East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST WIDE DOCUMENT

DOCUMENT TITLE:	Photography and Video Recordings: Policy and Procedure to maintain Confidentiality and Consent, Copyright and Storage
DOCUMENT NUMBER:	**ELHT/C88 Version1.7**

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1. Introduction

1.1. In this procedure, the term “recording” (or “recordings”) is used to refer to photography (either conventional or digital) and video recording (either conventional or digital).

1.2. All recordings that illustrate a patient’s condition or an aspect of the treatment must be considered part of the clinical records, whether they were originally created specifically for this purpose or not. Therefore, they have to be treated as rigorously as any other health record.

1.3. The patient has a right to informed consent to recording (unless exemptions apply) and to any future use to which the recordings might be put. Recordings must be available for disclosure as required.

1.4. Copyright in all medical recordings of its patients is held by East Lancashire Hospital NHS Trust, and must be protected on further use of the picture

2. Basic principles (based on GMC guidelines)

2.1. When making recordings you must take particular care to respect patients' autonomy and privacy since individuals may be identifiable, to those who know them, from minor details that you may overlook. The following general principles apply to most recordings although there are some exceptions, which are explained later in this guidance.

- Seek permission to make the recording and get consent for any use or disclosure.
- Give patients adequate information about the purpose of the recording when seeking their permission.
- Ensure that patients are under no pressure to give their permission for the recording to be made.
- Stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.
- Do not participate in any recording made against a patient's wishes.
- Ensure that the recording does not compromise patients' privacy and dignity.
- Do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.
- Make appropriate secure arrangements for storage of recordings.

2.2. Where children who lack the understanding to give their permission are to be recorded, you must get permission to record from a parent or guardian. Children under 16 who have the capacity and understanding to give permission for a recording may do so. You should make a note of the factors taken into account in assessing the child's capacity.

2.3. When a mental disability or mental or physical illness prevents patients giving their permission, you must get agreement to recording from a close relative or carer.

2.4. People agreeing to recordings on behalf of others must be given the same rights and information as patients acting on their own behalf.

2.5. Recordings for which permission is not required

2.5.1. You do not need to seek separate permission to make the recordings listed below. Nor do you need consent to use them for any purpose, provided that, before use, the recordings are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- Images taken from pathology slides
- X-rays
- Laparoscopic images
- Images of internal organs
- Ultrasound images

3. Clinical photography and video recording of patients

3.1. Only trust owned digital cameras or video recording equipment Should be used to produce a recording. (It is acknowledged that this may not be current practice but Clinical Divisions should review there ability to provide this by Sept 2009)

3.2. Under no circumstances should mobile phone cameras be used to provide clinical images.

3.3. Before undertaking a recording consent must be sought from the patient or guardian as per the consent policy, and identified in the clinical records. If a recording is (or is likely) to be used during another procedure then this should be identified within the consent process for the procedure. The consent process should include specifically the purpose and use of any recording.

3.4. If a recording only is to be made then Consent specifically for the recording must be completed and signed by the requesting doctor and countersigned by the patient. A copy of this form should be filed in the case notes, a copy given to the patient.

3.5. The consent for the recording should specify the purpose of the recording .these are likely to be

3.5.1. for medical purposes only,

3.5.2. for medical and teaching purposes

3.5.3. for one other specified purpose – for example to illustrate an article in a medical journal – to be obtained at the time of the original recording. This third level is a specifically limited additional consent to just one further use: it is not acceptable to describe such further use in an open-ended way such “publication as required”

3.6. In cases where it is impossible to obtain consent prior to the recording (e.g. photography of an unusual finding in the course of an operation where the patient is under anaesthetic), the may be carried out and

should be documented in the clinical record, but may not be used until consent has been obtained. Consent must be obtained as soon as is practical after the patient becomes capable. If the patient declines to consent the records must be destroyed and documented to that effect in the patient's clinical record.

3.7. Recordings of emergency treatment and of unconscious patients

3.7.1. If recordings are to be used only for training or clinical audit, you may record patients who need emergency treatment but cannot give their permission for the recording to be made. You do not need a relative's agreement before starting the recording but must stop it if a relative objects. Before these recordings are used, however, the patient's consent must be obtained or, if the patient has died, a relative must agree to it.

3.7.2. When no recording has been planned, but a record of an unexpected development would make a valuable educational tool, you may record patients undergoing treatment. If you cannot get permission at the time because, for example, the patient is anaesthetised, you must ensure the patient is later told about the recording and gives consent to its use.

3.7.3. With recordings made in these circumstances, you must follow patients' instructions about erasure or storage. The only exception is if you think you need to disclose the recording because of the advice in the GMC booklet Confidentiality: Protecting and Providing Information, for example to protect the patient or others from risk of death or serious harm.

3.7.4. Hospital policy on recording the treatment of unconscious patients should be adequately publicised, for example through notices in waiting areas.

4. Register of Equipment and those areas who routinely carry out photography

4.1. For clinical divisions it is the responsibility of the relevant Service manager to ensure that a register of trust owned recording devices is available, maintained and that local operational procedures exist, and is adopted, maintained and reviewed regularly.

4.2. The service manager should also be aware of all non trust devices that are currently used and work towards their replacement by Sept 2009.

4.3. The local operational policy for areas that routinely undertake recordings must ensure that

- If necessary, Ethical Committee approval has been obtained
- Consent procedures are appropriate
- The equipment proposed to carry out the work is suitable for the purpose
- Storage of recordings is secure at all times
- Suitable printing resources are available to provide an adequate picture for storage in the clinical record

- Copyright and reproduction rights are suitably protected
- The requirements of the Data Protection Act and the Caldicott Guardians are met
- That, where appropriate, the staff concerned are trained in using HISS to store digital images and are trained in the correct use if image manipulation is required
- The budgetary implications are understood

5. Publication of medical photographs

5.1. It is vital to ensure that copyright in any medical photograph that is published is retained by the Trust. Nearly all publishers' contracts require authors to sign away ownership of all copyrights associated with the publication.

5.2. Copyright is protected when the images are labelled with the words: "This print is the copyright of East Lancashire Hospital NHS Trust. Permission is granted for first publication in ……..(title of journal or book and date of publication)"

5.3. It is the author's responsibility in all cases to obtain permission to publish from the patient. This must be filed in the patient's health record and a copy given to the patient.

6. Minimum requirements of the recording

The recording must include preferably on the electronic image and any printed output

- Date
- Time
- Location
- Photographer
- Patient hospital number
- Full name
- Date of Birth
- Image reference number

For printed images a copy of the demographic label should be stuck to the rear of the image produced and additional details recorded if not included as part of the recorded image.

7. Basic Guidance on production of the photographic record

- Restrict the area of the photograph to the minimum area required
- Ensure that a measuring device is included in the photograph if measurement is required to be undertaken
- Ensure that the privacy and dignity of the patient is respected by undertaking the photography in an appropriate area, and ensuring ares that are not being photographed remain covered.
- Use of electronic zoom should be avoided, but optical zoom is acceptable.
- Use of conventional flash will not work well with close-up photography, ensure good general level of lighting

- Use of flash and conventions lighting can significantly affect the colours displayed in the resultant image
- Ensure that the images is correctly focused

Once the image is taken you should check that the image has

- No un sharpness created by camera motion or patient movement
- Good focus
- Good Light levels to reflect appropriate colour levels

8. Retention of the images

The printed photograph must be stored in the clinical record/case notes in the designated envelope for photographs, when it associated to the clinical care being provided. Duplicate images can be obtained for teaching purposes where consent is given. Images required as part of a research project will be stored in accordance with the research protocol

The electronic image must either then be deleted permanently from the recording device or if required for future use securely stored and backed up (preferably on a dedicated imaging database allowing appropriate reference in and archiving capability or a departmental server or network drive) prior to any image manipulation. The location of the stored image must be documented in the clinical records to enable retrieval of the image

Under no circumstances should any image be left on/in the recording device once the image has been transferred to a network drive

No patient images should be transferred to removable media without conforming to the Requirement of the Information security policy.

The retention of the image is determined by the type of image produced (See appendix 1 for retention schedules)

9. Clinical recording of children

9.1. There are particular requirements when recording children arising from clauses in the Protection of Children Act (1978). Separate guidance is laid out in Appendix 2.

10. Non clinical Photographic and Video records

Any photograph or video recording produced by trust employee or any of it agents should be formally recorded by the department producing the record. The recording should be produced using Trust recordingdevices wher ever possible, and copies of any recordings should be retained in line with the The recording must include preferably on the electronic image and any printed output

