



Reality CCTV Check

A Special Report by Eileen Chubb

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Introduction

There has been much discussion about the use of CCTV in care homes for a number of years. As a result of taking part in a recent discussion on this topic on BBC Radio Kent, I decided to write this in-depth report on the subject in order to address the many misconceptions on this issue.

All of the “what could happen” examples below are taken from direct experience of working in care and from daily discussions with care workers.

Firstly I must make it clear what our policy on this issue has always been. We campaign for [Edna's Law](#) as we know from our evidence that this is the solution, not CCTV.

We are not against families using **covert** cameras and we always advise that prior to using such a camera that:

- **The care home is informed in writing of all concerns.**
- **The CQC and Local Authority Safeguarding are informed in writing of all concerns.**
- **Then, when all trust has been lost that action will be taken to address the concerns, the use of covert cameras is entirely reasonable in the circumstances.**

I stress that what both covert filming by families, and what is highlighted by the media in undercover investigations, following whistle-blower information, is not only the abusive practices but also the fundamental failure of **all** those in authority who failed to take **any** action to stop those abusive practices.

The next issue that causes much confusion is

What is the difference between CCTV and Covert cameras?

- **CCTV** is used openly, everyone is aware the cameras are there but the footage is under the control of someone other than the Resident's family.
- **Covert cameras** are concealed, for example button hole cameras, these types of cameras are used by an individual such as a family member or an under-cover journalist. **Crucially, THEY have complete control of the footage.**

It is highly likely that **all** the film footage exposing abuse of vulnerable people that you have ever watched will have been captured **on COVERT cameras, NOT on CCTV**. We have seen numerous cases where CCTV companies have posted covert footage which then misleads the public into believing that this is the kind of incident that CCTV has captured, or would capture. It would not. We have never found any abuse captured by CCTV in our extensive research.

The misunderstanding about the difference between these two very different types of filming has led to the support for CCTV in care homes by some very well-intentioned people and we can understand why they thought it was a solution.

We do not support CCTV and all our reasons for this will be explained in detail in this report along with the robust evidence that supports our stance on this issue.

We have no conflict of interest or sponsorship loyalties in taking this stance and our only incentive for writing this report is to raise public awareness on this issue. The use of CCTV in care homes may sound like the easy answer but we want to find the **right** answer, to effectively stop abuse.

This cannot be achieved by CCTV and therefore we have to dispel the myth that has grown around CCTV campaigning - which has been fuelled by funding and sponsorship from the CCTV industry in some cases.

We have received verbally abusive and threatening messages as a result of our stance on this issue; however as we are an evidence-based charity we cannot

ignore the evidence that dictates our stance. We regret that some individuals who purport to want to stop abuse, resort to such aggressive tactics themselves.

Part One: Is CCTV a Deterrent?

In order to deter a behaviour you first have to understand what that behaviour might be and what is the driving force for it. In my book, *Beyond the Façade*, <https://www.amazon.co.uk/Beyond-Facade-Eileen-Chubb/dp/1847476333> I profile different types of abusers and give detailed examples of behaviours. I have listed the types of abusers below.

Type 1: The Ignorance Abuser

This is the only abuser type that can be retrained. An ignorance abuser is usually in a group of other types of abusers and is influenced by their behaviour. An Ignorance abuser will have a sense of right and wrong on some level and to some degree and will adapt their behaviour to different situations including CCTV.

Type 2: The Power Abuser

This abuser never acts in rage, their behaviour is controlled and pre-meditated, their motivation is the power they hold over others. They are highly intelligent and will be fully trained and qualified and often be involved in training other Staff.

This type of abuser will know all the guidelines and can reel off examples of what constitutes good practice without any hesitation. Power abusers are rarely identified and removed and the reason for this is that there is a refusal to accept that such evil could exist in such a personable and highly trained presentation.

Power abusers do not have horns on their heads, they are often popular with management because they always get all the boxes ticked, they are manipulative, and in total control at all times.

This abuser will have a circle of other types of abusers around them. A power abuser abuses for the same reason a rapist rapes, for the kick from having the power to harm. A typical power abuser will see CCTV as both an excitement because they can so easily manipulate what the CCTV sees by abusing out of view and they will get an extra thrill from that abuse knowing the CCTV is close by.

Power abusers have filmed themselves committing abuse for gratification, for example

<http://www.dailymail.co.uk/news/article-2806785/Care-workers-tormented-dementia-patients-jailed.html>

<http://www.yorkshirepost.co.uk/news/care-Staff-who-filmed-abuse-of-residents-now-face-jail-1-3022399>

These abusers do not see CCTV as a deterrent but as a buzz and also as protection. If a whistle-blower reported a power abuser in a home with CCTV, the first words out of the power abuser's mouth are very likely to be "But look at the camera footage, am I not always filmed giving excellent care?"

What we need to ask is do we want to use CCTV to questionably raise standards, if as a result it can be *mis-used* to protect the worst types of abusers working in the care system?

Type 3: The Complacency Abuser

This type of abuser can inflict the same level of harm as the power abuser but their motivation is different, what drives them to cause harm is that the vulnerable person they abuse has made the abuser's life harder in some way and therefore needs to be punished. A complacency abuser will not see the suffering they inflict because their victims are not people but objects to them, whilst a power abuser thrives on the suffering.

