**Trust Policy**

Worcestershire Acute Hospitals NHS Trust

# PATIENT ALERTS POLICY

| | |
|---|---|
| **Department / Service:** | Trustwide |
| **Originator:** | Clinical Lead for Data Quality and Coding |
| **Accountable Director:** | Chief Medical Officer |
| **Approved by:** | Information Governance Steering Group |
| **Date of approval:** | 21 July 2020 |
| **First Revision Due:** | 25th December 2024<br>This is the most current document and should be used until a revised version is in place |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | All |
| **Target staff categories** | All |

**Policy Overview:**

The addition of electronic patient alerts to an individual patient record highlight particular issues or circumstances to support the safety of patients and staff.

This policy describes how electronic patient alerts will be managed at Worcestershire Acute Hospitals NHS Trust. It will outline how alerts are governed, key responsibilities and the process for updating and making changes.

**Key Amendments made to document:**

| Date | Amendment | By |
|---|---|---|
| May 2020 | Policy created | Clinical Lead for Data Quality & Coding Data Quality Manager & Health Records Manager |
| June 2020 | Approved by Health Records Group | Health Records Manager |
| July 2020 | Reporting structure and minor amendments following approval by the Information Governance Steering Group | Health Records Manager & Data Quality Manager |
| May 2021 | Addition of Appendices 1 and 2 | Health Records Manager |
| June 2024 | Document extended for 6 months whilst review undertaken | Matthew Thurland |

**Contents page:**

## 1. Introduction

Patient alerts are added to an individual patient's record by staff using the Patient Administration System (PAS). Alerts are added to draw attention to a significant circumstance, medical condition or disability that might otherwise be overlooked. The successful use of alerts should lead to improved patient treatment and improved safety and experience for both patients and staff.

A live register of patient alerts will be maintained by the Health Records Manager and reviewed by the Health Records Group (HRG).

Any changes to the register will be approved by the Health Records Group (HRG).

## 2. Scope of this document

This policy covers the management and governance of patient alerts that are added by staff to a patient's record on the Patient Administration System (PAS).

## 3. Definitions

An 'Alert' is defined as an electronic flag attached to an individual patient record to draw attention to a significant circumstance, medical condition or disability that might otherwise be overlooked. The successful use of alerts should lead to improved patient treatment and improved safety and experience for both patients and staff.

'Administrative staff' is defined as medical secretaries, ward clerks and other staff involved in the preparation of the patient record.

'Assault-warning letter' is an alert applied to any individual who has assaulted a member of staff and has been formally warned about their behaviour.

'Assault-exclusion letter' is an alert applied to any individual who has continually committed assaults on members of staff and who has now been excluded from further treatment/appointments within the trust other than in an emergency situation via ED

'Violent due to lack of mental health capacity' is an alert that may be applied to a patient who is persistently violent or abusive due to their lack of mental health capacity. This would be used for a case where the issuing of a warning/exclusion letter would not be appropriate.

Research alerts will also be used to guide clinical care in the emergency situation and allow trials teams to report safety data as per the reporting requirements of the trial.

## 4. Responsibility and Duties

Management of alert categories defined in sub-policies.

**The Clinical Lead for Data Quality** has overall responsibility for the maintenance and clinical governance of patient alerts.

**The Health Records Manager** has responsibility for maintaining the live register of patient alerts and ensuring that the register is reviewed by the Health Records Group (HRG).

**The Health Records Group (HRG)** has responsibility for authorising changes to the register of alerts and overall governance. The reviewing the register of alerts to ensure they are fit for purpose

**The Responsible Owners** are responsible for the maintenance and governance of alerts in each sub-group and providing professional advice to the Health Records Group (HRG) when determining changes to the register.

**All employees** have a duty to take appropriate action as indicated by a patient safety alert and any incidents reported via the DATIX reporting system.

## 5. Policy detail

The patient alerts are grouped into subject categories, with each category overseen by a professional lead.

A live register of patient alerts will be maintained by the Health Records Manager and reviewed by the Health Records Group (HRG).

Any changes to the register will be submitted to the Health Records Group (HRG) for approval.

This policy will address the appropriate use of patient alerts, offering guidance to staff and addressing the management and governance for each alert or group of alerts in respect of the following issues:

- The appropriate sub-category of the alert;
- Who is authorised to apply the alert to the patient record;
- Who is the responsible owner and has overall governance of the alert;
- Whether patient consent is required before attaching an alert to a patient record;
- If a review of the alert is required, how frequently this should be carried out and by whom.
- The process for generating new alerts or removing/merging existing alerts.

