CLINICAL SYSTEMS ALERTS PROCEDURE

Document Reference	Proc468 (IG)
Version Number	1.5
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Consultation	
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Approving group/Committee/ Director **Date of approval**	QPaS 5 October 2022

VALIDITY – Policies should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*Oct 2016*	*Procedure*
1.1	*Aug 2017*	*Procedure review, rewrite of the introduction* *Added purpose section* *Added the principles section* *Added new categories of alert.* *Added Risk of Fire Setting to alert list* *Added Lorenzo alerts procedure*
1.2	*Jul 2018*	*Updated procedure to include SystmOne alerts* *Added SystmOne procedure to Section 11* *Moved section 12 and 13 to before the appendices*
1.3	*Sept 2018*	*Removal of the SystemOne alerts procedure*
1.4	*Dec 2021*	*Added Carers/family member/significant other is a service user to introduction and initiation of alerts section.*
1.5	*Sept 2022*	*Changed the title of the Procedure to Alerts Procedure* *Added permanent alert . temporary alerts and alerts/information from other organisations to Section 5* *Added Alert Icons paragraph to Section 6* *Updated Lorenzo Procedure* *Added SystmOne procedure to Section 13* *Updated alert list at Appendix 1* *Approved QPaS 5-Oct-22*

Contents

1. INTRODUCTION

More than one individual or service is usually involved in the delivery of care and treatment of patients. Staff may sometimes need to share key information. This might be to manage risk arising from patients / service users and associated persons throughout Humber Teaching NHS Foundation Trust via the use of alerts placed on the patient record.

Patient alerts are a method of informing users/clinicians that;

- there are aspects of care that they must be aware of when dealing with a particular patient.
- a means of identifying and recording individuals and associates who pose or could possibly pose a risk to the members of staff who come into contact with them.
- that a patient may have information or communication needs relating to a disability, impairment, or sensory loss.
- a patients' carer/family member/significant other is also accessing mental health services either within the Trust or via another provider.

2. PURPOSE

The purpose of this guidance is to;

- Enable a robust approach to be consistently applied to the management of alerts.
- To clarify the circumstances in which use of alerts are considered and applied.
- To set out the process for entering and removing an alert.
- To establish a process for review and monitoring alerts.

3. SCOPE

The procedure is aimed at all staff (including seconded, contract, temporary and agency staff) who may be involved in the handling of health records. This includes members of staff with an honorary contract or paid an honorarium. It establishes the Trust's commitment to the principles of clinical safety.

4. PRINCIPLES

The Clinician initiating the alert is solely responsible for the authorisation, content, and removal of an alert once it has expired, this responsibility cannot be devolved to non-clinical staff, although non clinical staff can apply the alert on behalf of the Clinician.

Alerts must be based solely on factual information and not subjective opinion. The clinician requesting or applying an alert must always be able to justify their decision on this basis to the patient or potentially in a court of law.

An alert must always be based on information from an appropriate source within health or social care organisations and the sharing of that information must comply with Caldicott Principles.

Data Protection Legislation applies equally to patient alerts as to any other part of a record held by the Trust. Staff are reminded that information contained within the alerts will normally be subject to disclosure on receipt of a Subject Access Request under Data Protection Legislation.

5. ALERT TYPES

There are a twelve alert types that can be placed on a patient's record. Each alert type contains a number of sub-categories. All alerts will have a type and a sub-category recorded.

Type of alert - *see Appendix 1 for alert list and sub-categories*

- Behavioural (R)
- Clinical
- Communication
- End of Life
- Environmental
- FGM
- Impairment
- Infection (R)
- MAPPA
- Preference
- Research
- Safeguarding (R)

(R) Indicates the Alerts to be reviewed on a regular basis.

The use of 'Behavioural and MAPPA' alert markers will help to alert staff and serve as an early warning of a particular individual, associate or situation that may present a risk to themselves, colleagues, or other patients. This will help to reduce the number of violent incidents at a local level and assist in creating a safe and secure environment for all.

NOTE: Behavioural Alert Type should not include details of contagious/infectious disease as guidelines regarding universal precautions are in existence. (Unless the Service User or relatives use this as a means of assault)

5.1. Permanent Alerts

Some alerts are permanent alerts, they alert staff to something about the service user that they should always be mindful of, eg learning disability or accessible information standard, these types of alerts would not have an end date.

5.2. Temporary Alerts

Some alerts may only be relevant for a time limited period eg an infection or behavioural risk
Where an alert has a known duration the end date should be included at the point of creation.
If an alert needs a periodic review the review date should be added to the alert.

5.3. Alerts/Information from other agencies

Information about risk and concerns may be received from other agencies eg police or housing. Clinicians will need to document the information received, the source of the information and actions in the service users record and manage the risk in line with established pathways.

Information on managing specific risks is available in;
Safeguarding Adults Policy
Safeguarding Children Policy
MAPPA Protocol
Sharing Personal Data with the Police SOP

6. ALERT ICON

If an alert is present on a record an alert icon is visible on the patients record. It is important that staff pay attention to the Icon when it appears in each system. It is notifying other professionals there may be a risk to themselves or others, that there is something they need to be aware of to ensure safe care or the service user has a specific need.

The icon is different in each system.

Lorenzo

 icon visible in the patient banner. The banner remains visible on all screens in the record. It is visible on the IP pegboard and OP pegboard. The alert information is not visible with the icon. Staff need to hover over the icon to view alerts on a record.

SystmOne

!! icon visible on the homescreen and throughout the record, on the sidebar down the left-hand side of the screen, and visible in the appointment booking module. The alert information is included with the icon.

7. INITIATION OF ALERT

When a clinician identifies a potential need to place an alert on a record. They should complete the patient alert form (Appendix 1). A copy of the form containing evidence to support the alert will be scanned onto Patient Administration Systems (PAS) for 24 hours availability.

Where an alert is to identify that a service users' carer/partner/significant other is also accessing mental health services, the clinician must offer a Carers assessment and complete the carers documentation in the service user's electronic record.

Where an alert is based on risk to staff or others the following risk factors should be considered when determining whether a record should be marked:

- nature of the incident (i.e. physical or non-physical)
- degree of violence used or threatened by the individual
- injuries sustained by the victim
- the level of risk that the individual poses
- whether an urgent response is required to alert staff
- impact on staff and others who were victims of or witnessed the incident
- impact on the provision of services
- likelihood that the incident will be repeated
- any time delay since the incident occurred
- the individual has an appointment scheduled in the near future
- staff are due to visit a location where the individual may be present in the near future
- the individual is a frequent or daily attender (e.g. to a clinic or out-patients)
- the individual is an in-patient
- the incident, while not serious itself, is part of an escalating pattern of behaviour
- the medical condition and medication of the individual at the time of the incident.

All details within a Behavioural alert must be listed within the patients' risk and relapse plan and entered onto PATIENT ADMINISTRATION SYSTEMS (PAS) giving enquirers further information.

Staff must check the Risk and Relapse Plan and check the patient's manual record or PAS prior to any contact with the patient or relatives.

NOTE: If the alert is temporary do not forget to end date the alert, or set a review date

8. NOTIFICATION OF ALERT

To comply with Data Protection Legislation the patient needs to be notified that an alert will be placed on their record. The patient should be informed as soon a reasonably possible following a decision to place an alert on their records. If a patient has a Care Co-ordinator, the Care Co-ordinator is responsible for sending a notification to the patient, otherwise it is the Clinician who raised the alert who is responsible for sending a notification (This is done by giving them a copy of the Patient Alert Form (Appendix 1) with a covering explanation letter for the reasons for the alert. The letter should

clearly explain:

- the nature of the incident;
- that their records will show an alert;
- the reasons why the alert is being placed on their records;
- who the information may be shared with and for what purpose;
- when the marker will be reviewed/removed;
- the process for complaints;
- relevant contact details;

The same principles will apply when considering an alert on the record of a patient's associate, relative, friend or carer. All decisions on marking records should be based on the risk to staff rather than on any relationship between the individuals concerned. If the incident is committed by an associate of the patient, a letter should be sent to both the patient and associate, if the associate's identity and whereabouts is known. The patient's letter should inform them of the decision that has been made; the associate's letter should include the same information provided to the individual taking care not to disclose any confidential medical information.

There may be exceptional cases when it is decided that notifying the individual / associate may increase the risk that they pose to staff, and that notification is not appropriate. These may include situations where:

- informing the individual may provide a violent reaction and put staff at further risk. In these cases, a detailed record of the evidence to support this (e.g. the individual has prolonged history of violence against NHS staff) must be kept along with the decision not to notify and the reasons for this course of action.
- Notification of a marker may adversely affect an individual's health. Any decision, based on exceptional circumstances, not to notify an individual must be evidenced in the patient's record explaining the reasons why notification may adversely affect an individual's health.

For other alerts the service user's key worker should explain that an alert has been logged and the reason for the alert and note the explanation on the record, eg Allergic to penicillin, Advanced Directive.

Right of Appeal

The patient or their relatives have the right to appeal against the decision to put an alert on the system. This is done via the Trusts standard complaints procedure.

Duration of Alerts

Alerts duration will vary dependent on the reason for the alert. Alerts must be reviewed and managed once placed on the system.

The period between reviews should not exceed one year.

Alert Monitor

A Senior Clinician should be made responsible for monitoring alert types within their teams to ensure alerts are applied and removed appropriately and monitors the usage of that Alert type; this person would be referred to as an Alert Monitor. The Alert Monitor may designate a deputy who will perform the reviews and monitor the alerts under their supervision. In reviewing the alert consideration should be given as to whether the alert content is still required based on gravity of the incident, the length of time since it has occurred and the previous and subsequent behaviour of the individual.