In a typical situation in a home with CCTV, this abuser will react if for example a person drops food, is incontinent, confused and in need of time in any way, as the complacency abuser sees the person as making their life harder and deserving punishment. This abuser will see having to take someone out of range of the cameras, to the toilet for example, as extra work and therefore warranting extra punishment. CCTV again will not identify this abuser but in addition may

well aggravate the abuse. It will however again be used as a defence against any allegations made.

Type 4: The Look the Other Way Abuser

This abuser will be in a position where they have the power to stop the abuse. This is not a whistle-blower or potential whistle-blower but is someone whose job requires them to keep people safe and act when a whistle-blower raises concerns. They could be any of the following, for example:

A Safeguarding Board member, a CQC inspector, a police officer, Ombudsman, someone employed to monitor CCTV, a Freedom To Speak Up (FTSU) Whistle-blower Guardian, the Chief Executive of an organisation, an Employment Tribunal Chairman or the Secretary of State for Health.

It is essential to realise that there are very many of this type of Look the Other Way abusers and too many people are fooled by their outward respectability.

Part Two: **The Consequences of Modified Behaviour**

Now that we have established that the very worst systematic abuse will not be stopped by CCTV, we now need to look at what other benefits CCTV could have and weigh those benefits against any adverse consequences in order to arrive at an outcome that considers all the facts.

In this section we will be looking at the effect of CCTV on both good Staff (and there are thousands of excellent hardworking care Staff who deserve recognition) and the not quite so good Staff, the average care worker.

Example One

A care home has CCTV in the communal areas, ie dining rooms, corridors and lounges. Having worked as a carer I know how hard all good care Staff have to work, when for example on an early shift you have to get everyone washed and dressed, and given their breakfast. Every shift you work is on a knife edge where

the slightest thing, such as someone being ill or having an accident, tips everything else over the edge. Care worker ratios of Staff are so tight that it does not take much for the best care Staff in the world, through no fault of their own, to neglect someone on a shift.

The accountability for this situation should be laid at the door of the company chief executive who sets the budget for the home. This responsible person has no CCTV scrutinising **their** actions yet they are directly responsible, while the hardworking Staff get the blame.

“What could happen?”

The following example is used to demonstrate what could happen when CCTV is installed. This hypothetical care home is rated good, has always been rated good and for that reason has been chosen from a large group of a provider’s chain of homes to have CCTV.

There are 17 residents on this unit and what normally happens every morning is that they are washed and dressed and brought to the dining room for their breakfast. **Then things change when CCTV cameras are installed.**

Day 1. Staff have been working since 7am to care for all 17 residents but Staff are now aware that 14 residents have been seated in the dining room waiting for their breakfast and it is nearly 8.30am and now that there is CCTV in the dining room they feel pressured by this.

So the decision is taken to leave the last three residents in bed and instead attend to the breakfast, assist people who need help to eat and drink and administer medication, and then assist people from the dining room to the lounge - because all these areas are covered by CCTV.

Then Staff go to attend to the last three residents who have now been in bed since 8pm the previous evening and who are finally attended to at 11am. A total of 15 hours in bed without food or drink or care.

If anyone questions the staffing ratios the paperwork would show staffing levels were sufficient. If anyone asks why were three people still in bed, Staff would say those residents did not wish to get up and that would be accepted.

This is just the beginning of the shift but the impact continues the whole day, the daily care records are not completed that day which is the first time this has ever occurred in this home.

Day 2 One of the Staff on this shift is not as fast as the other care workers, they are not a bad carer but just slower. This means that four people are left in bed on this shift. Again the care records, fluid charts, daily notes etc are not completed and throughout the shift, when out of sight of CCTV, corners are cut.

These are not bad Staff, they do their absolute best every day but on the average shift in **even the best care home with the best of Staff, care is neither poor nor perfect at all times.** For example breakfast can often be a bit late because everyone is cared for first. The CCTV sees breakfast being given to a room full of residents but does not pick up what is happening to the people who have been left in bed.

After a few weeks of CCTV impact, CQC inspectors visit the home and criticise the poor paperwork. CQC check and find there is the correct Staff ratio so they put any issues down to Staff deployment.

Those who sell CCTV will say that residents got their breakfast at the correct time and use this to claim that therefore CCTV improved the care.

Would you want your loved one to receive better care if the price that is paid is someone else's loved one gets no care at all? **Especially when you realise that one day, the person who gets no care at all IS your loved one?**

This is a good home but as time goes by the Staff become more demoralised and leave. They are replaced with Staff who are not so good but who are willing to go slow and perform good care for the CCTV even if more and more people are neglected out of CCTV range in order to do so.

What the CCTV does NOT see

Consider just one situation here, of a person being taken from the room. The CCTV will not pick up on all the unseen outcomes of this, whether they are being taken to the toilet or for bed rest or for a walk outside. There is no intelligent tracking of that person or knowledge of what is actually happening to them when out of CCTV range or how soon they should be expected to return. (Please see Summary for the limitations of CCTV.)

This can apply to any number of care situations, for example:

- If someone calls out to be taken to the toilet and two care Staff immediately respond and hoist the person to a wheelchair and leave the public area. The CCTV films all this being done correctly so therefore good care is presumed, but what might it not capture?
- The person is taken to the toilet but is already soaking wet and is taken back to the lounge to sit in that wet state for some hours.
- The person is taken to the toilet and left sitting there for over an hour before someone comes back.
- The person is taken to the toilet and intimidated or threatened not to call out.
- The person is taken to the toilet and assaulted.
- Other residents are left neglected in order to take this person to the toilet immediately and be seen to be doing so by CCTV.
- The person is taken to the toilet and given all the care needed.
- Someone says they want to go to bed so Staff help the person to their room where it is presumed that good care has been given, but in reality that person may have been left on a commode or in a wheelchair for hours after being taken to their room, before they are helped into bed.

There are also situations where for example Staff may need to accompany someone to hospital which would leave depleted Staff numbers.

Many people in care homes are too mentally or physically frail to tell anyone what is happening to them.

As we established earlier the worst abusers will not be detected by CCTV, only **covert** cameras have proven effective in this. CCTV would be used by the worst abusers to get an extra thrill and could end up actually protecting them.

So would CCTV drive up standards of care generally?

The questions that really should be asked are

- Would CCTV **appear** to drive up standards?
- Would CCTV cause adapted behaviour?
- Could adapted behaviour have a detrimental effect on care standards?

If genuinely good homes can be adversely affected by CCTV then why do so many people believe CCTV will stop abuse?

Part Three

The Evidence: What did happen in a real home

The following care home is real, we have chosen not to name it here only because good care Staff have worked hard to bring the home back to pre-CCTV standards. This home has always been consistently good until CCTV was installed at the beginning of 2015.

The *extracts in italics* below are taken from CQC inspection reports for this home to show how care deteriorated after CCTV installation and here we flag up some of the key issues:

- **Increased risk of pressure ulcers**
- **Medication risks** eg medication found in people's bedrooms and one person at risk of suicide was stockpiling medication without Staff being aware.
- **Fire safety and infection control risks**
- **Moving and handling risks**
- **Monitoring and audit issues**
- **Lack of risk assessments**

- Lack of care plans
- Hot water scalding risk
- Staff deployment issues
- Lack of training
- Some Staff did not know new Residents had been admitted to the home

Inspection Report 1: May 2012

The home was meeting all essential standards of quality and safety.

Page 2: *People told us that Staff respected their privacy and dignity and treated them well.*

Page 6: *We looked at care plans and we saw that people's likes and dislikes were discussed with them and recorded. This included discussions on their preferred place of care and their options for end of life care. We saw that instruction was included in care plans for Staff to support them in their choices.*

Page 7: *We saw that people were able to spend their time where and when they preferred. This included the time they got up and dressed and when they went to bed*

Page 8 *We observed that people's personal care needs have been met and saw that they looked well cared for. We discussed the assessment and care planning with the manager. She told us she had implemented person-centred care planning. This included a personal profile that had been developed with the person and/or their relatives. The profile detailed the person's needs from their perspective and how they liked to be cared for. When we looked around the home we saw personal profiles on display in each person's room. The manager said this had been agreed with the family so that Staff could understand the person, their lifestyle, what was important to them and how they would like to be cared for.*

Risk assessment of the environment, skin integrity, nutritional risk, moving and handling, risk of falls and fire risk were recorded with evidence of how the risks were minimised.

Page 9 *All the care plans viewed had been regularly reviewed to take account of changing needs and included evidence of good liaison with healthcare professionals, community psychiatric nurse, GP, district nurse or dietician involved in the person's care. Daily records viewed were detailed and showed good monitoring of the person's needs and actions taken where there were identified changes to the person's needs.*

Page 10 *The manager had raised a number of safeguard alerts on behalf of people at the home where they had received poor care in hospital.*

Page 11 *We looked at the recruitment records for three Staff who had been appointed since the last inspection. We found that all of the required checks had been carried out on all Staff before they started working at the home.*

Page 12 *We saw from the records that a substantial training programme was in place. Since January 2012 training had been provided in fire safety, health and safety, infection control, food hygiene, moving and handling, safeguarding adults from abuse, falls prevention, dementia care, first aid, nutrition, tissue viability, medicines administration and end of life care. Care Staff told us they felt well supported by their manager and their team colleagues. One Staff member told us they had regular handover meetings between shifts to report on any changes in people's needs and they had recently received supervision from the manager.*

Inspection Report 2 April 2013:

Compliant all standards.

Page 6 *Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We reviewed four people's records and found systems were in place to gain and review consent from people who used the service or their representative if appropriate.*

Page 8 *We looked at the individual care plans for four of the people living at the home. They were written in a person-centred way, identifying people's strengths and needs and supported by risk assessments. We saw that care plans and risk assessments had been regularly reviewed and updated where necessary*

so that Staff had the most current information available to consistently support people effectively and safely. From observations on the day it was clear Staff had a good relationship and communicated well with people living in the home. A relative said "it's brilliant here, I often see the Staff just sitting chatting to the people who live here".

Page 10 We looked at the medication administration records (MAR) charts and the medicines stored in the locked medication trolley. All charts were completed correctly throughout. Medication was signed for after being dispensed and stock reconciled correctly. Competency checks were carried out every month by the manager to ensure Staff maintained their skills to administer medication. We saw records of this supervision.

Page 11 All concerns even if they were raised verbally or informally were recorded in writing in order that trends and patterns could be identified, monitored and rectified.

Report 3 April 2014

(NB nine months before CCTV cameras were installed)

All standards met.

Page 4 We saw that care plans and risk assessments were informative, up to date, and regularly reviewed. The manager responded in an open, thorough and timely manner to complaints.

Page 6 Care plans had been developed that covered important areas of care such as personal care, mobility, skin care, communication and leisure. These care plans had been regularly reviewed. Three care Staff that we spoke with were knowledgeable about people's care needs and life histories.

Page 8 Medicines were delivered to the home from pharmacy in pre-packed boxes with dosages and set times for administration clearly marked. We saw that people's medicine administration (MAR) charts were up to date, easy to read, with Staff having signed appropriately when they had administered each medication. There were no gaps in any of the records we inspected.

PAGE 9 *Hot water temperatures were regularly tested to ensure they ran at safe temperatures to prevent scalding.*

Page 10 *We saw that detailed notes were kept from the interviews of each candidate. This indicated that care and attention went into recruiting people with the right skills and abilities to care for people in the home.*

Page 11 *The care records that we read had been signed by the people and their representatives. The provider held regular residents' and relatives' meetings and produced minutes of those meetings. The manager conducted regular Staff meetings, again producing detailed minutes.*

Report 4 September 2015

Eight months AFTER CCTV had been installed.

FAILED ALL standards and is in special measures as well.

EC COMMENT There was no registered manager in post, however the level of deterioration in this home cannot be explained solely by the departure of the manager, who had left only four weeks before this inspection.

Page 2 *People's medicines were not safely managed. Risk management plans both for individual people were not in place to support people and keep them safe.*

Page 6 *People were not protected against risks in the service, including unsafe medicines management, environmental and individual risks and those relating to Staff recruitment and employment. Due to our level of concern at the inspection relating to medicine and moving and handling practices, we reported this to the local safeguarding authority who were responsible for investigating circumstances where people may be at risk.*

Arrangements were not in place to ensure that medicines were ordered, administered, recorded and stored safely. In one person's bedroom we found two plastic medicine dispensing pots. Staff confirmed that these contained a total of five paracetamol tablets. The provider confirmed that Staff should have observed the person taking the tablets and not leave them in the person's room

for them to take later, while signing to confirm the person had taken the medication. The person's records showed that they had previously tried to harm themselves by taking paracetamol tablets.

EC COMMENT Paperwork is often the first thing to be neglected because Staff may feel that sitting down writing in front of the CCTV may be perceived as them being lazy. Medication duties will often be rushed because Staff doing medication are often called by Residents for attention. Staff do not want to ignore that even when doing a drug round, because they will feel the need to perform instantly for CCTV. Without the presence of CCTV they would feel able to concentrate more on the medication instead of responding instantly to the Resident, and that is how medication practices can suffer.

Residents may remain in pain if they do not receive their medicine and also Staff may hand it out or leave on a table without taking time to check it has been swallowed and recorded correctly.

Several packets of prescribed tablets, dated as dispensed in April 2015, were found in another person's en suite bathroom and were not securely stored. This person's MAR sheet showed that most of these medicines were no longer prescribed for the person.

Other people living with dementia who may have gone into that room were at risk of taking a large number of tablets that were not prescribed for them and could harm them.

One person indicated they were in pain when Staff attempted to help them to stand up. Staff confirmed that the person could not have their prescribed tablets because they had run out. We asked to see the MAR relating to this to check how long the medicine had not been available. Staff told us they could not find that page of the person's MAR but believed a Staff member had now gone to the pharmacy to get the medication.

The provider was unable to show us for example a current fire or legionella risk assessment and implemented action plans for the service to confirm people were protected from the risk of fire and infection. Individual risks for people were not always assessed when required so that suitable actions could be put in place to limit their impact on people. One person's records showed they had been admitted to the service in May 2015.

EC COMMENT NB This was eight weeks after CCTV was installed.

Their pre-admission assessment showed they required prompting to eat, had suicidal tendencies, used a walking frame to mobilise and were at risk of falls. There was no risk assessment in place in relation to the person's nutrition, pressure area care or moving and handling.

Several care record files did not contain an assessment of the risks for the person in their moving and handling requirements. . We saw Staff support a person to transfer attempting to lift them under their arms, which is not a safe way of assisting people and can result in injury to the person and to the Staff. The transfer stopped as the person showed they were in pain. The person's relative told us they had seen Staff routinely support the person in this way.

EC COMMENT This practice is often evident in homes where corners are being cut due to pressure of Staffing levels, however this home has the correct Staffing levels so the pressure is coming from elsewhere, ie CCTV, and this is a form of adaptive behaviour and poor care as a direct result of the CCTV. It must be noted this form of handling causes pain.

Risk assessments were not updated to ensure Staff were aware of an accurate level of risk for the person. One person was identified as being at risk of falls. Accident records showed that the person had recently had an unwitnessed fall. The risk assessment for falls had not been updated since 3rd June 2015

EC COMMENT ie 5 months after CCTV was installed.

