KUMEC Policy on Student Access to Records

1. Introduction This document outlines the expectations and responsibilities of King's College London (KCL) medical students working in primary care settings. These guidelines apply to all students from Year 1 to the final year and contribute towards ensuring a safe, effective and educational experience for students, clinicians, and patients.

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2. Access to Patient Records

- Students must have read and write access to patient notes to assist with patient care and enable their learning.
- Students must only access the notes of patients they are directly involved in caring for, encountered clinically, or have a legitimate reason such as local QI or audit project.
- Students must not access notes of friends, family, celebrities, or any patients without a legitimate reason.
- Where a patient is known personally to the student this should be highlighted to the supervising clinician in advance or at the time this becomes apparent to the student. It may be appropriate for that patient to be seen by an alternative clinician.
- Students should be familiar with and must comply with mandatory training and NHS Digital, General Data Protection Regulation (GDPR), and local data governance policies.

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3. Prescribing and Medication Management

- Senior students may prepare prescriptions for review and signature by a prescribing clinician.
- Students should not have independent prescribing logins and must never independently issue prescriptions.
- All prescription-related activity must be documented appropriately, with the prescribing clinician taking full responsibility for the final prescription.

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4. Documentation and Consent

- Students must document patient consent before involvement in their care.
- The student's role, full name, and level of training must be clearly documented in patient notes.

- Students must record the name of their supervising clinician.
- The following SNOMED / EMIS codes should be used in patient notes with a comment including the student's and supervisor's names:
    - **185292006** | Seen by medical student
    - **769011000000105** | Consent given for treatment by student
- **Example entry:**
    - *"Seen by medical student | Rodney McKay (Y5) supervised by Dr Carter; patient consent given."*

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5. Confidentiality and Professional Conduct

- Students must respect patient confidentiality in all settings, including digital records and physical conversations.
- To follow up patients securely and safely for educational purposes, students can locally note patient electronic records numbers. If identifiable data (e.g. Patient names, DOB) is stored locally e.g. handwritten or electronically, this increases the risk of accidental and unintentional disclosure, e.g. if a student notebook is left on public transport.
- Students must maintain up-to-date data protection and GDPR training.
- Students must be aware that patients have the right to access their own records and should document appropriately, ensuring clarity and professionalism in all entries.
- The student must be aware of online visibility and redaction of the entry where there might be undue distress caused (or even danger) if a patient views the entry or a third party gets access to the information. This is obviously something for the supervising clinician to lead on with student awareness of the issue.

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6. Supervision and Support

- Students must always work under the supervision of a designated clinician.
- Any concerns regarding patient safety, documentation, or prescribing must be escalated to the supervising clinician immediately.

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7. Compliance and Accountability

- Breaches of these guidelines may result in disciplinary action and could impact student progression through the MBBS course.
- Students must familiarise themselves with local policies of the primary care setting in which they are placed.

Any uncertainties or ethical concerns should be discussed with the clinical supervisor and/or KUMEC faculty.

Reference and essential reading:

GMC Professional Standards Guidance on Improper access and disclosure

117 Health and care records can include a wide range of material, including but not limited to:

1. handwritten notes
2. electronic records
3. correspondence between health professionals
4. visual and audio recordings
5. laboratory reports
6. communications with patients (including texts and emails).

118 Many improper disclosures of patient information are unintentional. Conversations in reception areas, at a patient's bedside and in public places may be overheard. Notes and records may be seen by other patients, unauthorised staff, or the public if they are not managed securely. Patient details can be lost if handover lists are misplaced, or when patient notes are in transit.

119 You must make sure any personal information about patients that you hold, or control is effectively protected at all times against improper access, disclosure or loss. You should not leave patients' records, or other notes you make about patients, either on paper or on screen, unattended. You should not share passwords.

120 You must not access a patient's personal information unless you have a legitimate reason to view it.

121 You should not share personal information about patients where you can be overheard, for example in a public place or in an internet chat forum.[46] While there are some practice environments in which it may be difficult to avoid conversations with (or about) patients being overheard by others, you should try to minimise breaches of confidentiality and privacy as far as it is possible to do so.

Redacting Information for online access https://www.england.nhs.uk/long-read/redacting-information-for-online-record-access/

Suggested reading:

1. MDDUS guidance on accessing patient records (2022)
2. What if the patient reads this? A student guide to writing in the GP electronic patient record. Sprake, S., Sprake, C., Brown, J., Lister, J., Gormley, S., Sykes, S. C., & Kelly, W. (2024). What if the patient reads this? A student guide to writing in the GP electronic patient record. *Education for Primary Care*, 1–6. https://doi.org/10.1080/14739879.2024.2435613
3. Download the Student Guide to writing in the Electronic Patient Record (EPR) Members of the UK Council for Clinical Communication (UKCCC) Electronic Patient Record (EPR) writing group for educators, healthcare professionals and students have produced a student guide to writing in the EPR. The guide helps students to write good quality entries, which fulfil the need of clinical communication, are medico-legally appropriate, and have the patient in mind, who is entitled to access their records.