To facilitate the Alert Monitor's role an electronic report can be created in report manager which

gives details of all patients in their teams who have a particular alert against their record both current and historical with the alert owners/Information Source and current key workers or co-ordinators for those patients.

Alert reviews should form part of the service user/s regular clinical case review, eg MDT/Community Team Review, CPA* review and at any other time that the risk/relapse plan is reviewed.

Removal of Alerts

All Alerts must be reviewed at natural assessment review, MDT, or each Care Programme Approach (CPA)* review or as circumstances change and revoked as appropriate.

Alerts will be removed, subject to the correct documentation being completed authorising the removal by the Alert Monitor/Information Source. Appendix 2
(*CPA system is under review and will be changed to Person Centred Planning)

9. DUTIES & RESPONSIBILITIES

Chief Executive
Will assume overall responsibility for ensuring the Trust has appropriate arrangements in place for the management and response to alerts. The Chief Executive delegates responsibility for the management of alerts to the Director of Nursing, AHP and Social Care Professionals

Director of Nursing, AHP and Social Care Professionals
Has delegated responsibility for ensuring the Trust has in place appropriate policies and procedures for the management and response to all alerts.

Managers and Clinical/Professional Leads
Responsible for the implementation of this Procedure in their areas of responsibility and ensuring that systems are in place to achieve the standards within this Procedure for information, dissemination, monitoring, incident reporting and employee training.

Team Leaders and Charge Nurses
Responsible for implementing operational systems to ensure adherence to the principles and standards of this procedure.

Safeguarding Adults Team
The Safeguarding Adults team is the Trust's Single Point of Contact (SPOC) for MARAC and PREVENT

Multi-Agency Public Protection Arrangements (MAPPA) Champions
The MAPPA Champions are the SPOC for MAPPA.
Where requested through MAPPA process or by the Trust's Security Manager, to place an alert on individual's medical records they will be responsible for placement of alert on: -

- E-Record and SystmOne (within reminder function) and any other Trust Systems. Comment alert will only be on Electronic Systems.
- Reviewing alerts on a 12 monthly basis to ensure these remain appropriate.
- Removal of alert at the request of MAPPA or Security Manager.
- Maintenance of MAPPA / Security Alert database.
- Provision of advice to staff in hours regarding security risk and measure required once alert has been tagged.

All Staff

Responsible for keeping Alerts accurate and checking the Trusts PAS on each occasion of patient contact, in order to access existing alerts, pick up details of changes or requirements for a new additional alert.

10. EQUALITY & DIVERSITY

The introduction of an Alert System will have positive benefits for the individual service user; her/his family; caregivers and the community in terms of reductions in actual/potential risks; maintenance of individual dignity and feelings of self-worth; and enhancement of the therapeutic relationship.

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

11. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

12. MONITORING & AUDIT

Compliance with this Procedure will be monitored in the following ways:

Training: Inclusion in Clinical Procedure Update session.
Key staff need to be competent to input onto Patient Administration Systems (PAS) and will require training session if not already trained.

Communications/Dissemination: Communicate to all practitioners via global/Team Talk and staff meetings. Place a copy of the procedure on clinical document store via the Intranet.

Audit: as part of normal record keeping audits

Data/Information Requirements: data protection information and advice included in policy.

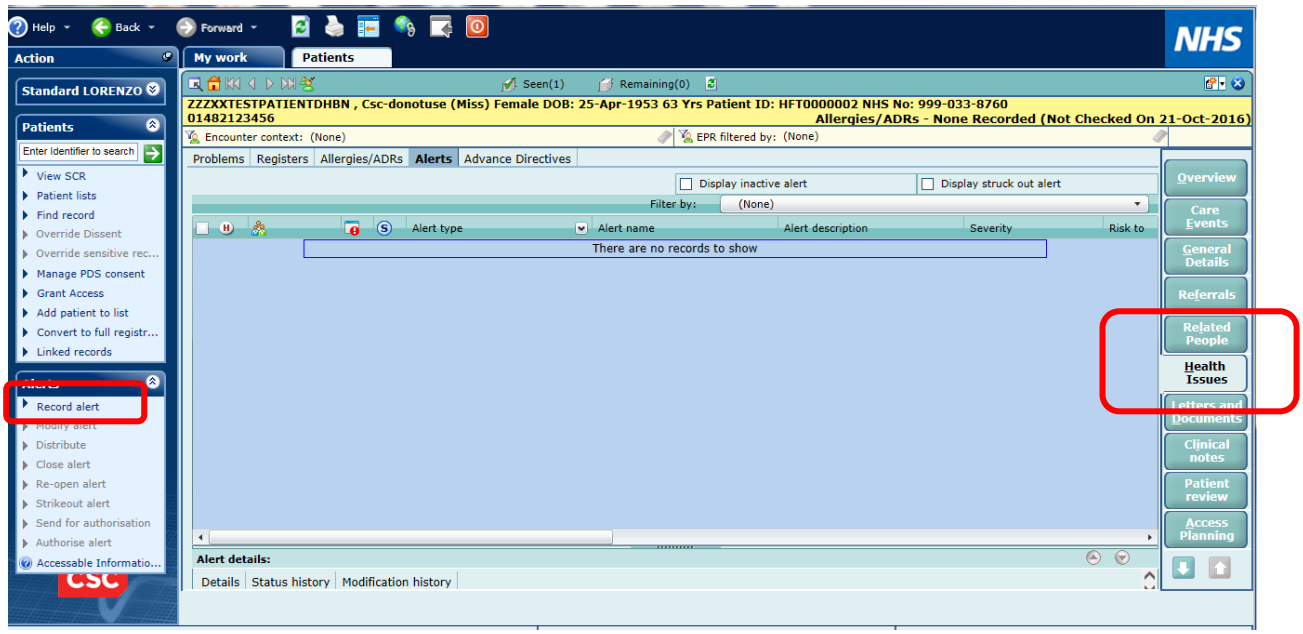
Effectiveness of Procedure– monitored through Trend Analysis to incidence reports/Datix

13. PROCEDURES FOR ADDING AN ALERT TO PATIENT ADMINISTRATION SYSTEM

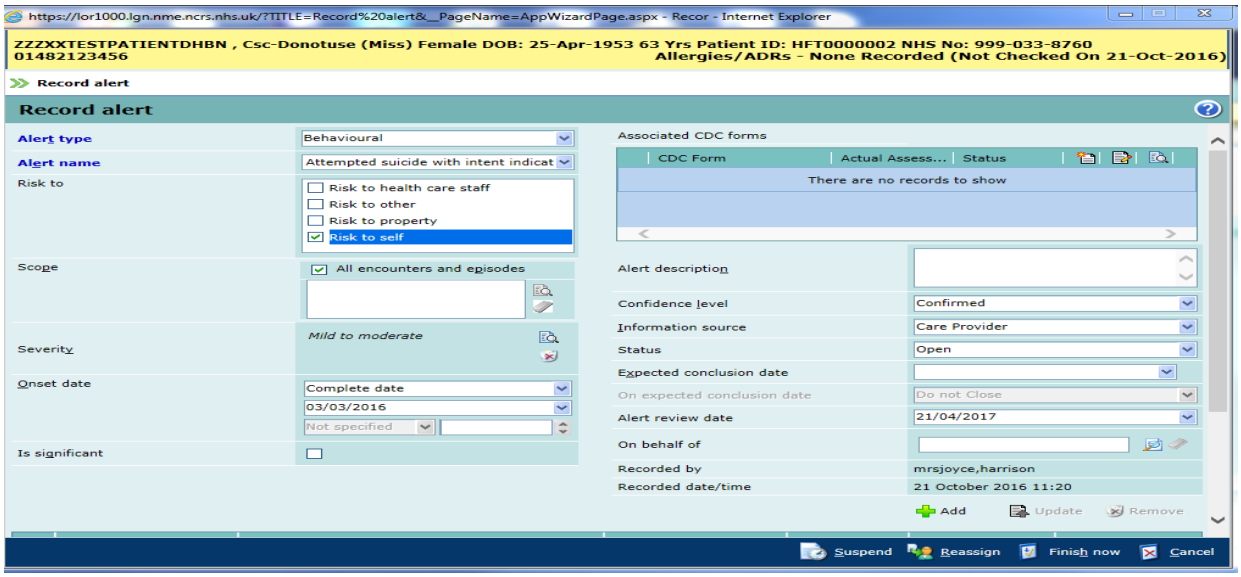
LORENZO – An alert on a Lorenzo record will be shown in the patient banner as a symbol.
Hover over the symbol in the banner to view the alerts placed on the record.