### 5.1 The appropriate sub-category of the alert

Each alert will be allocated to one of eight sub-categories which are:

1. Allergy
2. Security
3. Infection Control
4. Safeguarding
5. Medical
6. Patient experience
7. Research
8. Health Records

The appropriate sub-category for each alert will be authorised by the Health Records Group (HRG) before adding to the live register.

### 5.2 Who is authorised to apply the alert to the patient record

Authority will be given to a specific member of staff or groups of staff to apply each alert. This will be stated in the live register.

### 5.3 Who is the responsible owner and has overall governance of the alert

A professional lead will be allocated for each alert. They will be responsible for providing advice on the application and review of each alert.

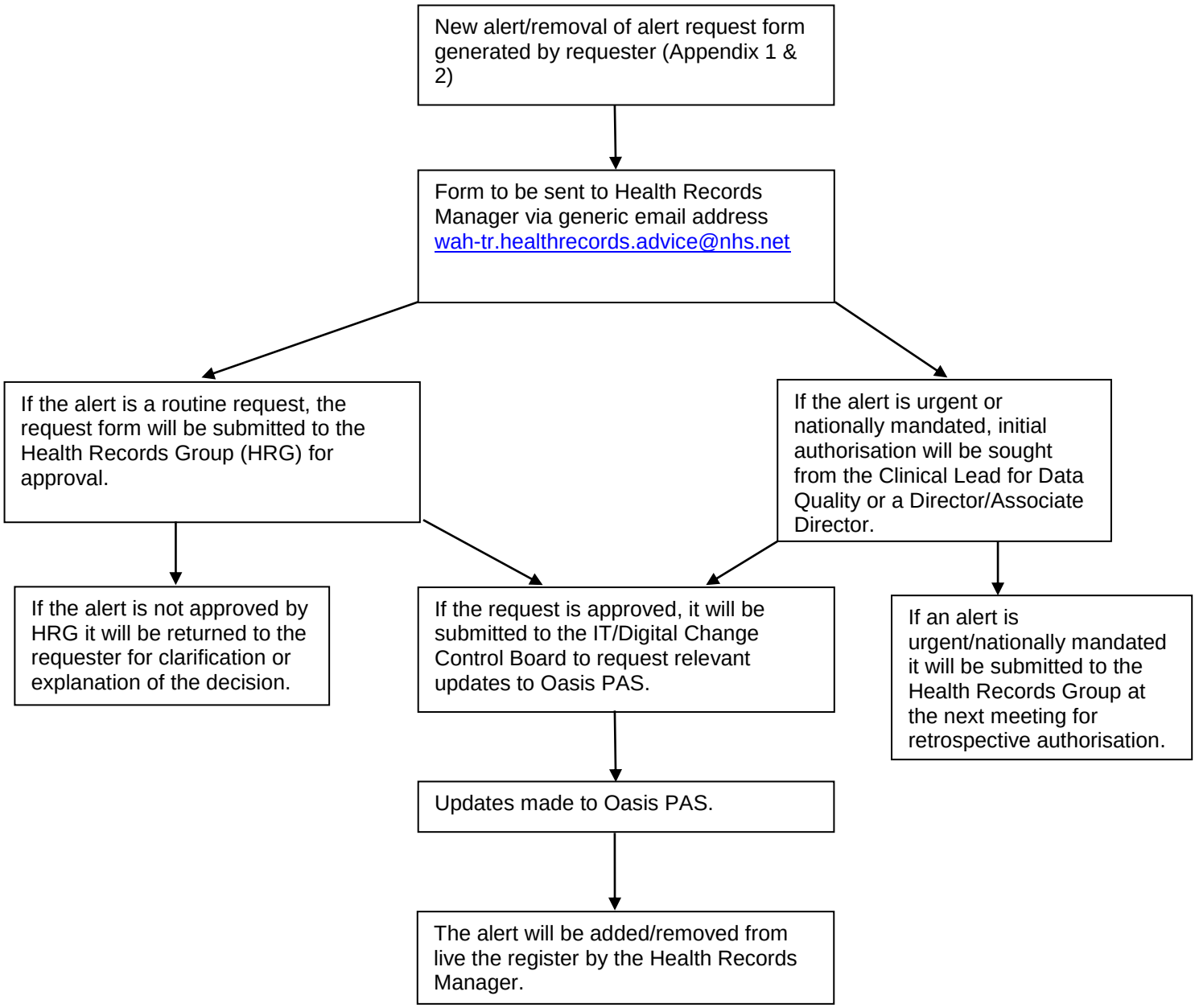
### 5.4 Whether patient consent is required before attaching an alert to a patient record

The register will outline whether patient consent is required prior to an alert being added to an individual patient record.

