

In-room surveillance of residents in long term care: it's complicated

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Distressing images of inappropriate care of older nursing home residents on a recent RTÉ exposé of two nursing homes made appalling viewing for nursing home residents, their relatives and the population in general. There had been similar findings in 2005 in an RTÉ investigation into Leas Cross Nursing Home in Dublin, and in 2014, filming in a unit of Aras Attracta, a HSE-run facility for people with intellectual disabilities, showed residents being force-fed, slapped and kicked by carers.

Similar scandals in other countries have resulted in debates about enhanced surveillance using monitoring cameras (with or without audio) in residents' rooms to detect the abuse and neglect of older people.^{1,2} Such devices (often unfortunately termed 'granny cams' as an echo of the 'nanny cams' used to monitor childcare providers) are allowed in residential care facilities under the laws of some states in the United States.³ Anecdotal reports suggest an increase in queries regarding monitoring cameras from families of Irish residents. Indeed, politicians and the then director general of the HSE briefly floated the idea of encouraging covert filming in the wake of the Aras Attracta scandal.⁴

Seeking more monitoring cameras in nursing homes is a very understandable reaction from those concerned that their loved one might be the subject of neglect or abuse. A camera might serve as a deterrent as well as providing evidence of poor treatment. Cameras are already common in public areas, such as entrances and corridors, in nursing homes. However, their use in residents' rooms raises significant ethical, legal and practical issues.

The most important concern is that recording devices will infringe the privacy and dignity of the residents concerned. This is especially true during activities like dressing or bathing (although blurring or pixilation of images might provide some mitigation).

If recording devices are to be used, this should always be with the consent of the person themselves whenever such consent is possible. However, some of the residents most vulnerable to abuse may be unable to provide consent. Their wishes, if ascertainable, must

still be considered, and those close to the person, including any decision supporters under the Assisted Decision Making (Capacity) Act must also be consulted. Given that consideration of in-room surveillance is often initiated by families rather than residents themselves, the results of a very large survey of over 12,000 staff, residents and family members conducted a large UK nursing home provider are salutary.⁵ Asked their views of a possible opt-in scheme for use of visible cameras in residents' bedrooms, support was expressed by 87% of relatives, 63% of staff but only 47% of residents consulted.

The privacy rights of others must also be considered. Carers, many of whom are themselves socioeconomically vulnerable and most of whom are not neglectful or abusive, might have reasonable concerns about being continually monitored (and such concerns does not mean they have 'something to hide'). The rights and views of other residents who may be recorded, especially if a person is in a multi-occupancy room, are also important. Also, in some cases, the care provider may have rules regarding the use of recording equipment in their facility to ensure the protection of people's privacy.

If there are genuine concerns about possible neglect or abuse, this should be reported in the first instance to the care provider who should investigate the concerns. If a recording device is proposed, even if only for the peace of mind of those close to the person, it should in the vast majority of cases be overt, with the knowledge and consent of the resident, other involved residents, carers and the care provider. This open approach would also allow for explicit consideration of the important data protection issues, particularly given the potentially sensitive nature of the images. For example, how will the data be stored securely, for how long and who will have access?

The greatest challenge is the use of hidden or covert recording. Installing recording devices, without the knowledge and agreement of a care provider and their staff, could be in breach of staff privacy, of data protection laws, of contracts of care and in some cases of the rights of the resident him or herself. However, the right to privacy often needs to be balanced against other competing rights of individuals. It is necessary to consider the intended purpose of making a recording and whether it may be reasonable and proportionate and necessary in the specific context. For example, the issue of covert filming by RTÉ In Leas Cross was considered in the High Court.⁶ The nursing home's management claimed RTÉ had breached the reasonable entitlement to privacy and confidentiality of staff and patients. Mr Justice Clarke weighed this against the right of RTÉ to freedom of expression on a matter of public concern. While he refused an application to restrain RTÉ from showing the footage, he did restrain RTÉ from obtaining further footage.

There is no current directly related standard or guidance from the Health Information and Quality authority (HIQA) regarding in-room surveillance. (The issue has only been raised, to our knowledge, in one inspection report from HIQA:⁷ in a disability centre, the provider's use of closed-circuit television cameras in residents' rooms was regarded as a restrictive practice used without adequate consideration of the individual rights of residents). In contrast, their counterpart in Britain, the Care Quality Commission, while acknowledging continued legal uncertainty, has issued guidelines both for family members contemplating use of covert or overt surveillance and for healthcare providers.⁸⁻¹⁰

Given the now widespread availability of cheap recording devices, in-room surveillance in nursing homes is now readily achievable. It is possible that these devices are already being used in Irish facilities, perhaps surreptitiously. It has potential benefits in detecting and perhaps preventing abuse and neglect but there are also real privacy and legal concerns. Anyone considering covert filming, in particular, should be aware that they are entering an ethical and legal minefield.

It is essential that use of surveillance technology in residents' rooms only occurs after the full range of factors involved have been considered and within an appropriate safeguarding framework. In our view, this will best be achieved if use of this technology is subject to regulation by, and notification to, HIQA.

Finally, enhanced surveillance alone will not address the core problems revealed by the recent scandal. This will require a fundamental re-examination of how residential care is organised and funded, of the balance between public and privately run units, and of the need for adequate staffing levels, and pay and training for those staff.

Declaration of Conflicts of Interest:

None declared.

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