Recording an Alert on behalf of another Clinician

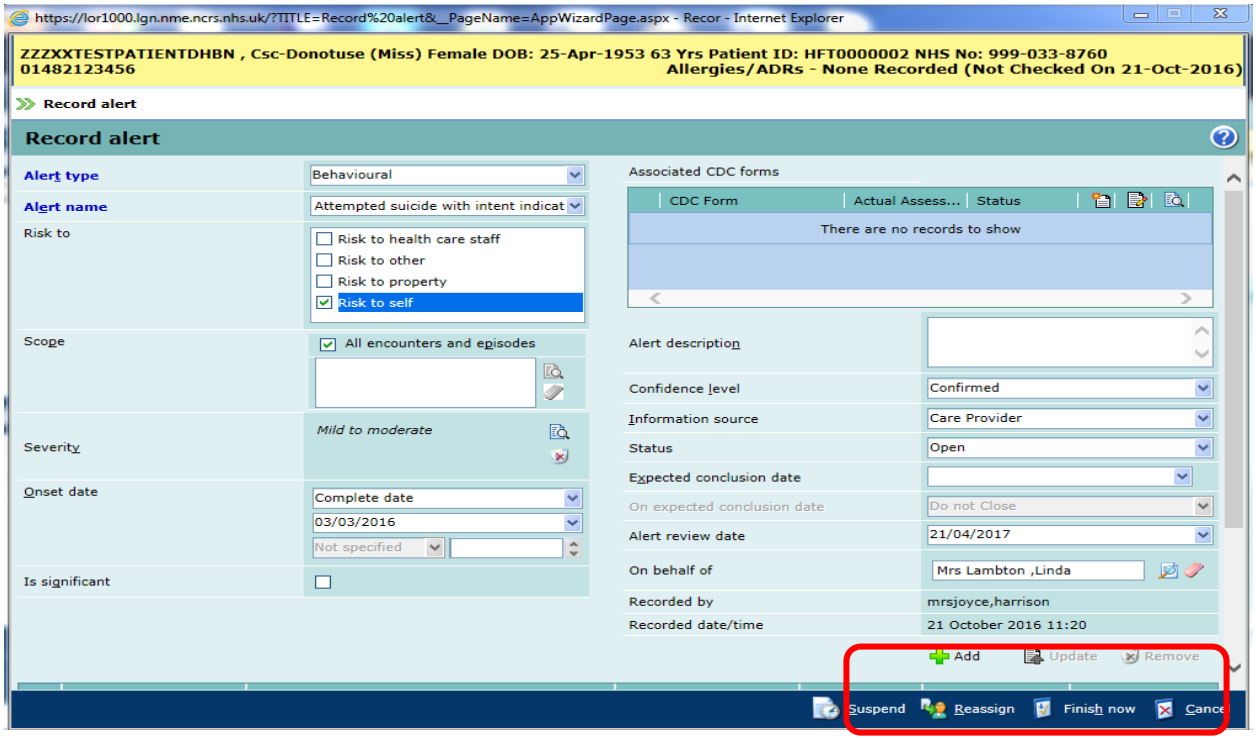
1. Search for the correct patient in the Patients Application tab
2. Select the Health Issues EPR tab
3. Select the Alerts faux tab and select Record alert from the task pane



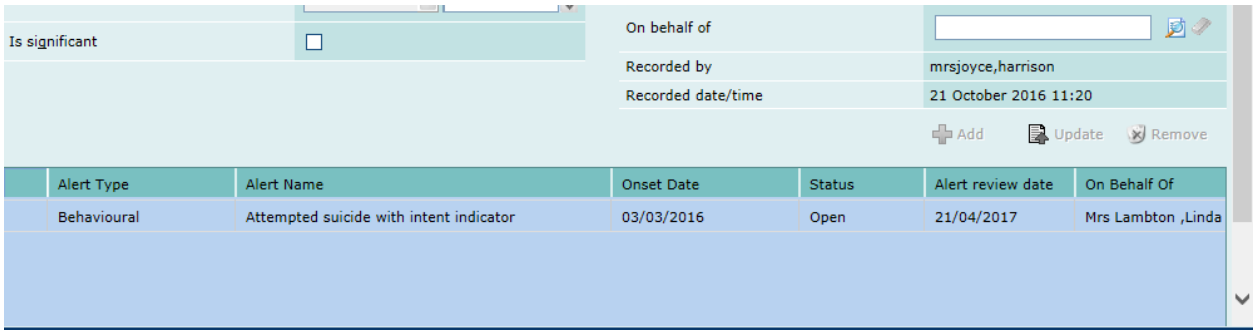
4. Select the appropriate alert from the drop down list
5. Depending on the Alert type chosen, the Alert name field will change to dislay the appropriate choices
6. Select the appropriate Alert name from the drop down list
7. Complete details of the alert as required



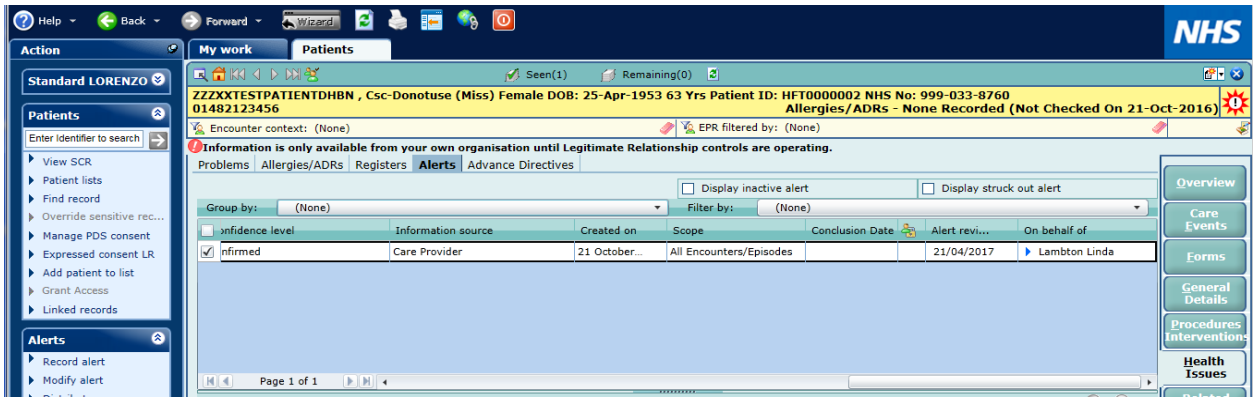
8. If you are recording an alert on behalf of a Clinician, click on the 'On behalf of' SFS and search for the relevant Care Provider



9. Click Add to move the information to the bottom grid



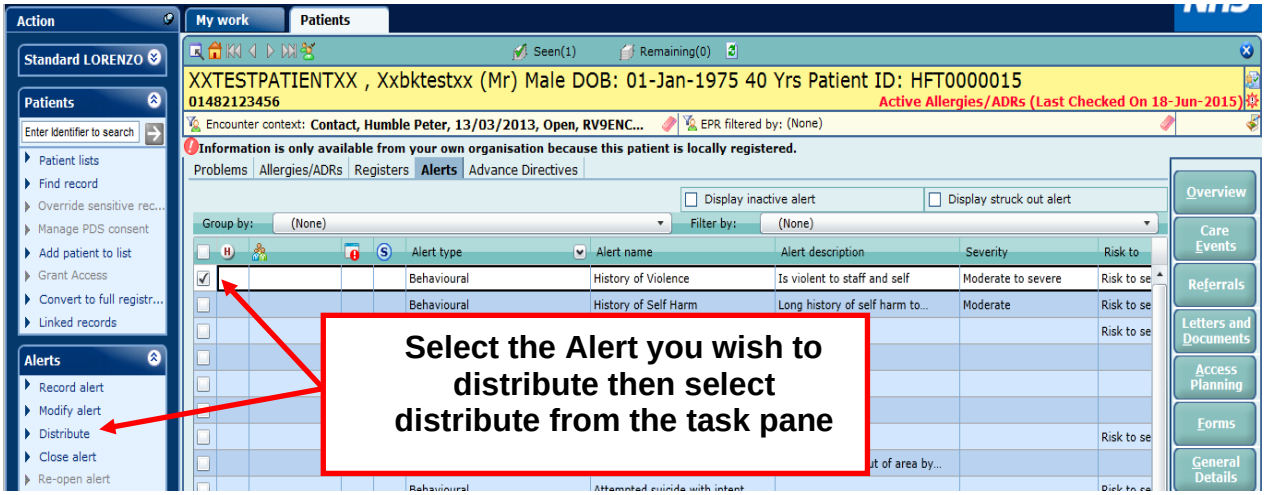
10. Click Finish now
11. Scroll along on the screen and the On behalf of Clinician's name will display