Some people were assessed as at high risk of developing pressure ulcers. We checked the settings of pressure-relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating. One person's mattress was set for a person who weighed 100kg.

EC COMMENT Again, this is a result of cutting corners and not completing proper documentation, and again this is a direct result of CCTV because this home previously had always had excellent paperwork.

The person's weight, which was to be checked monthly due to their risk relating to nutrition and weight loss, was last recorded as checked in June 2015. This record showed the person to weigh less than 65kg.

Page 7 Additionally the electric pump that supported the pressure-relieving mattress to inflate showed four lights as lit, including a red light indicating a

power failure. This clearly showed there was a fault. Staff had not noted the incorrect setting on the mattress or the failure light.

People were at risk from poor food hygiene practices. People were not supported to clean their hands before receiving their meals. Catering Staff handled people's food directly when putting it onto their plates while serving lunch.

EC COMMENT This is more evidence of Staff rushing to make up for lost time from the beginning of the shift.

People were at risk of being unable to gain help and support when they needed it. One person who stayed in their upstairs bedroom called out to us for help as we walked past the room. The person was visibly distressed and told us that night Staff had removed their call bell to stop them calling for assistance. We called for Staff assistance for a person using a call bell in a nearby bedroom. The senior Staff member who responded searched the person's bedroom, en suite bathroom and the garden outside their window in case the call bell handset had fallen out. The Staff member confirmed that the person did not have a call bell available to them to gain support.

Staff deployment was not effective. There was no clear system in place for Staff to monitor people who stayed in their bedroom and who may not have the capacity to use their call bell.

EC COMMENT: If they do not have capacity to use a call bell, (assuming they actually had one available and it had not been removed by Staff to prevent use), then they do not have capacity to choose to stay in their room all day.

CQC have misinterpreted what they are seeing, it is not a question of Staff deployment, it is a question of CCTV adversely affecting the previous working routine due to Staff adapting their behaviour in response to CCTV. Call bells sounding for long periods would be captured on CCTV so Staff would feel pressurised to minimise the chance of persistent call bells.

While a Staff presence was often available in the main lounge area, there were periods of time when people sitting in the rear lounge were not monitored by Staff. Two of these people's records identified that they were at high risk of falls and required constant supervision.

EC COMMENT At this point CCTV was in the bedrooms as well as the lounge, meaning that Staff were adapting their behaviour throughout all care processes. So the greater the number of CCTV camera locations, the greater

the adverse impact on the working shift, resulting ultimately in poor standards of care.

Another person was found on the floor in that room later in the afternoon. On one occasion when there were no Staff in the dining room, one person who was sitting alone at a table waiting for their food to be served, stood up, took a sandwich from another person's plate and attempted to eat it. Staff had told us that the person could not eat solid food due to the risk this posed for them. We intervened and called a Staff member to support the person.

EC COMMENT Remember that Staff would have been in the bedrooms still getting people up and doing this slower than usual for the CCTV. As the shift progresses, more corners need to be cut in order to make up the lost time, such as not assisting people to the toilet or giving drinks.

A relative told us that they felt Staffing levels were suitable as call bells stopped ringing so they were answered promptly.

EC COMMENT: Call bells had never been a problem in this home previously but now people were being left in their rooms longer than normal. This relative assumed that the fact that bells had stopped was positive, but it may be that bells had been taken away to stop the cameras triggering an alert when heard to ring for prolonged periods.

People were not protected by a robust Staff recruitment process. One member of Staff was recorded on the rota only by their first name. We asked the provider and deputy manager for the full name of this Staff member, who the rota showed was regularly working in the service as a care worker. The management team told us they were unaware of the worker's full name. We asked to see the person's recruitment record to show that the required references and checks, including criminal record history checks, had been completed before the person started working in the service. The provider confirmed that this information was not available.

EC COMMENT No points given for sitting down doing paperwork when it is felt more important to put on a good show for the CCTV.

Page 8 Copies of the provider's or the local authority's protocols in relation to safeguarding and whistleblowing were not available when requested.

Page 9 *Closed circuit television cameras i.e. CCTV were fitted in all bedrooms. They were directed in such a way as to view and record the whole room including when people undressed or were supported with personal care whilst in their bedroom. There were no assessments of people's capacity regarding this and no record of people's consent to the people's CCTV. One person, assessed as having capacity, had signed their agreement to their draft care plan. The person told us they were not aware that there was CCTV in their bedroom.*

They also told us they did not like this and had not given their permission for it. The provider told us that they had contacted everybody's relatives for agreement to the CCTV being operational in people's bedrooms. The provider did not have confirmation that relatives making that decision had the legal authority to do so on each person's behalf so as to comply with the legal requirements of the Mental Capacity Act 2005. The provider told us they had not considered this as they were not aware that this was required. This is in breach of Regulation 11 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

The deputy manager told us that Staff supervision was no longer taking place and that assessments of Staff practice and competence were not completed. Staff did not use the learning from their completed training effectively in their day to day practice as observed in relation to, for example, medicines and moving and handling of people. The poor practice and skills levels we observed showed that Staff had not received suitable training, ongoing observation and assessment of their practice to make sure they were competent.

