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Legislation to Protect the Right to Video Monitoring In Care Facilities

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1. PROPOSAL SUMMARY

Purpose: To protect the rights of residents in skilled nursing facilities ("SNF") and residential care facilities for the elderly ("RCFE") who want to install their own soundless videocam monitoring in their rooms to improve the quality of their care, and for their safety. This proposed legislation is a revised version of a 2013 Oklahoma statute which was enacted by unanimous votes in both the Oklahoma Senate and House. The revised version of the Oklahoma statute was drafted by the California Office of Legislative Counsel.

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2. PROBLEM

It is impossible for staff in nursing facilities to peer relentlessly into each patient's room, to see if the patient needs care. So instead, staff visit rooms on a rotating schedule, which may be every 15 minutes or more or less frequently depending on various factors. That is a 20th century approach that ignores modern tools, and wastes the time of often inadequate nursing staff. Nursing staff could be more responsive to total care patients if each of the patients had a videocam monitor through which the nurses at the nursing station could see, for example, six rooms at once. The ability of the nursing staff to respond to the patients' needs would increase substantially. More efficient care could be provided by staff.

Neglect in nursing homes is usually due to staff being overloaded and understaffing. To appear to comply with state and federal regulations, it is common for overworked nursing staff to falsely document in nursing notes that they provided services which they lacked the time to provide, but which the patients needed. See Falsified Patient Records Are Untold Story of California Nursing Home Care By Marjie Lundstrom, Sacramento Bee, September 18, 2011. Despite residents' wishes for video monitoring, video monitoring is prohibited in many nursing facilities and residential care facilities, even if there is no cost to the facility.

For example, the California Department of Social Services' (DSS') Community Care Licensing Division (CCLD) told a residential care facility, Vista Gardens Memory Care, that, even if a resident wants video monitoring, neither the resident, nor Vista Gardens may conduct video recording in the residents' rooms. CCLD prohibited video cameras in Vista Gardens Memory Care, even though residents or their health care agents want the video monitoring by Vista Gardens administrators for the residents' protection, and the residents or their health care agents gave a detailed written consent for the video cameras.

In another case, a nursing home removed a private videocam after the videocam recorded elder abuse neglect. A Superior Court judge allowed the nursing home to remove the videocam despite the patient's right to have her son monitor her care through the videocam.

3. SOLUTION / THE PROPOSED LEGISLATION

I. HOW IT WOULD WORK. Optimally, all facilities would install their own video monitoring system for those patients who consent. But this legislation does **not** require anyone to install video monitoring.

This legislation codifies residents' rights under existing law to install their own private video monitoring, at each resident's expense (e.g., for the resident's child or conservator or health care agent to watch). Under this legislation, video monitoring may be done only where a competent resident consents, or a lawfully appointed health care agent consents; and if the room is shared, only if the roommate consents. Warning signs must be posted wherever video monitoring is being performed. This legislation would **not** require any facility to provide video monitoring. This legislation also would prevent CCLD and the California Department of Public Health's Licensing and Certification Program, which regulates nursing homes, from unlawfully prohibiting video monitoring.

II. BENEFITS. By preventing CCLD and facilities from unlawfully prohibiting patients from installing video monitoring, the bill would foster video monitoring. What are specific benefits of video monitoring? The most important benefit would be a more productive allocation of resources, if the facility chooses to install its own video monitoring system, i.e., better patient monitoring. Video monitoring is a common procedure in intensive care units.

Video monitoring by the patient's family or by the facility itself also protects the facility, the staff and the residents from misconduct. A conservator or health care agent could monitor care and alert management about problems. **Nursing staff will benefit** because **management would no longer be free to overload** the staff. Employers would have to adequately staff facilities. Why? Falsifying nursing notes would become less prevalent if videocam recording were possible, since staff could not be pressured by management to falsely document services that were not performed. Proof of what did or did not occur would be on video recordings.

Improvements in the quality of care may reduce the number of lawsuits, and the filing of complaints with regulatory agencies. Many families would install their own videocam monitoring camera if the facility did not provide monitoring. Cameras with 24 hour recording should lower liability costs and worker compensation premiums. Recordings would show injuries and/or lack of injuries for both patients and staff. Care relatives would choose facilities where videocam monitoring is offered by the facility.

One good example is an RCFE named Vista Gardens Memory Care, in San Diego County in the town of Vista, built with cameras installed for the protection of the residents who want video monitoring.