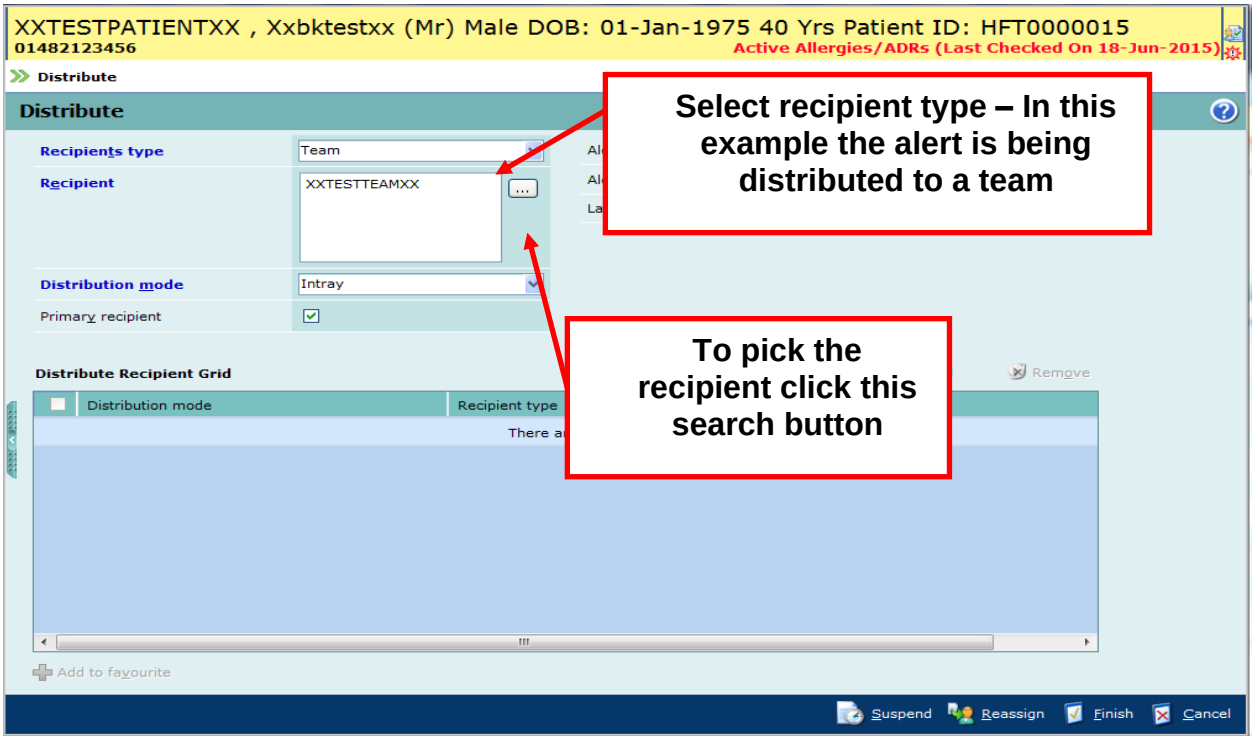


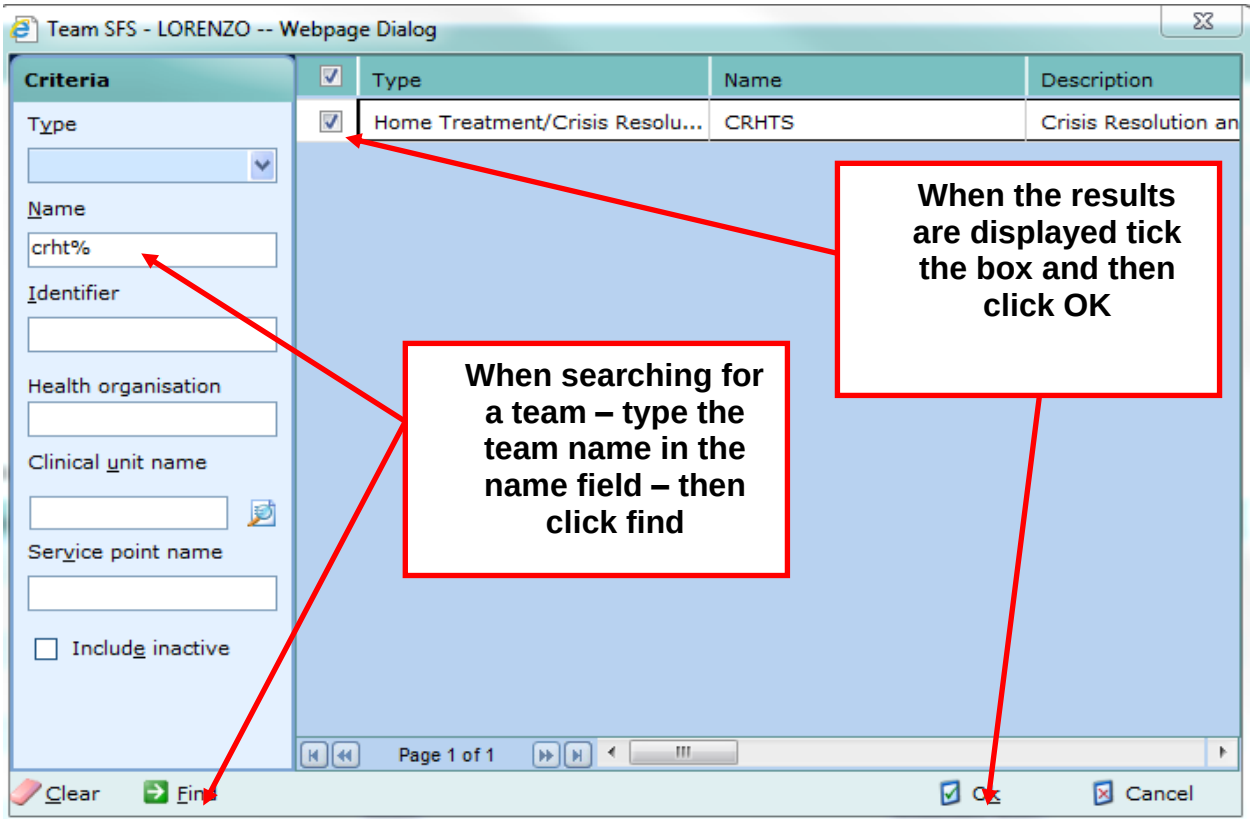
Distributing the Alert to Teams

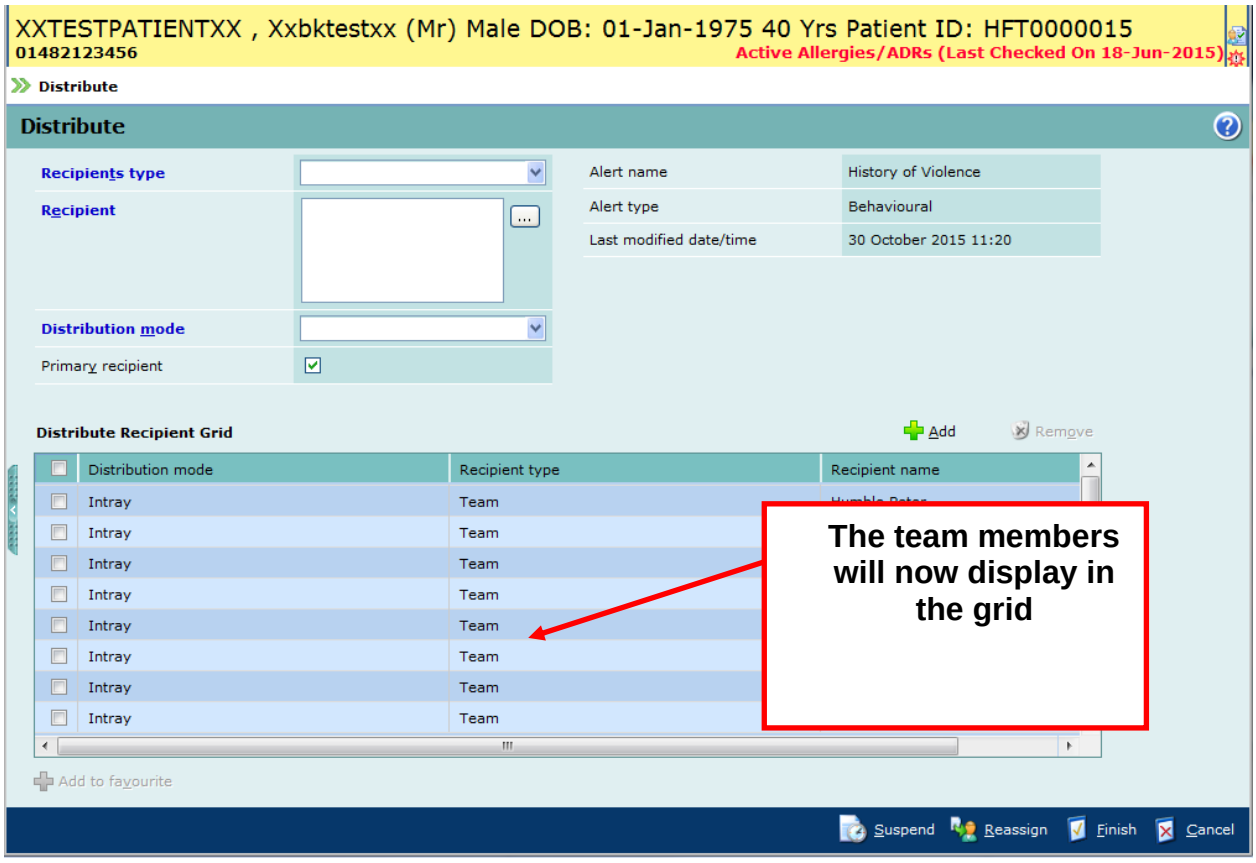
Once an alert has been recorded on a patient record it is good practice to then inform members of a team or certain individuals.

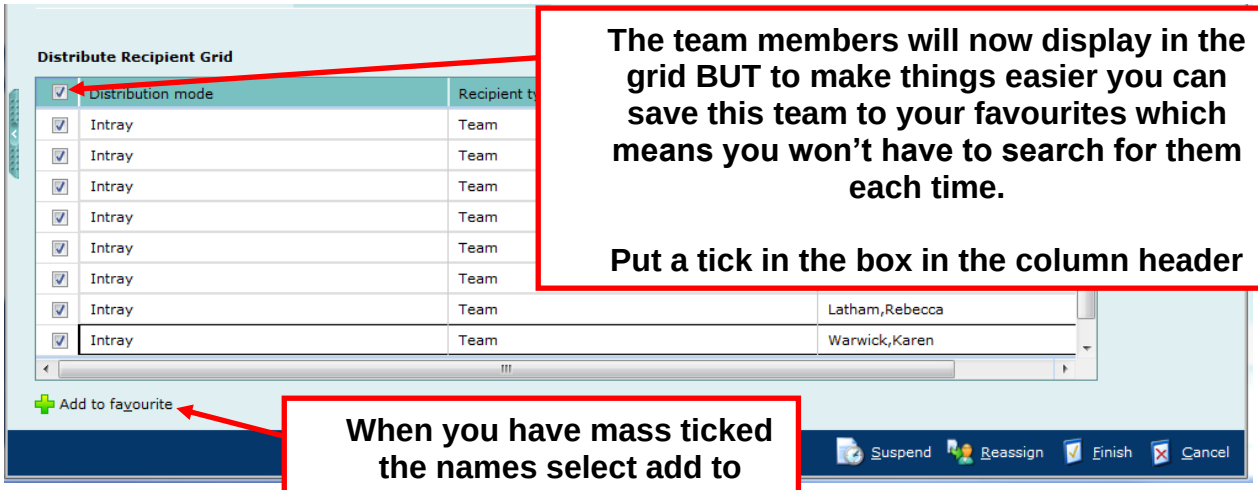
This can be done by distributing the alert to team / staff in-trays.






