The ethics of using cameras in care homes

In this article...
- How technology can be used to improve care
- Why cameras can be considered an invasion of privacy
- How technology could safeguard care home residents

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Abstract

There are concerns about how cameras in care homes might intrude on residents’ and staff privacy but worries about resident abuse must be recognised. This article outlines an ethical way forward and calls for a rethink about cameras that focuses less on their ability to “see” and more on their use as data-gathering tools.

At the Royal College of Nursing Congress in 2015 a resolution was passed opposing “the use of covert video and audio surveillance and recording in nursing and residential homes”. Most delegates (79.5%) backed the resolution, reflecting a concern about how camera use has the potential to damage caring relationships. No resolution was proposed on the overt use of cameras or other technologies, despite a high level of public support for camera use in care homes (ComRes, 2014; HC-One, 2014).

Concern about the quality of care and safeguarding of vulnerable people in various care settings is widespread so it follows that there are concerns about abuse and a need to protect those at risk. Technological developments may help address these issues but many health professionals think using cameras is going a step too far because of their perceived intrusiveness and potential adverse impact on privacy. But this perception of their intrusiveness may be misplaced – the technology could guarantee greater privacy for residents than has so far been possible, along with protection against abuse.

What is wrong with technology?
In general, nurses seem to have few concerns about technology. Part of modern healthcare, it enables health to be monitored in various contexts and is used within safeguarding frameworks. Some nurses may baulk at the notion of using cameras in care homes but none would deny that observation, as part of their duty to monitor residents’ wellbeing, is part of their work.

A range of technologies can assist with such observation – from a nurse’s spectacles to movement monitors and bed, seizure and incontinence sensors. Observation is at the core of nursing and fully ethically justified. Social theorist Joan Tronto (1994) identified the ethical “touchstones” of caring, which include “attentiveness” (and therefore observation) and “responsiveness”. Cameras have the potential to help such observation and facilitate responses.

There is an alternative approach to care, in which nurses take full responsibility for observing and responding to patients. Arguments against using technologies to support observation weaken when the harms that occur because staff fail to, for example, “notice” patient deterioration are considered (National Patient Safety Agency, 2007). As such, the wider argument requires an appreciation of appropriate technologies as, among other things, observational tools that can help gather personal health data and enable nurses to be both attentive and responsive. It is clear that technologies do bring benefits; with the right safeguards in place, the same can be true for cameras.

Using cameras in care homes to safeguard residents is controversial but, seen from a different perspective, there may be ways the technology can be used effectively.
The issue of abuse

Relatives of care home residents may sometimes, quite naturally, raise concerns with service providers about abuse. They may see cameras as a tool to help monitor the care of their loved ones. According to ComRes’s (2014) survey, 80% of adults in Great Britain “support the installation of visible cameras in care homes”, while 87% of relatives of residents in HC-One care homes favour “an opt-in scheme for visible cameras” (HC-One, 2014).

While evidence is scant, it is likely that an increasing number of families are using miniature cameras (or audio recording devices) to monitor the care received by their relatives. And, as long as there are no clear frameworks for the use of cameras in care homes, families are likely to continue to “do it for themselves”. It could be argued they have a right to do so but there is a risk that trust between residents, relatives and care home staff may be undermined.

What about cameras?

The key question is: how can the potential of cameras be harnessed to guarantee a high level of privacy for care home residents and staff, while affording protection against abuse? Only when this is answered can we consider more fully when and how camera use should be sanctioned, embracing the seven principles proposed by Fisk (2015a):

- Any reasonable level of surveillance (including cameras) is appropriate for common or public areas in care homes;
- Care homes should be able to provide, or willing to permit or facilitate, the use of surveillance technologies within a resident’s room or other private areas;
- The location of surveillance technologies should be carefully considered. They should be visible or otherwise known to be present;
- Staff should be fully aware of their responsibilities in relation to surveillance technologies;
- Access to surveillance data should be restricted to authorised persons or agencies, in defined circumstances;
- Data, images, audio or video footage should be treated as if owned by the resident where it is gathered, held and used for his/her benefit;
- Use of surveillance technologies that have the potential to intrude excessively on privacy should be subject to approval by the appropriate regulatory agency.

Safeguarding data

Information on surveillance and the use of cameras provided for service providers (Care Quality Commission, 2014) and relatives (CQC, 2015) miss an essential point about the ability of camera-like devices to gather data in fully encrypted, secure ways. A wider understanding of their capability may help move the argument from “all-seeing” cameras towards a debate around data and images. The CQC did address the issue of privacy – hence its caution to obtain legal advice before considering camera use – but this may hold little weight with concerned relatives who have ready access to low-cost miniature cameras that can be embedded into household items.

Further to the argument we must justify the notion of cameras as “all-seeing” and any misconceptions about people (including staff) being able to view live or recorded footage (Fisk, 2015b). Instead, we must think of encrypted datastreams that are gathered (in communal and private areas of care homes) then sent to specialist data-holding centres in a way that prevents any possibility of images being aggregated or even “seen”. Exceptional circumstances could be where there is reasonable suspicion that abuse took place or when falls, accidents or thefts have occurred.

The viewing of images would only be possible by authorised people, with authorisation mainly confined to safeguarding officials or those with appropriate legal powers. In this context, cameras are simply tools that collect and transfer data.

Different levels of viewing would apply in accordance with degrees of aggregation, enabling controlled viewing of blurred or pixelated images for example, or that in images have been substituted with virtual representations (Padilla-López et al, 2015). Data not required for aggregation would be deleted after a pre-determined period. This allows for unauthorised people to be prohibited from being able to view images or footage. The focus is on the ethical use of cameras as a safeguarding measure by which there is recourse to use an independent “technological witness” in a way that takes account of privacy issues.

The question to be asked then is: does gathering data that will, in most cases, not be aggregated into images represent an intrusion on privacy? It can be argued that it is not. Behaviours and normal day-to-day practice in care homes, it is suggested, are unlikely to change even though there would be an awareness that cameras are in place. Further reassurance would, however, be provided to residents and their families, and a new level of protection afforded to staff. Levels of privacy are, at the same time, unlikely to be undermined and there is even the potential for cameras and other surveillance technologies to be used to enhance, rather than reduce, privacy.

Conclusion

There is no doubt technologies will play an increasingly significant role in nursing and ethical questions about their impact on privacy should be raised. As such, this article calls for a rethink about cameras. We need to consider them within the wider range of technologies used in care and accept them as tools to support (with provisos) observation and safeguarding, gather data that can help with personal health monitoring, and help with caring tasks.

The provisos relate to issues around consent, those who might have authorised access, and the protocols that would relate to data aggregation and, therefore, the viewing of images. The success of an approach involving cameras depends, however, on robust frameworks to ensure the gathering, safe storage and management of what is and must remain personal data. The technologies that we now have can help give a place to cameras within the range of observational tools by which residents and staff of care homes (and, potentially, other care settings) can be safeguarded.

References

Care Quality Commission (2015) Thinking about using a Hidden Camera or Other Equipment to Monitor Someone’s Care? Bit.ly/CQCHiddenCamera
Fisk MJ (2015b) Using cameras in care homes to combat abuse – why the argument? Primary Care Nursing Review; 8. pcnr.co.uk

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