As Harry Crowell, a co-owner of Vista Gardens noted, if a hallucinating resident claims something improper occurred (e.g., a lady claiming a naked man was in her room), or if there is any question about whether a staff person misbehaved, Vista Gardens could review the video to ascertain what did or did not happen, and then correct any problem immediately, and when appropriate, notify the appropriate authorities and individuals. If a resident is found on the floor with a bruise on the head, the video recording will show how the bruises occurred. If the bruising was caused by a falling out of bed due to reaching for a night stand while in bed, the facility would use the information to move the night table closer to the bed. The video of the resident falling would enable the facility to relay pertinent information to paramedics or the emergency room.

Many health care agents ("caregivers") will not want the hassle and expense involving in installing their own video monitor and watching the video feed. But in choosing between a facility where the caregiver must depend on the nursing notes to ascertain whether a loved one was kept clean and dry, and a facility where video monitoring is provided by the facility (whether for viewing by the administrators or the family, or for both), most people will choose the latter. The economic pressures of the marketplace will eventually lead to video monitoring being provided in all facilities and improved quality of care. Why? The availability of multiple monitors at a nurses' station will enable staff to monitor patients much better than now. Too, objective evidence will prove in many cases that the care was provided properly as required by the admission agreement and law, or that care was withheld and/or abusive. Nursing notes will become reliable instead of fiction.

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4. EXISTING LAW

42 Code of Federal Regulations § 483.15(h)(1), part of the residents' bill of rights, specifies that the resident is entitled to a "safe, clean, comfortable, and homelike environment, **allowing the resident to use his or her personal belongings** to the extent possible." A health care agent monitoring care via videocam would strengthen the resident's right to a "safe, clean, comfortable and homelike environment." A videocam owned by a resident is by definition a "personal belonging" which a nursing home must allow the resident to use.

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5. STATE AGENCIES AFFECTED BY THE BILL

The Community Care Licensing Division (CCLD) of the California Department of Social Services (DSS), California Department of Public Health's Licensing and Certification Program, and California Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA).

6. COST

There will be a small cost for the development of relevant regulations, and a California State approved consent form. Currently, there does not appear to be any state funding available for this purpose.

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7. ORGANIZATIONAL SUPPORT

Support likely would come from:

- AARP
- Older Women's League
- Senior Legislature
- Alzheimer's Disease Association
- Multiple Sclerosis Association
- Parkinson's Association
- ALS Association

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8. ARGUMENTS IN SUPPORT

The proposed legislation would:

1. Allow nursing home residents to install electronic monitoring devices in their private rooms if that resident pays for the installation and monitoring.
2. Enable family members and facility operators to monitor care to ensure that facility staff is providing the services that patients need, where lawful patient consent for videocam monitoring is given, and warning signs are posted. This measure will give families peace of mind being able to monitor their loved ones and know what's happening in their loved one's rooms at all times.
3. Inhibit elder abuse. The bill should also help decrease the number of reported cases of suspected abuse and neglect by providing video and audio evidence to support or refute such claims. Therefore, empowering residents and their families and holding nursing facilities more accountable for their staff.
4. Codify existing law and prevent DSS and facility owners from interfering with patients' right under 42 CFR § 483.15(h)(1) to videocam monitoring.

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9. ORGANIZATIONAL OPPOSITION

The following organizations would likely oppose the proposed legislation since video monitoring would oblige facilities to increase staffing so that video monitoring would

not reveal the falsification of nursing notes and inadequacies in the current delivery of care.

California Association of Health Facilities
California Assisted Living Association

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10. ARGUMENTS IN OPPOSITION

Opponents may argue that video monitoring:

1. Violates patient's right to privacy [Contra: Monitoring will only be done where a competent patient consents, or a lawfully appointed health care agent consents]
2. Violates roommate's right to privacy [Contra: No monitoring unless roommate consents, and the camera will see only the patient's bed, i.e., not the roommate]
3. Violates caregiver staff's right to privacy [Contra: Caregiver staff has no right of confidentiality in the work setting, and a warning sign will be posted on the doorpost]
4. Increases stress on caregiver staff [Contra: Increased staffing will reduce staff stress, and remove the need to falsely record in nursing notes that needed services were provided even though they were not.]
5. Will foster litigation [Contra: Video will introduce reality/objectivity and prevent unjustified lawsuits against nursing homes and residential care facilities for the elderly, where video shows that the operator is innocent]

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11. BACKGROUND INFORMATION

Reports, studies, etc. that support the need for the proposal.

Falsified Patient Records Are Untold Story of California Nursing Home Care
By Marjie Lundstrom, Sacramento Bee, September 18, 2011

Oklahoma AARP article: New Oklahoma Law Will Provide Increased Protections for Nursing Home Residents

Draft legislation and *additional information* have been posted at this URL:
http://tinyurl.com/nwauy8q

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12. PROMINENT EXPERTS WHO, AS INDIVIDUALS, SUPPORT THE RIGHT TO VIDEO MONITORING FOR PEOPLE WHO WANT IT

Harry Crowell IRVINE, CA [One of the owners of Vista Gardens Memory Care, a Residential Care Facility for the Elderly]

"I am in the Alzheimer's care business and this is a subject every patient asks for. They are concerned for their personal safety. Our facility wants to be as careful as possible. Our employees, visitors and the residents are comfortable that they are watched over as carefully as possible."

Robert Neshkes, MD, LOS ANGELES, CA [Head of Geriatric Psychiatry, West Los Angeles VA Hospital]

"There are many times, I have been uncertain as to what the cause has been for a patient's recent fall, how bad the fall was, and what part of the body took the impact. ICUs for example, commonly have video monitoring of patients in all rooms. Video monitoring allows doctors and nurses to provide better care. I think it's a good financial move for patients, families, nursing homes, and insurance carriers. It would reduce regulatory agencies' workloads."

James Spar, MD, LOS ANGELES, CA [UCLA Professor of Psychiatry, and Director of Geriatric Inpatient Unit, Resnick Neuropsychiatric Hospital at UCLA]

"I have professional experience with physical abuse of elderly residents of RCFE's, and this is one way to prevent it."

OTHERS WHO SUPPORT THIS PROPOSAL IN CONCEPT (also, as individuals and not on behalf of the organizations with which they are associated):

Phoebe Leibig, PhD, LOS ANGELES, CA [Associate Professor of Gerontology and Public Administration at USC; A Fellow of the Gerontological Society of America and the first Hanson Family Assistant Professor of Gerontology, she also served as senior economic policy analyst for AARP's Public Policy Institute; written numerous book chapters and articles on housing and long-term care, with particular emphasis on intergovernmental relations, state policies and cross-national comparisons. In 1997-1998, a Fulbright Senior Scholar award and conducted field research on old-age homes and services in India; in 2003, she received the Clark Tibbitts Award for Excellence in Gerontology from the Association for Gerontology in Higher Education.]

Laura Mosqueda, MD, LOS ANGELES, CA [Dr. Mosqueda, is chair of the USC Department of Family Medicine, professor of family medicine and geriatrics (clinical scholar) and associate dean of primary care at the Keck School of Medicine of USC. Dr. Mosqueda is the co-director of the National Center on Elder Abuse. While at UCI, Mosqueda co-founded the nation's first Elder Abuse Forensics Center.]

Deborah Newquist, PhD, IRVINE, CA [Assistant Clinical Professor of Gerontology at the University of Southern California (USC), past President of the National Association of Professional Geriatric Care Managers and has held positions on numerous community agency boards including the Alzheimer's Association of Orange County; Dr.Newquist's publications include a chapter on functional assessment for The Handbook of Geriatric Care Management, and co-editorship of the Technology for Aging in Place edition of the Journal of Geriatric Care Management. She has been featured in the New York Times on services for eldercare.]

Jon Pynoos, PhD, LOS ANGELES, CA [UPS Foundation Professor of Gerontology, Policy and Planning at the Andrus Gerontology Center of the University of Southern California. He is also Director of the National Resource Center on Supportive Housing and Home Modification, and Co-Director of the Fall Prevention Center of Excellence which is funded primarily by the Archstone Foundation. He has written and edited six books on

housing and the elderly. Dr. Pynoos was a delegate to the last three White House Conferences on Aging and is currently on the Public Policy Committee of the American Society of Aging (ASA). He previously served on ASA's Board and as Vice President of the Gerontological Society of America. He is a founding member of the National Home Modification Action Coalition.]

Kathleen H. Wilbur, LOS ANGELES, CA [Mary Pickford Foundation Professor of Gerontology; Professor of Health Services Administration at the Andrus Gerontology Center of the University of Southern California. Dr. Wilber's research has focused on improving the quality of life of people with chronic physical and mental health conditions, by improving the formal health and long term care delivery system. Her work on collaborative relationships among providers has examined cost effectiveness and health outcomes of different service delivery structures. In addition to health care, Dr. Wilber's research has focused on protective services including the identification and treatment of elder abuse, adult protective services, guardianship and conservatorship, and alternative supportive and surrogate decision-making approaches.]

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13. CONTACT

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