People's weights were not routinely recorded and monitored to support their wellbeing and nutrition.

We had received information of concern prior to our inspection relating to poor support for people's foot and nail care.

EC COMMENT **Complaints are now going outside the home for the first time. The Staff are not bad Staff, they know very well what they should be doing and have done it previously but their behaviour is now the behaviour of Staff that have been tipped over the limit in their everyday tasks by having to adapt their practice for the CCTV.**

Page 11 *Overall people and their relatives told us that Staff cared for people in a caring and compassionate way. Our findings however, in terms of how well Staff were trained and supported to ensure people's wellbeing and all support*

functions including care records and management support, did not concur with people's comments about a caring service.

EC COMMENT CQC do not recognise what is going on, and are saying maybe it is because the Staff are not trained, but previous reports had noted comprehensive training and even if Staff do not have training updated every few months, they do not suddenly become UN-trained. CQC inspectors have failed to understand the connection with the CCTV installation date.

Page 12 *We had received information prior to our inspection that care plans were not developed for several people who used the service, and this included people who had lived in the service since April 2015.*

EC COMMENT three months after CCTV was introduced, the paperwork that the care Staff had previously completed excellently was now non-existent and this is because they had adapted their behaviour for the CCTV.

Care plans were not in place for an additional two people admitted to the service during the inspection.

Staff did not have clear guidance on how to provide person-centred care to people who used the service. On the second day of our inspection we found that some Staff were not aware of two newly admitted people who were living in the service.

EC COMMENT It is clear that effective handovers had not taken place. Staff conducting a handover could easily be misinterpreted by CCTV as just sitting and chatting.

Staff had therefore not been given any written or verbal information on the people's needs or how to meet them. A visitor told us they were concerned that Staff supporting their relative did not know that the person had recently had a fall.

We were not reassured that people who remained in their bedrooms received appropriate encouragement and support to meet their nutritional care needs. Records were not available for example, to show whether Staff had responded to one person's deteriorating mental health needs and if they had any food or fluids during the day and it was also not clear if the person had received any contact from Staff providing contact and engagement at any point during the day.

EC COMMENT We always said we knew that the most vulnerable people with deteriorating mental health needs and highest need for support would be neglected while Staff would pander to the needs of someone else's loved one and perform for the CCTV. Meanwhile another person would be left in bed all day and night in abject neglect - as happened in this case, where there was no evidence that they had any food, drink or human contact all night and most of the day. It must have been bad for a CQC inspector to even notice.

Page 13 *The provider told us that they had become aware that complaints had been raised but that records were not available to demonstrate any action or learning identified.*

Page 14 *The provider had not notified the Commission as required by regulation, of the registered manager leaving their post or that they were not aware of their legal responsibility in relation to this or that they were required to have notified us of a serious injury to a person living in the service, or that a safeguarding concern had been raised.*

The provider told us there were no systems in place (EC COMMENT No systems in place now but there were before CCTV) to assess and monitor the quality of service provided to people. No audits were available, such as in relation to medicines, care records, health and safety or infection control. Checks were not put in place to monitor pressure mattresses and not all falls were recorded. No analysis was completed for example of falls or pressure ulcers. The required records were not properly maintained, for example in regard to people's care, Staff recruitment and training or complaints. The provider told us that they were unable to locate a number of care records they expected to find maintained in the service.

Report 5 December 2015 DETERIORATION.

The provider has agreed to voluntary suspension of all new admissions.

EC COMMENT The deterioration in care is clearly linked to CCTV even though the CQC does not recognise this.

Page 2 *Improvements have been made to respecting people's rights and CCTV cameras are only operating in communal areas and not in people's private bedrooms.*

Page 5 *At this inspection on 16/17 December 2015, a current fire risk assessment or legionella risk assessment and action plans remained unavailable to confirm that people were protected from the risk of fire, or infection from legionella.*

The existing fire risk assessment had not been updated since 2012. It relied upon people's personal emergency evacuation plans (PEEPS) to help them leave the building safely in the event of a fire. The manager confirmed that PEEPS were not available for any of the people living in the service currently.

Whilst checks of the temperature of the water were completed routinely in some areas, they were not in other areas, potentially putting people at risk.

At our last inspection we found that some people's pressure-relieving equipment was not used properly or checked regularly to ensure it promoted their safety and wellbeing. At this inspection we found again that some people's pressure-relieving equipment was not at the correct setting or that the equipment was indicating a fault. This had not been identified by Staff to ensure the risk had been mitigated.

The manager had introduced a system to support safe Staff deployment. This identified where each member of Staff was to work during their shift

EC COMMENT Such a system is hardly a ground breaking concept and should have been an obvious part of routine management. In reality the deployment will be to put Staff as much as possible where the CCTV can see them.

Page 8 *We noted however that not all areas of people's assessed needs were included in their plan of care and not all of their individual risks were assessed. Records showed that some people were routinely refusing their prescribed medication.*

EC COMMENT Recording that someone refused their medication is a way to cut how long the drug round takes. Also it should be noted that CCTV would not show what medication is being given and would not be a deterrent to anyone intent on medication abuse. e.g. overdose of sedatives makes less work for Staff.