Team SFS - LORENZO -- Webpage Dialog
Criteria
Type
Name
crht%
Identifier
Health organisation
Clinical unit name
Service point name
Include inactive
Type
Name
Description
Home Treatment/Crisis Resolu...
CRHTS
Crisis Resolution an
When the results are displayed tick the box and then click OK
When searching for a team – type the team name in the name field – then click find
Page 1 of 1
Clear
Find
Ok
Cancel

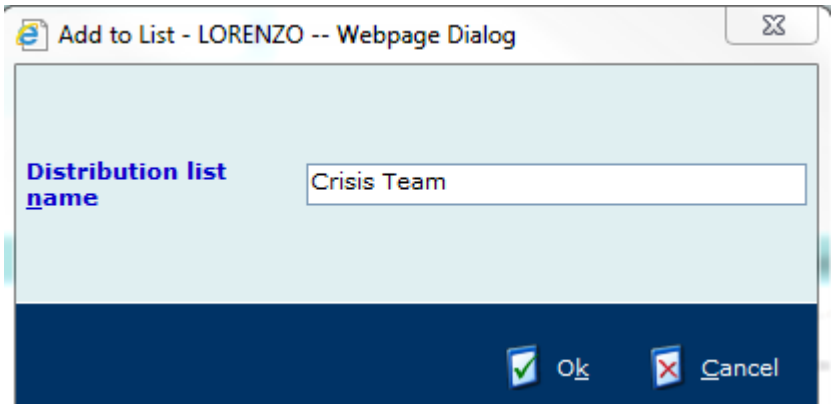

XXTESTPATIENTXX , Xxbktestxx (Mr) Male DOB: 01-Jan-1975 40 Yrs Patient ID: HFT0000015
01482123456
Active Allergies/ADRs (Last Checked On 18-Jun-2015)
Distribute
Distribute
Recipients type
Recipient
Distribution mode
Primary recipient
Alert name
History of Violence
Alert type
Behavioural
Last modified date/time
30 October 2015 11:20
Distribute Recipient Grid
Add
Remove
Distribution mode
Recipient type
Recipient name
Intray
Team
The team members will now display in the grid
Add to favourite
Suspend
Reassign
Finish
Cancel



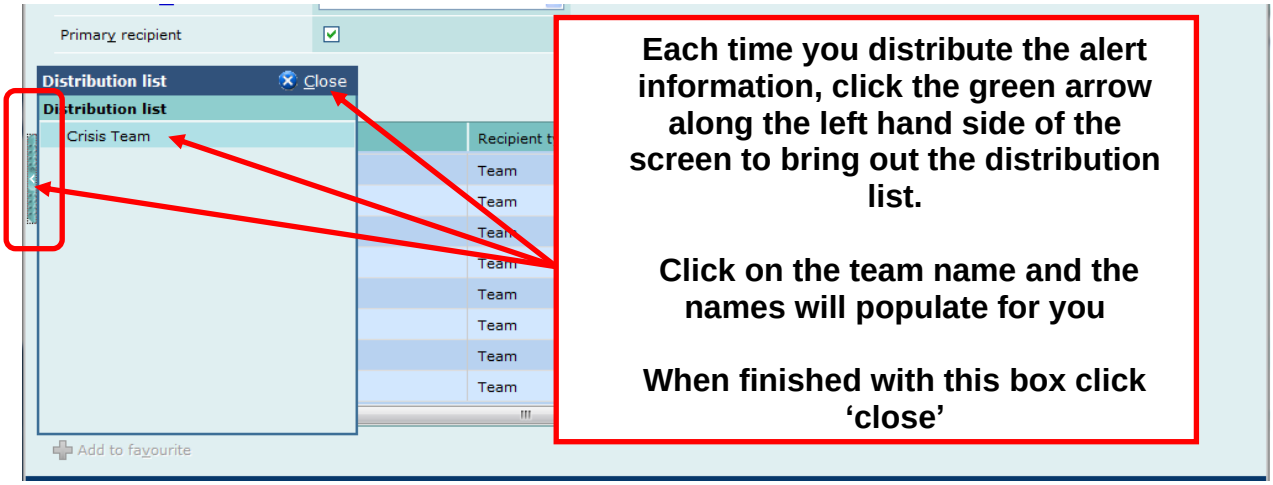
The team members will now display in the grid BUT to make things easier you can save this team to your favourites which means you won't have to search for them each time.

Put a tick in the box in the column header

When you have mass ticked the names select add to favourites



Name your team

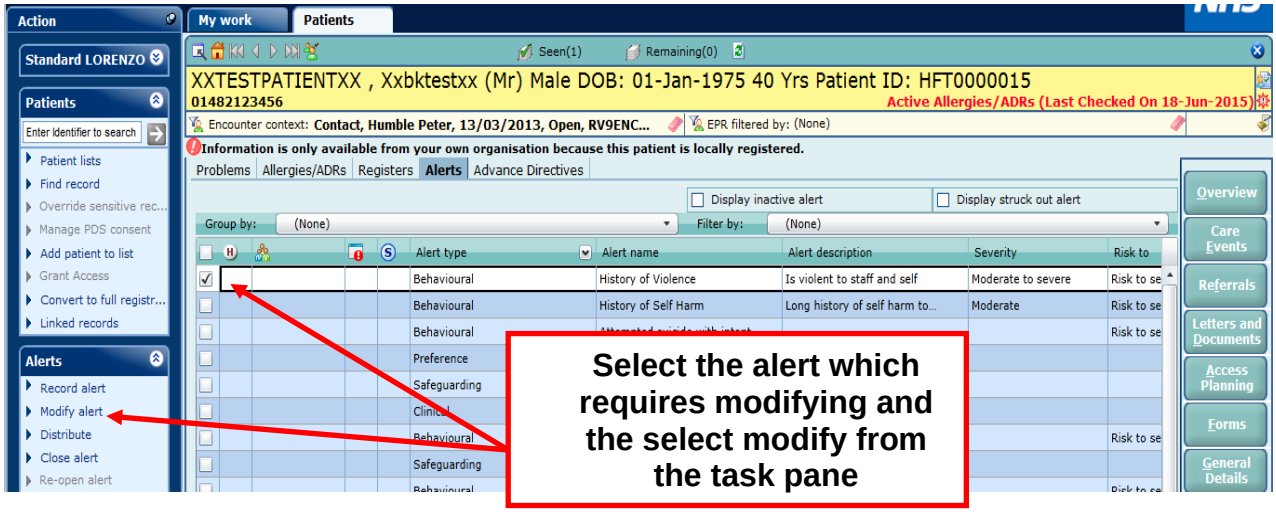


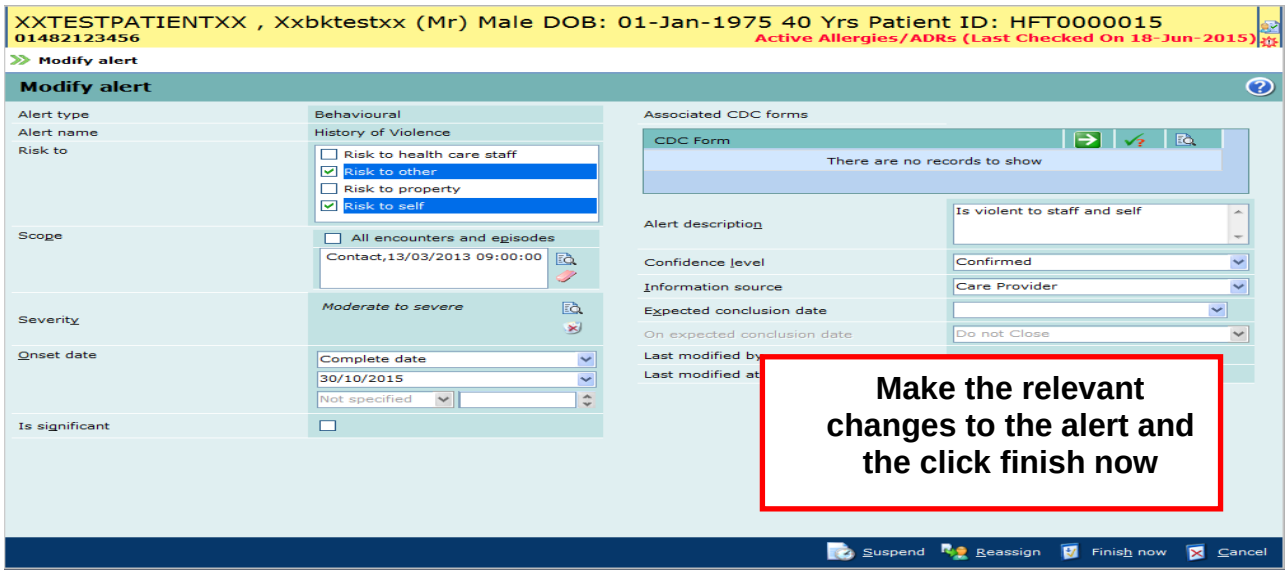
Each time you distribute the alert information, click the green arrow along the left hand side of the screen to bring out the distribution list.

