

Deansgrange Medical Centre

PRIVACY STATEMENT

PRACTICE NAME	Deansgrange Medical Centre
PRACTICE ADDRESS	2, Clonkeen Road, Blackrock, Co Dublin
PHONE NUMBER	(01) 2892116
DATA CONTROLLER	Dr Emer Fahy
LEAD FOR DATA PROTECTION	Dr Emer Fahy

Practice Privacy Statement

This Practice wants to ensure the highest standard of medical care for our patients. We understand that a General Practice is a trusted community governed by an ethic of privacy and confidentiality. Our approach is consistent with the Medical Council guidelines and the privacy principles of the Data Protection Regulations. It is not possible to undertake medical care without collecting and processing personal data and data concerning health. In fact, to do so would be in breach of the Medical Council's 'Guide to Professional Conduct and Ethics for Doctors'. This information is about advising you of our policies and practices on dealing with your medical information.

Legal Basis for Processing Your Data

This practice has voluntarily signed up for the ICGP Data Protection Guideline for GPs. The processing of personal data in general practice is necessary in order to protect the vital interests of the patient and for the provision of health care and public health. You can access the Guideline at <http://www.icgp.ie/data>. In most circumstances we hold your data until 8 years after your death or 8 years since your last contact with the practice. There are exceptions to this rule and these are described in the Guideline referenced above.

Managing Your Information

In order to provide for your care here we need to collect and keep information about you and your health on our records.

- We retain your information securely.
- We will only ask for and keep information that is necessary. We will attempt to keep it as accurate and up to date as possible. We will explain the need for any information we ask for if you are not sure why it is needed.
- We ask you to inform us about any relevant changes that we should know about. This would include such things as any new treatments or investigations being carried out that we are not aware of. Please also inform us of change of address and phone numbers.
- All persons in the practice (not already covered by a professional confidentiality code) sign a confidentiality agreement that explicitly makes clear their duties in relation to personal health information and the consequences of breaching that duty.

Access to patient records is regulated to ensure that they are used only to the extent necessary to enable the secretary or manager to perform their tasks for the proper functioning of the practice. In this regard, patients should understand that practice staff may have access to their records for:

- Identifying and printing repeat prescriptions for patients. These are then reviewed and signed by the GP.
- Generating a sickness certificate for the patient. This is then checked and signed by the GP.
- Typing referral letters to hospital consultants or allied health professionals such as physiotherapists, occupational therapists, psychologists and dieticians.
- Opening letters from hospitals and consultants. The letters could be appended to a patient's paper file or scanned into their electronic patient record.
- Scanning clinical letters, radiology reports and any other documents not available in electronic format.
- Downloading laboratory results and Out of Hours Coop reports and performing integration of these results into the electronic patient record.
- Photocopying or printing documents for referral to consultants, attendance at an antenatal clinic or when a patient is changing GP.
- Checking for a patient if a hospital or consultant is back or if a laboratory or radiology result is back, in order to schedule a conversation with the GP.
- When a patient makes contact with a practice, checking if they are due for any preventative services, such as vaccination, ante natal visit, contraceptive pill check, cervical smear test, etc.
- Handling, printing, photocopying and postage of medico legal and life assurance reports, and of associated documents.
- Sending and receiving information via Healthmail, secure clinical email.
- And other activities related to the support of medical care appropriate for practice support staff.

Disclosure of Information to Other Health and Social Care Professionals

We may need to pass some of this information to other health and social care professionals in order to provide you with the treatment and services you need. Only the relevant part of your record will be released. These other professionals are also legally bound to treat your information with the same duty of care and confidentiality that we do.

Disclosures Required or Permitted Under Law

The law provides that in certain instances personal information (including health information) can be disclosed, for example, in the case of infectious diseases.

Disclosure of information to Employers, Insurance Companies and Solicitors:

- In general, work related Medical Certificates from your GP will only provide a confirmation that you are unfit for work with an indication of when you will be fit to resume work. Where it is considered necessary to provide additional information we will discuss that with you. However, Department of Social Protection sickness certs for work must include the medical reason you are unfit to work.
- In the case of disclosures to insurance companies or requests made by solicitors for your records we will only release the information with your signed consent.

Use of Information for Training, Teaching and Quality Assurance

It is usual for GPs to discuss patient case histories as part of their continuing medical education or for the purpose of training GPs and/or medical students. In these situations the identity of the patient concerned will not be revealed. In other situations, however, it may be beneficial for other doctors within the practice to be aware of patients with particular conditions and in such cases this practice would only communicate the information necessary to provide the highest level of care to the patient.