This had not been risk assessed and a plan of care put in place to support the person and mitigate this risk. Another person had recently been prescribed a thickener for their drinks due to swallowing difficulties. No risk assessment was in place with regard to their risk of choking. Records showed that one person

had lost a significant amount of weight in recent weeks. There was no care plan or risk assessments in place for the person's medical condition or nutritional needs to support improved nutrition and well-being.

Care plans and risk assessments were not always updated as people's needs changed. One person was identified as at very high risk of developing a pressure ulcer. The person's plan of care had not been updated to reflect instruction from a healthcare professional that the person was to go to bed every afternoon for bed rest. Bed rest is prescribed to reduce the pressure on certain areas of the body so as to help prevent or improve pressure ulcers in that area. The person had been assessed as having a grade 2 pressure ulcer three days before our inspection, which was reassessed as a grade 3 pressure ulcer on the day before our inspection. This meant that Staff did not have clear information to guide them in ensuring that the person received care in line with their current care needs and to limit risks.

EC COMMENT The reason the person may have been left in bed for long periods before getting up is because Staff were busy performing for the CCTV in the communal areas. By the time people had been got up, it might have been time for their prescribed bedrest so another way to cut corners to save time is by leaving them in bed. Even if there had been no CCTV in the bedrooms and only present in the communal areas, the CCTV would still have adversely affected the care.

Page 9 *Systems to support safe Staff recruitment, skills development and competence assessment in providing quality care were now in place.*

Report 6 March 2016

Requires improvement in all areas.

One year 3 months after CCTV was first installed.

Page 2 *At this inspection of 16/17th March 2016, improvements were noted in all areas from the previous inspection. Further minor improvements were needed in regards to aspects of how people's individual care needs and risks were assessed and planned for, and one area of medicine management.*

The manager took immediate action to address shortfalls in Staff practice and ensure a good meal time experience for the people using the service.

EC COMMENT This type of wording glosses over problems to hide facts instead of informing the public fully by describing what the problems were.

Page 4 *People were not always listened to and treated with respect. The concerns were isolated to a couple of Staff members and the manager responded immediately to improve their practice.*

EC COMMENT "...isolated to a couple of Staff members" makes it sound as if it is only a minor issue but if you are the vulnerable person who sees only these Staff all week the impact on your well-being is far from minor.

Also it was not the CCTV that picked up this problem, nor any of the other problems in the report and there are plenty to choose from, in fact so many that the local authority eventually enforced a ban on admissions.

If CCTV was the solution that some claim it is, why did it not prevent or even at least highlight any of these issues?

Page 7 *We found that most medication administration records were consistently completed. However we noted that the site of one person's medicated patch was not recorded on eight occasions.*

The manager told us there had been no safeguarding events raised in the service since our last inspection of 16/17 December 2015, however they were clear on their responsibilities relating to this. The manager confirmed that all previous safeguarding events raised in the service, all of which had been upheld at least in part, had now been closed by the local authority.

Page 11 *We saw that the majority of Staff interacted with people in a respectful way. However Staff did not always take note of what people said or give due attention when speaking with people. We saw several occasions where Staff asked individual people a question but then did not wait for the person's response or did not respond in a timely way to the person's response. One person said they did not feel well and we could see from their physical movements that they wished to leave the dining table. One Staff member who stood behind the person's chair did not listen to the person and continued to talk about other things, to the person's increasing anxiety.*

People were able to make choices and decisions about their day to day lives, for example, to spend time in their bedrooms or get up later in the morning.

Page 13 *The local authority had placed a restriction on the admission of any further people to the service in October 2015. In response to this the local authority had reviewed each person's placement in the service including their plan of care. People and their relatives were involved in these reviews and this was demonstrated within the care plans.*

EC COMMENT So in fact it was the local authority which was involved in writing the care plans which the inspection report said the home had improved. **NB** This is the first time we hear that it was the local authority which placed a restriction, and it was not voluntary as stated earlier.

Report 7: 5th January 2017

Two years after CCTV was first installed.

EC COMMENT This home was good on the day CCTV was installed, it then became terrible for two years, even leading to enforced restrictions and a very significant spike in untoward incidents.

This inspection is heading back to how the home was before CCTV, with audits and the Staff are completing the required paperwork.

There were some minor issues found, such as some Staff did not always offer people a drink. Complaints had been recorded, fully investigated, and responded to, to the person's satisfaction, and records and documents relating to the service were clear and well-organised.

The PIR told us that the service was part of a project to improve safety, reduce harm such as from falls and pressure ulcers, and to reduce emergency hospital admissions for people living in care homes. Training to support this was provided by the local authority in agreement with the provider.

The registered manager told us that two Staff had won an award linked to this initiative relating to a change in culture in the service and a reduction in falls.

The manager also told us of their plans to be part of other local initiatives to improve the quality of the service people received.

Part Four: SUMMARY

We will continue to follow all homes where we find out that CCTV is installed but there are currently very few.

Other concerns that we have are that if CCTV was installed in every public area in every care home, it would require thousands of hours of CCTV to be monitored and it is totally unrealistic to rely on this happening.

Monitoring alone would not work because those monitoring CCTV would need to have read every care plan of every resident they are observing in order to know if they were receiving poor care.