Click on the team name and the names will populate for you

When finished with this box click 'close'

Modifying an Alert


Action
My work
Patients
Standard LORENZO
Patients
Enter Identifier to search
Patient lists
Find record
Override sensitive rec...
Manage PDS consent
Add patient to list
Grant Access
Convert to full registr...
Linked records
Alerts
Record alert
Modify alert
Distribute
Close alert
Re-open alert
Seen(1)
Remaining(0)
XXTESTPATIENTXX , Xxbktestxx (Mr) Male DOB: 01-Jan-1975 40 Yrs Patient ID: HFT0000015
01482123456
Active Allergies/ADRs (Last Checked On 18-Jun-2015)
Encounter context: Contact, Humble Peter, 13/03/2013, Open, RV9ENC...
EPR filtered by: (None)
Information is only available from your own organisation because this patient is locally registered.
Problems
Allergies/ADRs
Registers
Alerts
Advance Directives
Display inactive alert
Display struck out alert
Group by:
(None)
Filter by:
(None)
Alert type
Alert name
Alert description
Severity
Risk to
Behavioural
History of Violence
Is violent to staff and self
Moderate to severe
Behavioural
History of Self Harm
Long history of self harm to...
Moderate
Preference
Safeguarding
Overview
Care Events
Referrals
Letters and Documents
Access Planning
Forms
General Details
Select the alert which requires modifying and the select modify from the task pane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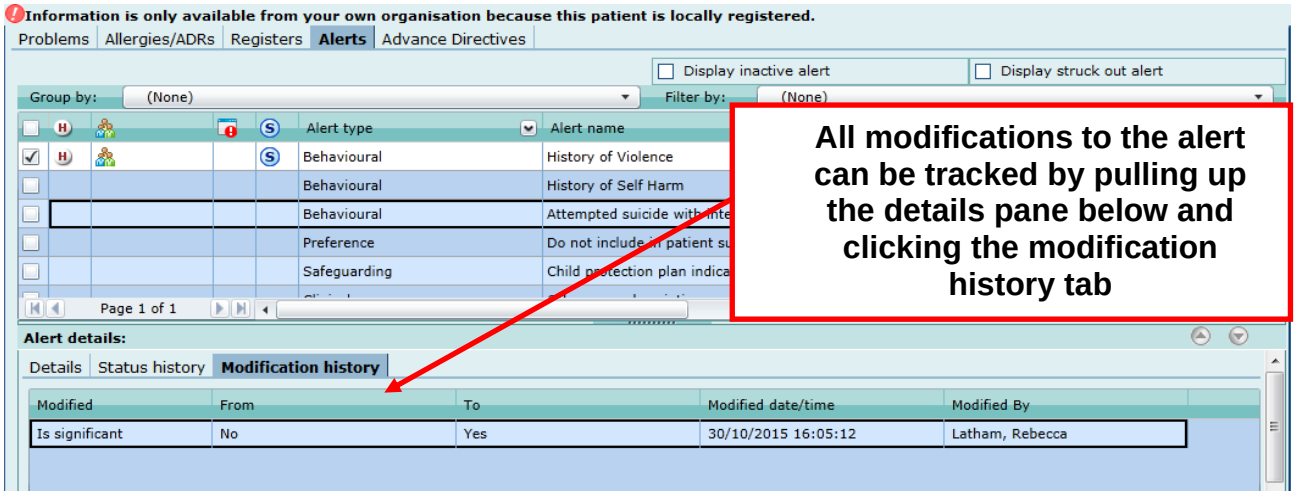
Modify alert
Modify alert
Alert type
Behavioural
Alert name
History of Violence
Risk to
Risk to health care staff
Risk to other
Risk to property
Risk to self
Scope
All encounters and episodes
Contact,13/03/2013 09:00:00
Severity
Moderate to severe
Onset date
Complete date
30/10/2015
Not specified
Is significant
Associated CDC forms
CDC Form
There are no records to show
Alert description
Is violent to staff and self
Confidence level
Confirmed
Information source
Care Provider
Expected conclusion date
On expected conclusion date
Do not Close
Last modified by
Last modified at
Make the relevant changes to the alert and the click finish now
Suspend
Reassign
Finish now
Cancel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(None)
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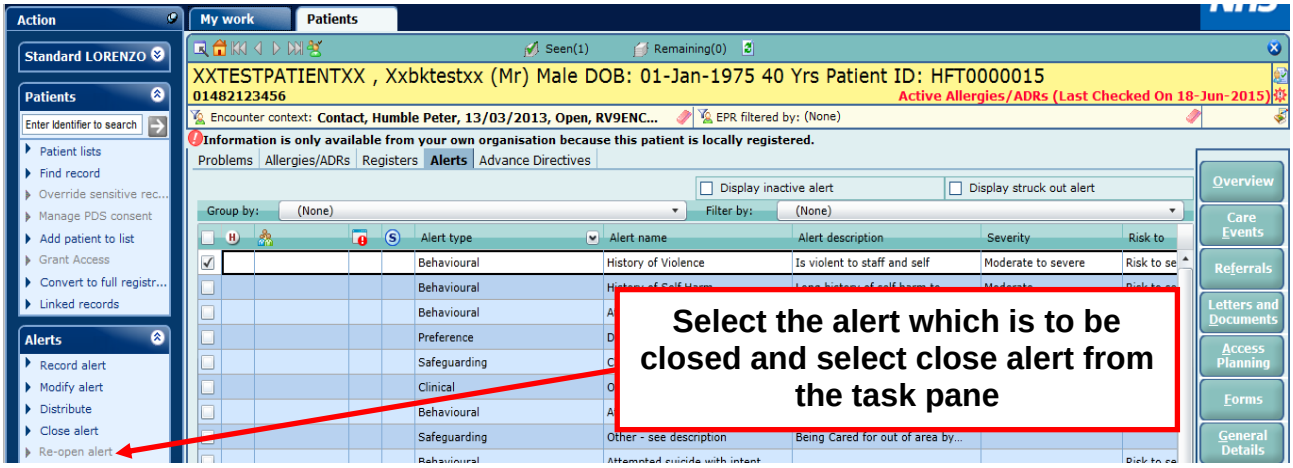
Behavioural
History of Violence
Behavioural
History of Self Harm
Behavioural
Preference
Safeguarding
Page 1 of 1
All modifications to the alert can be tracked by pulling up the details pane below and clicking the modification history tab
Alert details:
Details
Status history
Modification history
Modified
From
To
Modified date/time
Modified By
Is significant
No
Yes
30/10/2015 16:05:12
Latham, Rebecca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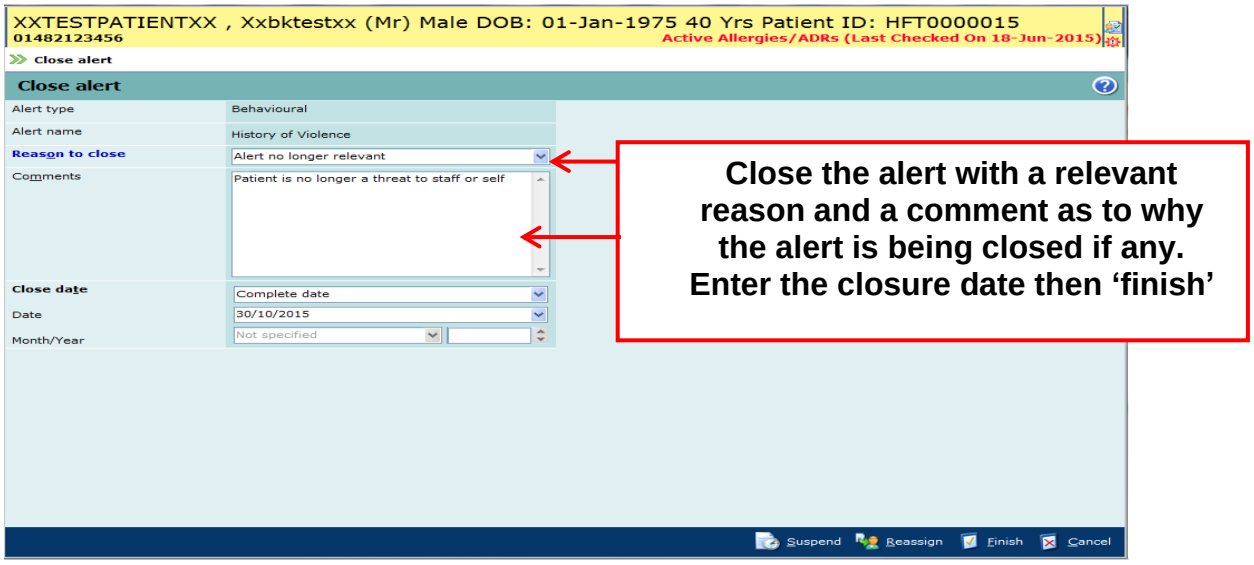
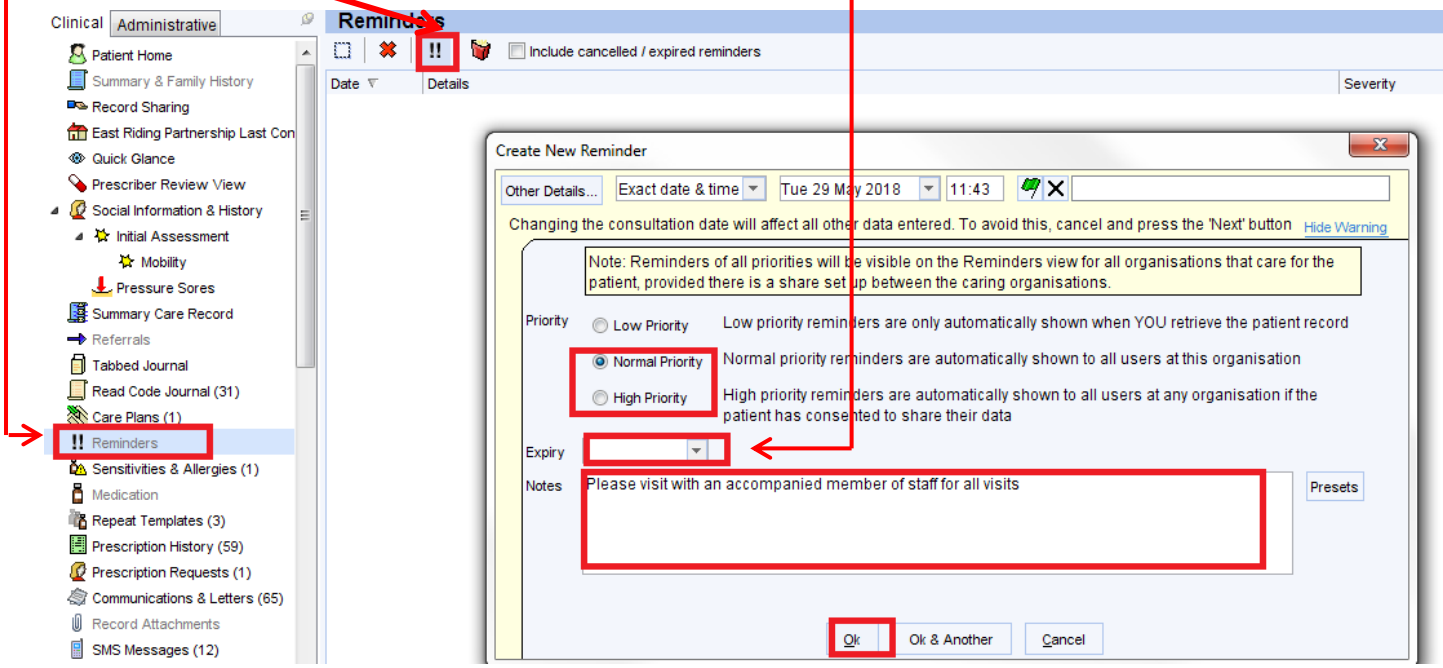
Registers
Alerts
Advance Directives
Display inactive alert
Display struck out alert
Group by:
(None)
Filter by:
(None)
Alert type
Alert name
Alert description
Severity
Risk to
Behavioural
History of Violence
Is violent to staff and self
Moderate to severe
Behavioural
Behavioural
Preference
Safeguarding
Clinical
Behavioural
Safeguarding
Other - see description
Being Cared for out of area by...
Overview
Care Events
Referrals
Letters and Documents
Access Planning
Forms
General Details
Select the alert which is to be closed and select close alert from the task pane


