interventions. NHS England will lead on developing a plan for conducting this research with independent groups.

Phase 1: Ensuring compliance with technology and Mental Health processes and procedures

Providers must ensure that any digital products in use are compliant with the Digital Technology Assessment Criteria [[HYPERLINK "https://transform.england.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/"](https://transform.england.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/)] [which incorporates:

- Clinical safety assessments
- Data protection standards
- Technical security standards
- Data sharing standards

Providers must ensure there is an appropriate evidence base that the technology supports patient outcomes before it is implemented

Phase 2: Implementation principles

There are a number of key considerations when implementing VBPM technology in Mental Health settings. Trusts implementing the technology should ensure that these principles (set out below) are all adhered to and embedded in working practices.

In addition, it is the responsibility of the implementing Trust to ensure the use of the technology is in line with and reflects the overall Trust values, supports a positive culture

Commented [CL1]: We need to engage LDA colleagues in refining these principles before publication

Commented [CL2R1]:

Commented [DL3R1]: And should we make the point about blanket use of this approach could be considered blanket restriction?

Commented [DL4]: I think we should be a bit stronger that we are not endorsing/supporting and recognise the need for review of the ethics, evidence base and patient experience to truly understand the appropriateness of such technology, but want to support in interim given current use?

which promotes patient autonomy and choice, and reflects individual Trust policies and procedures.

1. Explicit patient consent is the default position for implementation.

- Explicit informed consent is required to ensure safe and effective care. Gaining and recording consent for the use of VBPM systems to support care should be considered the default position for people with capacity. A clear protocol should be developed for establishing consent in all settings where VBPM is being implemented and staff should receive appropriate training to follow this protocol.
- For patients that do not have capacity, a decision should be made on an individual basis in line with the Mental Capacity Act.

2. Products must be implemented in line with trauma informed care approaches and not negatively impact on patient outcomes and therapeutic relationships.

- Remote observation risks impinging on patient privacy if implemented in a way which is not thoughtful and trauma-informed. Patients should always be informed when this technology is in place, along with an explanation as to the benefits, privacy considerations, and to address any misconceptions about how the system works. For example:
 - The technology should not be used in a blanket approach across a ward or service, and its use and implementation should be varied to suit each individual patient's needs and preferences.
 - Safeguarding policies and procedures must be adapted to the use of the technology.
 - Risk assessments should also reflect the presence of the technology on a ward.

3. Primary usage of the technology must enhance care and patient safety, and not replace therapeutic interventions or meaningful interactions.

- The technology does not replace meaningful interactions or therapeutic interventions.
- Trusts should ensure that as a consequence of implementing the technology, no patient:
 - Receives fewer or less meaningful therapeutic interventions
 - Receives less meaningful interactions with staff or other patients
 - Is negatively impacted in their daily schedule or activities for example, spending more time in isolation
- Whilst there are benefits that this type of technology can bring in terms of improved efficiency, this is a bi-product of the use of the technology and not a primary aim of its use. If staff time is freed up from administrative tasks or non meaningful interactions, this time should be redirected to activities that benefit patient outcomes.

4. Consider how the culture of the environment can influence the way in which new policies, procedures or technologies are successfully (and ethically) implemented into clinical practise.

- When new technologies are introduced into the environment it is essential that they are embedded in ways that meet the conditions for effective, compassionate, trauma-informed care.
- In order for the technology to enhance patient safety and therapeutic relationships and mitigate poor practise, service-user views and feedback is essential.

Commented [RA(E-X5): I do understand the background to this paper, but I wonder about the phrasing of this section. Whilst of course the default is to work with patients in a collaborative way, we also need to bear in mind that a lot of care on acute in-patient units is delivered under the auspices of the MHA which is not infrequently in conflict with people's wishes, but that is justifiable on the basis of protecting the patient or others. Monitoring physical and MH obs is a safety measure, and if patients decline this when delivered via traditional means, it presents a safety risk. The way that this section is framed seems to have lost sight of the fact that VBPM can actually enhance the safety of care we currently deliver compared with Treatment as Usual. For example, we often cannot undertake ANY monitoring when a person is in seclusion, when they may have been administered powerful psychotropic medication, making them even more vulnerable to circulatory collapse. By framing this as requiring explicit consent means that we potentially lose an opportunity to prevent serious sequelae. I think this section needs a rewrite to acknowledge this.

Commented [DL6R5]: I think the challenge is this approach enables filming if a patient in their bedroom – we cannot advocate that such an approach should be possible without informed consent – it isn't ethical. However, think we should at an earlier stage acknowledge the potential benefit – eg not disrupting sleep and supporting the safe monitoring of peoples vital obs – can we add in at the start?

Commented [DL7]: Need a bit more information on how it could – eg TR built on trust etc – am sure there is some good evidence we can point to – Emma W should be able to support

Commented [CL8]: Requires input on Trauma Informed Care approaches

Commented [DL9R8]: Yes perhaps add in the principles of trauma informed care – especially mutuality and therefore the need to co-produce approaches together?

Commented [DL10]: Think we should ref here the issue re: staff using surveillance on patients and risk of closed cultures/total institutions – can ask Tim what to ref?

- Teams should be supported to have a regular safe space to process the challenging nature of the clinical work and think about their own practise in order to learn, reflect and improve how they deliver care using this technology.

5. Staff are appropriately trained in the use of the technology and the ethical considerations in its application.

- Staff are trained regularly, in line with staff policies on:
 - Technical capabilities of the technology, including what it can and can not do
 - How to use the technology safely and appropriately
 - Consent with vision based technology
 - Speaking to patients about the use of vision based technology and what it means for them
 - Safeguarding implications of vision based technology
- In addition, use of this technology may mean that staff feel there is less need to be as observant or that the technology takes away some responsibilities on monitoring. This is not the case and staff must be skilled in ensuring that they understand their responsibilities, and how this interplays with the technology.