Examples:

A person should be moved using a particular type of hoist but the wrong hoist is used placing the person at risk.

A person should be moved using their assessed hoist sling attachment but this is not happening, therefore placing the person at risk.

A person is assessed at risk of pressure sores but is left sitting in a chair without their pressure relief cushion.

A person is not assessed as being at risk of pressure sores but is left sitting in a chair for long periods of time and this is now causing a pressure sore to develop.

A person is given a drink but without the prescribed thickener they need because they are at risk of choking.

A person is sleeping part of the day as their dosage of sedative medication is too high.

A person is dehydrated and sitting in the lounge, they have not drunk any fluids for 24 hours but their care is not being tracked by CCTV.

As mentioned earlier, there are many outcomes to a person being taken from the communal area and no way for anyone monitoring the CCTV (assuming anyone is in reality) to understand what was happening. The list is endless.

CCTV street and security cameras are a useful tool in crime detection after the crime has been committed. CCTV plays a part in combating street crime and anti-social behaviour but these are very different types of problems.

Abuse and poor care are very different issues. There are very complex, intelligent, manipulative abusers, and the worst abuse of victims will **always** happen in the darkest corners. **In addition the everyday poor care may be filmed by CCTV but in reality it will be invisible to all but those aware of what care needs are being denied.** So CCTV will not stop either the worst abuse or poor care.

Also there is the question of security in an age where hacking, data breaches and other wrong-doing are all too common no matter what assurances are given by the CCTV companies trying to make a sale.

Many academic studies are available, and a note of caution is particularly needed regarding those studies sponsored by the CCTV industry.

Another issue which we have found is that some homes have installed CCTV in both bedrooms and public areas without attempting to gain the consent of residents or families first, this says much about respecting individual rights.

I report as someone who has seen the worst abuse and suffering, and as someone who speaks with families who have had someone abused, as well as with whistle-blowers who try to stop abuse but are silenced by both the lack of legal protection and the lack of accountability.

If there were the slightest chance that CCTV was the answer then I would wholeheartedly support its use. However I know from the evidence that it is NOT the answer and the debate and campaigning for CCTV is doing more harm than good.

The **only** camera that would be truly effective, is the camera that goes everywhere, even into the darkest corners and can understand what is really happening and raise the alarm and bear witness.

That camera **is the eyes of the whistle-blower.**

Eileen Chubb
Founder & Director of Compassion In Care

Cases captured by COVERT cameras (NOT CCTV)

NB The crucial difference between **COVERT cameras** and CCTV needs to be understood properly and the media could do a lot to help when reporting cases.

United Kingdom

<http://www.bbc.co.uk/news/uk-england-birmingham-38833510>

<https://www.youtube.com/watch?v=N5hjHBtO-yY>

<http://www.express.co.uk/news/uk/664991/Care-home-Staff-BANNED-dementia-sufferer-video>

<http://www.independent.co.uk/news/uk/home-news/shocking-footage-shows-elderly-residents-being-taunted-and-abused-at-essex-care-home-9303888.html>

<https://www.theguardian.com/society/2012/aug/29/care-home-worker-hidden-camera>

<http://metro.co.uk/2017/09/28/shocking-footage-of-evil-carers-abusing-95-year-old-woman-and-calling-her-silly-bh-6962748/>

<http://www.birminghammail.co.uk/news/midlands-news/shocking-castle-vale-oap-care-10083974>

<https://www.standard.co.uk/news/health/hidden-camera-footage-reveals-abuse-at-kentish-town-care-home-7669558.html>

<http://www.mirror.co.uk/news/uk-news/carer-jailed-after-caught-video-3748376>

http://www.lancashiretelegraph.co.uk/news/11191608.Rossendale_care_worker_jailed_for_abusing_brain_damaged_patient/?ref=mac

Australia

<http://www.abc.net.au/news/2016-07-25/secret-camera-captures-nursing-home-attempted-suffocation/7624770>

<http://www.couriermail.com.au/news/care-worker-assaulted-elderly-patient/newsstory/86a45cc65c47ac075352a4b4a57c22c6?sv=789cbfa595b6a135d8abe72d68f6e52e>

Canada

<http://www.dailymail.co.uk/news/article-2327442/Hidden-camera-nursing-home-shows-worker-shove-feces-covered-rags-elderly-ladys-face-blow-nose-sheets.html>

<https://www.msn.com/en-nz/news/world/carer-filmed-attacking-elderly-dementia-patient-in-canada/ar-BBDPNqo?li=AA59FU>

USA

<http://www.fox25boston.com/news/hidden-camera-captures-nursing-aides-abusing-grandmother/503393355>

https://www.youtube.com/watch?v=7CMB_F33OY

<http://www.myarklamiss.com/news/caught-on-camera-elderly-abuse-in-florida-nursing-home/160867409>

<https://www.nbcnews.com/video/nurses-elder-abuse-of-alzheimers-patient-caught-on-cam-350392899879>

<http://www.nursinghomeabuseguide.org/hidden-video-camera-in-east-hartford-nursing-home-records-six-weeks-of-elder-abuse/>

New Zealand

<http://www.stuff.co.nz/national/crime/83410824/Rest-home-caregivers-slap-caught-on-hidden-camera>