XXTESTPATIENTXX , Xxbktestxx (Mr) Male DOB: 01-Jan-1975 40 Yrs Patient ID: HFT0000015
01482123456
Active Allergies/ADRs (Last Checked On 18-Jun-2015)
Close alert
Close alert
Alert type
Behavioural
Alert name
History of Violence
Reason to close
Alert no longer relevant
Comments
Patient is no longer a threat to staff or self
Close date
Complete date
Date
30/10/2015
Month/Year
Not specified
Suspend
Reassign
Finish
Cancel
Close the alert with a relevant reason and a comment as to why the alert is being closed if any. Enter the closure date then 'finish'

SYSTMONE – Alerts on a SystmOne record will be placed in the Reminders

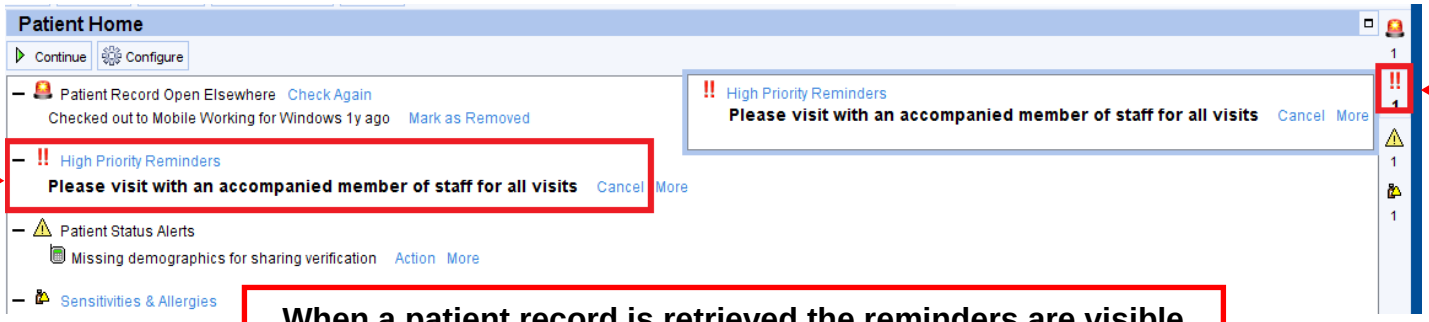
Recording a reminder alert in SystmOne

1. Click Reminders
2. Click !! icon to add a new reminder
   - **Never record low priority** – not used in Humber Teaching NHS Foundation Trust
   - Expiry date: if short term reminder put end date at time of inputting reminder on the record.



3. Click Ok

Viewing the Reminders

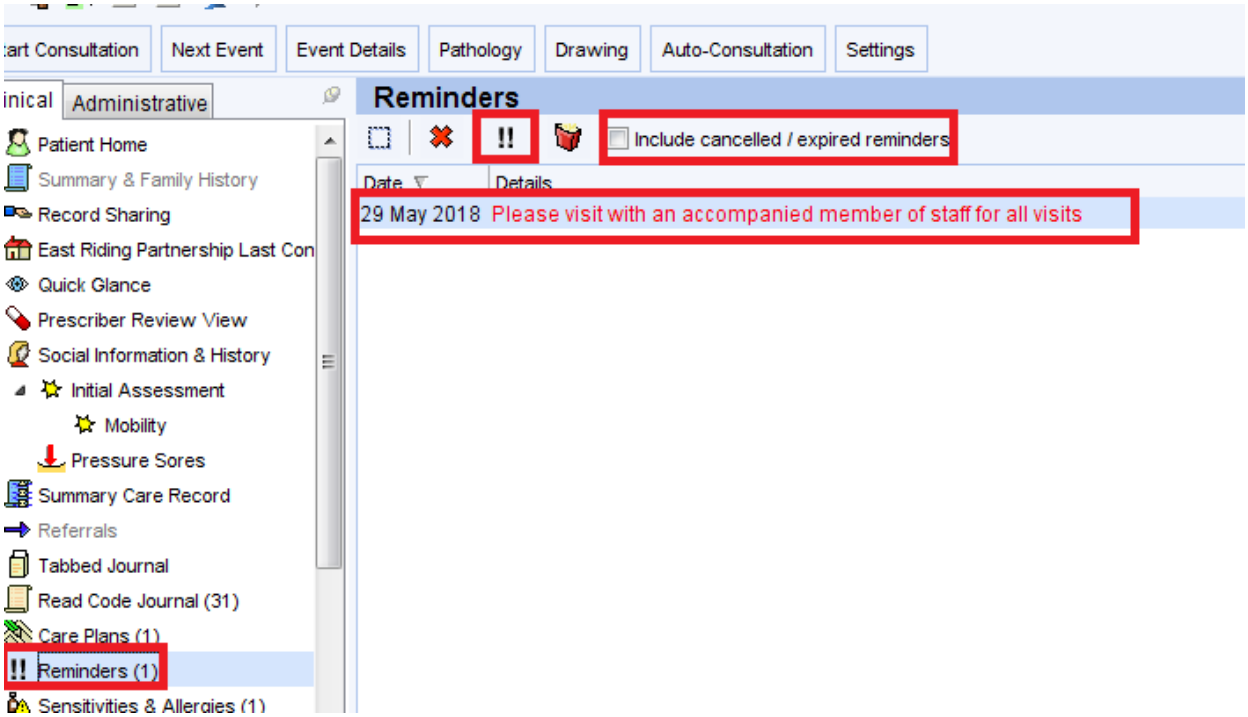


When a patient record is retrieved the reminders are visible on the home screen and throughout the record.

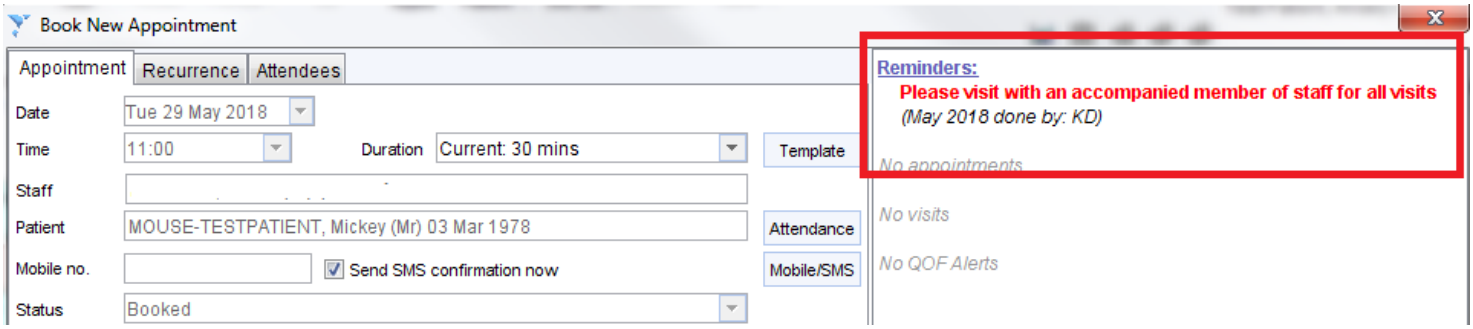
Reminders can be accessed by clicking the reminder icon !! on the sidebar down the left-hand side.