Our practice is involved in the training of Medical students & is attached to U.C.D & Trinity College for this purpose. As part of this programme medical students may sit in on consultations with your consent, and be informed of your care.

Use of Information on for Research and Audit

It is usual for patient information to be used for research and audit in order to improve services and standards of practice. GPs on the specialist register of the Medical Council are required to perform yearly clinical audits. Information used for such purposes is done in an anonymised or pseudonymised manner with all personal identifying information removed.

If it were proposed to use your information in a way where it would not be anonymous or the Practice was involved in external research we would discuss this further with you before we proceeded and seek your written informed consent. Please remember that the quality of the patient service provided can only be maintained and improved by training, teaching, audit and research.

Your Right of Access to Your Health Information

You have the right of access to all the personal information held about you by this practice. If you wish to see your records, in most cases the quickest way is to discuss this with your doctor who will review the information in the record with you. You can make a formal written access request to the practice and receive a copy of your medical records. These will be provided to you within thirty days, without cost.

Transferring to Another Practice

If you decide at anytime and for whatever reason to transfer to another practice we will facilitate that decision by making available to your new doctor a copy of your records on receipt of your signed consent from your new doctor. For medico-legal reasons we will also retain a copy of your records in this practice for an appropriate period of time which may exceed eight years.

Other Rights

You have other rights under data protection regulations in relation to transfer of data to a third country, the right to rectification or erasure, restriction of processing, objection to processing and data portability. Further information on these rights in the context of general practice is described in the Guideline available at <http://www.icgp.ie/data> .You also have the right to lodge a complaint with the Data Protection Commissioner.

Questions

We hope this information has explained any issues that may arise. If you have any questions, please speak to the practice secretary or your doctor.

CATEGORIES OF DATA COLLECTED, PURPOSE AND LAWFULNESS

Category of Personal Data		Purpose of Processing	Lawfulness of Processing
<u>Administrative:</u> name, address, contact details (phone, mobile, email), dates of appointment		Necessary to support the administration of patient care in general practice	Article 6.1(d): processing is necessary in order to protect the vital interests of the data subject or of another natural person; Special Categories are processed under the derogations in Articles 9.2(h) and 9.2(i). Please see the notes under this table.
<u>Medical Record:</u> Individual Health identifier, GMS number, PPSN, date of birth, religion, sexual orientation, gender, family members, family history, contact details of next of kin, contact details of carers, vaccination details, medication details, allergy details, current and past medical and surgical history, genetic data, laboratory test results, imaging test results, near patient test results, ECGs, Ultrasound scan images, and other data required to provide medical care.		Necessary to provide patient care in general practice. The PPS number is needed for specific schemes such as sickness certification (Department of Social Protection), childhood immunisation programme, mother and child scheme, cervical screening, etc. (HSE).	
<u>Account Details:</u> record of billable services provided, patient name, address, contact details, billing and payment records for GMS and private patients		Required for providing a service and billing. Also required for submission of reimbursement claims to the HSE Primary Care Reimbursement Service	Article 6.1(c): processing is necessary for compliance with a legal obligation to which the controller is subject (Revenue, Medical and Legal Obligations), and Article 6.1(b) in relation to getting paid for providing a service to private patients

CATEGORIES OF RECIPIENTS WITH WHOM WE SHARE PERSONAL DATA

Categories of Recipient	Description
Health and Social Care Providers	Data Processors, with a contract Other GPs, Health Service Executive, Voluntary Hospitals, Private Hospitals and Clinics, Private Consultants, Physiotherapists, Occupational Therapists, Speech and Language Therapists, Social Workers, Palliative Care Services, Out of Hours Services, Pharmacies, Nursing Homes, Counselling Services, Diagnostic Imaging Services, Hospital Laboratories, Practice Support Staff, GP Locums and other health care providers
Data Processors, with a contract	GP Practice Software Vendors, Online Data Backup Companies, Healthlink,
Legal Arrangements	Coroner, Revenue, Social Protection, Medical Council,
Public Health	Infectious disease notifications, influenza surveillance, National Cancer Registry and other National Registries,
Third Parties, with explicit patient consent	Solicitors, Insurance Companies, Health Insurance Companies, Banks,

DURATION OF DATA RETENTION

Type of Healthcare Record	Retention Period
General (adult)	8 years aFter last contact, unless in the interest of the Data Subject to retain
Deceased persons	8 years after death
Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period

Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child
Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient/client/ service user and any healthcare professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner