CLINICAL PROTOCOL FOR THE USE OF PHOTOGRAPHY, VIDEO RECORDING AND AUDIO RECORDINGS

RATIONALE

The reason for this protocol is to ensure when recordings of images or conversations are made from patients/service users, they are done in such a manner that consent has been sought from the beginning from the patient or person involved and they are aware what the recording will be used for.

TARGET GROUP

The protocol applies to all clinical staff within the Trust who are required to make recordings (photographic, video or audio recordings) of a patient in order for clinical care to be evidenced, or alternatively enhanced.

TRAINING

All staff in the Trust are required to comply with mandatory training as specified in the Trust’s Mandatory Training Matrix. Clinical Staff are also required to comply with service specific mandatory training as specified within their service training matrix.

RELATED POLICIES

Please refer to relevant Trust policies and procedures

CLINICAL PHOTOGRAPHY, VIDEO RECORDINGS AND AUDIO RECORDINGS

Photographs of patients are increasingly required for clinical and non-clinical reasons. Photographic recording techniques include photographic film, digital image and video. This protocol deals with aspects of consent, confidentiality, and the safe storage of images.

The Trust has a duty to protect the privacy and interests of the patient by providing them with the information why photographic and video recordings are required. With that information the patient can make an informed choice of how their image can be used. In every case, such photographs must only be taken after valid consent has been obtained using Consent Form 6.
Consent form 6 is to be used to gain consent for taking clinical images (excluding wounds) for clinical reasons to support and inform assessment and/or a treatment plan.

Consent form 5 should still be used for when taking photographs of wounds and other wound related images. Photographic and video recordings made for any use, form part of the patient’s medical records and should always be protected in the same way. Patients have the right to access their medical records; therefore the Trust has a responsibility to disclose those records made by Trust staff in the course of their work irrespective of why the image was taken.

Negatives, master transparencies and original digital camera files must always be logged and stored in a locked storage system. In the case of digital camera images, the file must not be treated in anyway before storage. It is recognised that while digitally originated images are intrinsically no different to traditional photographs; they are easier to copy in electric form and are therefore more at risk of both image manipulation and inappropriate distribution. Particular care must be taken by Trust staff to protect the image and maintain its integrity.

All Trust staff who take photographs are responsible for:

- Adhering to this protocol and ensuring appropriate written consent is obtained using Consent Form 6.
- Security of recording equipment including media containing patient information.
- Quality and accuracy of data recorded.

Photographic, video and audio recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient’s care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient / client. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

When Trust staff wish to make a photographic, video or audio recording of a patient specifically for education, publication or research purposes, they must ensure that patients know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, Trust staff should seek the agreement of the parent / person with parental responsibility / legal guardian to the patient. Trust staff must not make any use of the recording, which might be against the best interests of the patient. Again, Trust staff should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

At all times, staff must use Trust owned equipment. A recording using mobile phones (Trust owned or personal) is not acceptable under any circumstances.
Staff must ensure that any digital images / recordings taken are downloaded to a Trust computer at the earliest convenience. Digital images / recordings (if they cannot be stored alongside or within the patient records) must be stored on the Trust server in a password protected folder, with access only granted to those that have a legitimate ‘need-to-know’ reason for access to this information, and clearly labelled for ease of identification.

Reference to the existence of a digital image / recording must be entered in the patient records. Where practicable, a print out of the image should be stored in the patient’s records. Once images / recordings have been downloaded successfully, memory cards for digital equipment must be erased.

Signed Trust consent forms must be stored within the patient’s records.

CONFIDENTIALITY AND CONSENT

Confidentiality is the patient’s right and may usually only be waived by the patient or by someone legally entitled to do so on their behalf. Trust staff should remember that any breaches of confidentiality can amount to serious professional misconduct with inevitable disciplinary consequences.

In order to ensure that patients’ right to confidentiality is preserved, the Trust requires:

- That the patient’s consent is obtained in writing for the original photography and for its use as part of treatment and/or for teaching
- That only authorised copies are made
- That prior to publication in journals, books or elsewhere or for any use other than as described above, the patient’s permission for the specific use proposed is sought and written consent obtained using Consent Form 6.

The practice of obtaining written consent from patients only in the case of full length or facial photographs, from which the patient can be easily identified, is not sufficient. It is sometimes possible for people to be identified from other categories of photograph, e.g. showing a tattoo or other distinguishing mark. Nor is it sufficient to rely on the photographer’s judgement that a particular patient is unlikely to be identified from a particular photograph. Therefore the Trust has therefore adopted the rule that informed consent must be obtained from all patients in all cases.

In the case of minors, the parent or guardian should sign the consent form, however when the minor reaches 16 or is judged to be capable of consenting in their own right (Fraser Guidelines) during the course of treatment, new consent will need to be obtained.

Photography without consent may be necessary only in explicit circumstances, for example, suspected non-accidental injury of a child, where it is unlikely that the parent or guardian will give consent and the recording of injuries is demonstrably to the patient’s benefit. When these circumstances arise, Trust staff must provide a thorough and comprehensive rationale within the health care records and complete a Trust incident form.
In all cases of photography or video/audio recording, care must always be taken to respect the dignity, ethnicity and religious beliefs of the patient. Furthermore, patients have the right to withdraw consent for use of their images at any time. Trust staff should be aware that a patient’s image must not be altered in any way to achieve anonymity and so avoid the need for consent.

**NON-CLINICAL PHOTOGRAPHY OF PATIENTS**

Please contact the Trusts Communication team for taking photographs for other than clinical reasons.

**LOGGING AND STORAGE**

Since the medical record has to be available for disclosure if required, it is essential that every photograph is evidently logged in the health care records. In the case of photographic negatives, these must be securely stored in the originating department within a secure setting. In the case of photographic transparencies, a second copy should be made at the time of photography to be used as a master transparency. This must be securely stored in the originating department, again in a secure setting. Where it is possible to obtain a master as well as a show copy, the original photographs should be regarded as masters and duplicates made for further use.

The Trust’s Tissue Viability Service will obtain images which include a reference graduated ruler displaying patients’ names and NHS numbers. This is specific to the Tissue Viability Service and is used to compare changes in wound aetiology.

**DIGITAL PHOTOGRAPHS OF PATIENTS**

Where digital photography is to be used to record images of patients, due care must be given before the start of the project to ensure that the quality of the image is adequate for its purpose.

In order to maintain the integrity of the image, manipulation may only be carried out to the whole image, and must be limited to simple sharpening, adjustment of contrast and brightness and correction of colour balance. A copy of the original image before manipulation should be saved and stored to show manipulation has been to improve clarity and not change the image.

Trust staff leaving employment from the Trust must erase any digital images of patients from their personal computer, unless specific permission to retain images for teaching purposes has been obtained from the Caldicott Guardian.

**WHERE TO GET ADVICE FROM**

For clinical photography contact your line manager, for non clinical photography contact the Communications Team

**INCIDENT REPORTING**

Clinical incidents or near misses must be reported via the Trust’s Incident Reporting System.
SAFEGUARDING

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow the Trust Safeguarding Adult Policy and discuss with their line manager and document outcomes.

EQUALITY ASSESSMENT

During the development of this protocol the Trust has considered the clinical needs of each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.

If staff become aware of any clinical exclusions that impact on the delivery of care a Trust Incident form would need to be completed via the Trust’s Incident Reporting System and an appropriate action plan put in place.

REFERENCES

## CONTROL RECORD

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<td>Caroline Hewitt</td>
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