- Date
- Time
- Location
- Photographer

Appendix 1 Record types and retention periods with summary Trust recommendations

DOH Record type	DOH Retention Period	ELHT proposed guidance Record Capture device	ELHT proposed guidance Minimum record Requirements
Medical illustration	As per clinical records	Digital Camera	Record of medical illustration needs to be recorded in the clinical record A record of the location of the medical illustration must be recorded, and image reference number, Date, time, patient name and Hospital Number, and the person recording the image. Unless an ELHT approved database is available to store the image a printed copy of the image must be produced for retention in the clinical records
		Mobile Phone camera	Not permitted for clinical photography
		Photographic film	Only to be used by Medical illustration department where processing of film is managed in secure environment
		Instant image (Polaroid) technology	Not to be used as archival permanence can not be guaranteed
Photographic record - where images present the primary source of information for the diagnostic process	30 years		Due to the quality of images required to act as the source of primary diagnosis. These images should only acquired by bespoke systems and technologies that comply with current professional standards and guidance

DOH Record type	DOH Retention Period	ELHT proposed guidance Record Capture device	ELHT proposed guidance Minimum record Requirements
Photographs (where the photograph refers to a particular patient it should be treated as part of the health record)	As per clinical records	As medical illustration	As medical illustration
Telemedicine	As per clinical records	As medical illustration	Bespoke industry standard system that complies with the information security requirements for transfer of patient identifiable data as defined by the Connecting for Health Programme and the Information Governance toolkit .
Video records/voice recordings relating to patient care/video-conferencing records	As per clinical records	Digital Video Camera	Preferred imaging device as File formats can more easily be archived. Archiving of the records should not be undertaken on CD/DVD
		Conventional Video camera	A local archiving policy and procedure need to be in place and records made in the clinical record for where these can be found
		Mobile Phone Camera	Not permitted for clinical video imaging
		Cine Film	Only to be used by Medical illustration department where processing of film is managed in secure laboratories

Appendix 2 - Photography and Recordings of Children

Additional requirements

This appendix offers specific additional guidance for those recording children, and should be read in conjunction with the main Trust Policy. Recordings may be necessary when a child is thought to have been harmed as a result of abuse or neglect. In such cases the recordings should be authorised by a senior doctor with child protection responsibility for the case and an appropriate entry should be made in the patient's health record justifying the recording, especially if parental consent is not given. See also 2.4

1. Records of children should be taken only if there are specific features that need recording for clinical reasons (e.g. assessing the progression of a skin lesion) or teaching (e.g. an important clinical sign that might only be seen rarely).

2. Records should only include the specific areas of interest. Whole body shots should only be taken if completely necessary.

3. Recordings of genital areas must only be taken if deemed absolutely necessary and appropriate. It is strongly recommended that a clear indication be recorded in the patient's health record justifying the recording.

4. Recordings of the chest in peri or post-pubescent girls must only be taken if deemed absolutely necessary and appropriate. It is strongly recommended that a clear indication be recorded in the patient's health record justifying the recording. Where appropriate, consent should be obtained from both the child and the carer(s). If a child declines to consent, then – no matter the opinion of the parent/carer – the records should not be made.

Appendix 3 - GMC guidance on remote prescribing via telephone, email, fax, video link or a website

1. From time to time it may be appropriate to use a telephone or other non face-to-face medium to prescribe medicines and treatment for patients. Such situations may occur where:
    a. a. You have responsibility for the care of the patient
    b. b. You are deputising for another doctor who is responsible for the continuing care of a patient or
    c. c. You have prior knowledge and understanding of the patient's condition/s and medical history and you have authority to access the patient's records.
2. In all circumstances, you must ensure that you have an appropriate dialogue with the patient to:
    a. a. Establish the patient's current medical conditions and history and concurrent or recent use of other medications including non-prescription medicines;
    b. b. Carry out an adequate assessment of the patient's condition
    c. c. Identify the likely cause of the patient's condition
    d. d. Ensure that there is sufficient justification to prescribe the medicines/treatment proposed. Where appropriate you should discuss other treatment options with the patient
    e. e. Ensure that the treatment and/or medicine/s are not contra-indicated for the patient
    Make a clear, accurate and legible record of all medicines prescribed.
3. If you are not providing continuing care for the patient, do not have access to the patient's medical records, or are not deputising for another doctor, you must follow the advice above and, additionally you must:
    a. a. Give an explanation to the patient of the processes involved in remote consultations and give your name and GMC number to the patient
    b. b. Establish a dialogue with the patient, using a questionnaire, to ensure that you have sufficient information about the patient to ensure you are prescribing safely
    c. c. Make appropriate arrangements to follow the progress of the patient
    d. d. Monitor the effectiveness of the treatment and/or review the diagnosis
    e. e. Inform the patient's general practitioner or follow the advice in paragraph 9 if the patient objects to the general practitioner being informed.
4. Where you cannot satisfy all of these conditions you should not use remote means to prescribe medicine for a patient.

GMC website - http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp#16
Accessed 02/11/10