Viewing and managing reminders from the Reminders section

1. Click on Reminders on the clinical tree
2. Right click on reminder to cancel if no longer relevant
3. Click !! icon to add further reminders
4. Tick the box to include cancelled/expired reminders to see full reminder history recorded in the record.

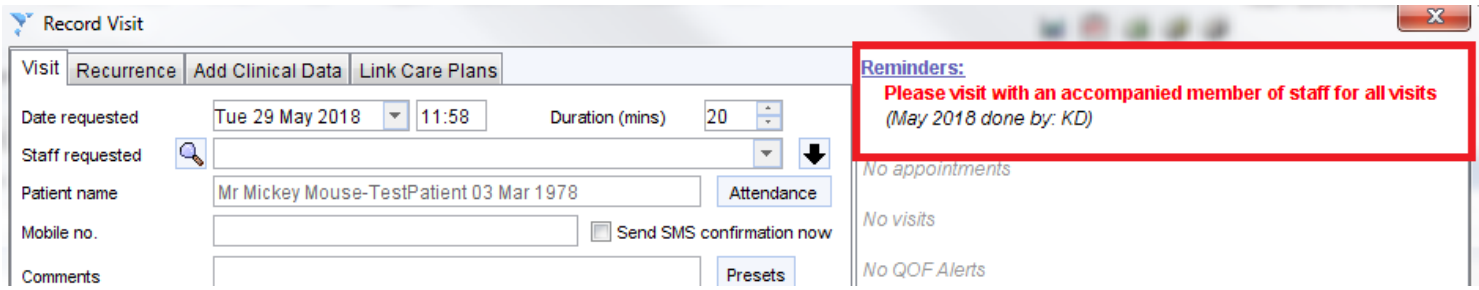


Booking an appointment/visit for a Patient who has a reminder recorded in the record



Booking appointment screen

When an appointment or visit for a patient with reminders recorded is booked – these will be visible at the time of booking the appointment/visit without having to open the patient record.



Booking visit screen

14. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

NICE Guideline CG 10 Management of Violence & Aggression 2015, https://www.nice.org.uk/guidance/ng10/
Data Protection Act 2018, https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted
General Data Protection Regulation, https://gdpr-info.eu/
Data Protection Good Practice Note - The use of violent warning markers, Information Commissioner's Office (2006)
http://www.ico.gov.uk/what_we_cover/data_protection/guidance/good_practice_notes.aspx
Mental Health Capacity Act 2005, http://www.scie.org.uk/publications/mca/principles.asp
Directions to NHS bodies on security management measures, Department of Health (2004)
http://www.nhsbsa.nhs.uk/SecurityManagement/2286.aspx
The Health and Safety at Work Act (1974) http://www.hse.gov.uk/legislation/hswa.htm
The Management of Health and Safety at Work Regulations (1999) ISBN0110856252
http://www.opsi.gov.uk/SI/si1999/19993242.htm

15. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Information Security and Risk Policy
Inpatient Identification Policy and Procedure
Management of Violence and Aggressive Behaviour Policy
Clinical Management of Drug and Alcohol Users Policy
Risk Management Policy
Patient Objection to the Creation or Use of their Health Record
Safeguarding Adult Policy
Safeguarding Children Policy
Information Governance Policy
MAPPA Protocol

APPENDIX 1 - PATIENT ALERT REGISTRATION FORM

<table>
<tr><td colspan="3">Patient Name:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td>NHS Number:</td></tr>
<tr><td colspan="2">Home Address and Postcode:</td><td>Telephone No:</td></tr>
<tr><td colspan="3">Name and Title of Manager Approving the Alert</td></tr>
<tr><td colspan="3">Signature of Manager Approving the Alert

Date:</td></tr>
<tr><td colspan="3">Alert Type – Tick alert type on back of this form</td></tr>
<tr><td colspan="3">Reason for Alert
Alerts must be based solely on factual information and not subjective opinion. The clinician requesting or applying an alert must always be able to justify their decision on this basis to the patient or potentially in a court of law.
An alert must always be based on information from an appropriate source</td></tr>
<tr><td colspan="3">Special Precautions:</td></tr>
<tr><td>Start Date of Alert:</td><td>End Date of Alert:
(if date known or short term alert)</td><td>Review Date of Alert:
(Must have a review date if no end date)</td></tr>
</table>

Please ensure that this alert is regularly reviewed through appropriate forums i.e. Care Co-ordination Group, Community Team meeting or built into natural assessments.
Copies for:

- Patient
- Medical File (and place a note in the relevant alert box on the inside cover of the medical record)

The patient must be provided with an explanation when an Alert is created.
* Copy to be logged with the Risk and Relapse Plan on Patient Administration Systems

Tick alert type to be applied to record

Alert Type	Alert Name
Behavioural	ASBO or Injunction in Effect
	Attempted Suicide with intent indicator
	History of Damage to Property
	History of Self Harm
	History of Theft
	History of Verbal Abuse
	History of Violence
	History of Violence by Significant other
	Inappropriate Multiple Attendee
	Other - See Description
	Previously Absconded from Care Setting
	Previously known Drug User/Seeker
	Previously Known to Carry Weapon
	Risk of Fire Starting
	Part 3 MHA Detention
	Referred under MARAC
	Vulnerable in Case of Civic Emergency
Clinical	A&E Attention - check notes
	Patient Requires Irradiated Blood
	Pet Hazard
	Patient Relative is a Service User
	Bleeding Discharge
	Blood Transfusion Hazard
	Frequent Attender
	High Dose Antipsychotic Treatment
	Patient at Risk of Sudden or Unexpected Death under age 18 as assessed by clinician
End of Life	Do not Attempt CPR
	Advanced Directive in Effect
	Hospice Patient
	Not for Resuscitation - see comment
	Other
	Palliative Care Patient
Impairment	Communication Difficulties
	Housebound
	Learning Disability
	Mobility Difficulties
	Other - See Description
	Visual Impairment
Safeguarding	No safeguarding issues identified

Preference	Patient objects for record been used for non-direct care purposes
	Patient objects to record been shared with other organisations providing care
	Does NOT consent to share Information
	Other – see description
	At risk of FGM (Female Genital Mutilation)
FGM	Child with parent history of FGM
	Confirmed FGM
Infection	C.difficile positive (or carrier
	CPE1 (Carbanphamase producing entero bacteria ceae
	Norovirus positive
	CPE1 positive case
	CPE2 contact of a positive case
	Coronavirus/Covid 19
	Extended-spectrum beta-lactamase
	Glycopeptide Resistant Enterococci
	Isolate patient
	MRSA Positive
	Shielding from Covid 19
	Other – see description
	Positive for blood-borne virus
	Risk of Creutzfeld-Jakob disease (CJD)
	TB
	Vancomycin-resistant Enterococci
MAPPA	MAPPA Category 1 and Risk Level 1
	MAPPA Category 1 and Risk Level 2
	MAPPA Category 1 and Risk Level 3
	MAPPA Category 2 and Risk Level 1
	MAPPA Category 2 and Risk Level 2
	MAPPA Category 2 and Risk Level 3
	MAPPA Category 3 and Risk Level 1
	MAPPA Category 3 and Risk Level 2
	MAPPA Category 3 and Risk Level 3
Research Patient	Patient Requires Irradiated Blood
	Research Patient
	Risk of Creutzfeldt-Jakob disease (CJD)
Communication	Cannot Receive Posted Letters
	Accessible information Requirement
	Suspected victim of sexual abuse

	Child on a CPP
	LAC
	Child domestic abuse
	Child at risk or victim of sexual exploitation
	Confirmed victim of FGM
	Child at risk /victim of trafficking
	Adult at risk of harm
	Adult detained in Hospital under MHA
	Adult (DOLS) under DOL Act
	Frequent Attender of A&E dept

	Suspected victim of child exploitation
	Suspected victim of sexual grooming
	Alleged victim of sexual assault
	Suspected non accidental injury to child
	Suspected victim of child abuse
	Suspected victim of domestic abuse
	Suspected victim of physical abuse
	Suspected victim of bullying
	Alleged been suspected of abuse
	Child protection is present on CPIS please review

	Delay in seeking medical advice
	Child is cause for safeguarding concern
	Adult safeguarding concern
	Family is cause for concern
	Carer behaviour is cause for Safeguarding concern
	Unborn child is cause for safeguarding concern
	At risk for deliberate self harm
	At risk for physical abuse
	At risk for other directed violence
	Child at risk
	Vulnerable Adult
	At risk of financial abuse
	At risk of discriminatory abuse
	At risk of institutional abuse
	At risk of radicalisation
	Has a child subject of CPP
	Family member of CPP subject
	Domestic abuse victim in household
	At risk of domestic violence
	At risk of sexual abuse
	At risk of sexual exploitation
	At risk of FGM
	At risk of honour-based violence
	At risk of forced marriage
	At risk of emotional abuse
	At risk of psychological abuse
	Suspected alcohol abuse
	Family history of alcohol abuse
	Suspected drug abuse
	Family history of drug abuse
	Suspected victim of child neglect

	Self neglect
Environment	Access Difficulties to Patient
	Other - See Description
	Pet Hazard
	Possible Drug User on Premises
	Possible Drug User on Premises

APPENDIX 2 – REMOVAL OF AN ALERT

Name of Patient:	**NHS no:**
Date of Birth:	**Patient Identifier/Unit Number:**
Address and Postcode:	
Date of Alert Review	
Reason for Alert Removal	

The Alert which commenced on …… is now discontinued.

I confirm that I am authorised to discontinue an alert for this Service User.
The Patient has been notified of the change and their records manually and electronically amended appropriately.

Signed: …….

Print Name: ……

Designation ……

Base Address: ……..