### 5.5 If a review of the alert is required, how frequently this should be carried out and by whom

Some alerts will be time-limited. This will be stated on the register and on the individual patient record when it is added to PAS. Time-limited alerts will be reviewed by the Health Records Group (HRG) to ensure application.

### 5.6 The process for generating new alerts or removing/merging existing alerts



## 6. Implementation

### 6.1 Plan for implementation

Policy developed within Health Records Group (HRG) and Data Quality Steering Group (DQSG), owned by Trust Clinical Lead for Data Quality supported by Deputy Chief Medical Officer and Nursing Leads.

### 6.2 Dissemination

New policy disseminated through divisions and publicised with communications.

## 7. Monitoring and compliance

See below ('Key Controls')

| Page/ Section of Key Document | Key control: | Checks to be carried out to confirm compliance with the Policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | Ensure that alerts are not applied by individuals who are not authorised to apply those alerts. | Regular audits to ensure compliance with policy with reference to alert application authorisation. | Information report to be devised and performed for each alert sub-group with reports sent to group lead. Themes of non-compliance to be reported to the Health Records Group (HRG). | Group leads supported by Information Team reporting to Health Records Group (HRG). | Health Records Group (HRG). | Twice annually (HRG Lead to analyse dataset and report to HRG) |
| | Ensure that time-limited | Regular audits to | Information | Information | Information report to | Information |

| | | | | | | |
|---|---|---|---|---|---|---|
| | alerts are appropriately closed when expired | ensure compliance with policy | report to be devised and performed for each alert sub-group with reports sent to group lead. Themes of non-compliance to be reported to Health Records Group (HRG). | report to be devised and performed for each alert sub-group with reports sent to group lead. Themes of non-compliance to be reported to Health Records Group (HRG). | be devised and performed for each alert sub-group with reports sent to group lead. Themes of non-compliance to be reported to Health Records Group (HRG). | report to be devised and performed for each alert sub-group with reports sent to group lead. Themes of non-compliance to be reported to Health Records Group (HRG). |
| | Ensure that patient consent is obtained for relevant alerts | Regular audits to ensure compliance with policy. | Information report to be devised and performed for each alert sub-group with reports sent to group lead. Themes of | Group leads supported by Information Team reporting to Health Records Group (HRG). | Health Records Group (HRG). | Twice annually (HRG Lead to analyse dataset and report to HRG) |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | non-compliance to be reported to Health Records Group (HRG). | | | |

## 8. Policy Review

Every 3 years.

## 9.

**References:**

| | |
|---|---|
| **Nottingham NHS Alerts Policy** | |

## 10. Background

### 10.1 Equality requirements

The assessment conducted for this policy reveals no equality issues. This is appended as Supporting Document 1.

### 10.2 Financial risk assessment

A financial risk assessment has been performed and reveals that there are no financial implications for this policy. This is appended as Supporting Document 2.

### 10.3 Consultation

The views of key stakeholders have been sought via the Health Records Group and Information Governance Steering Group.

**Contribution List**

This key document has been circulated to the following individuals for consultation:

| Designation |
|---|
| Rebecca Brown Deputy Chief Digital Officer |
| Graham James Deputy Chief Medical Officer |
| Nicola O'Brien Associate Director of Performance and Information |
| Health Records Group |
| Information Governance Steering Group |

This key document has been circulated to the chair(s) of the following committees / groups for comments:

| Committee |
|---|
| Health Records Group |
| Information Governance Steering Group |

### 10.4 Approval Process

This section should describe the internal process for the approval and ratification of this Policy.

### 10.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

| Date | Amendment | By: |
|---|---|---|
| May 2020 | Policy created | Clinical Lead for Data Quality & Coding<br>Data Quality Manager &<br>Health Records Manager |
| June 2020 | Approval by the Health Records Group | Health Records Manager |
| July 2020 | Reporting structure and minor amendments following approval by the Information Governance Steering Group | Health Records Manager |

**Appendix 1**

# Oasis – New Alert Generation Form

| | |
|---|---|
| **Name of proposer** | |
| **Job Role** | |
| **Speciality/Department** | |
| **Contact telephone/email** | |

| | |
|---|---|
| **Proposed name of alert** | |
| **Type of alert (please specify from the list which sub category the alert will fall into)** | **Allergy**<br>**Security**<br>**Infection Control**<br>**Safeguarding**<br>**Medical**<br>**Patient experience**<br>**Research**<br>**Health Records** |

| | |
|---|---|
| **What has prompted this request?** | |
| **Why is this needed – benefits / risks?** | |
| **Who is authorised/will add the alert to patient's Oasis record?** | |
| **Does this alert require review and if so how frequently?** | |
| **Is specific patient consent required before applying this alert?** | |
| **If appropriate is this alert time limited? If so for how long?** | |
| **Who is the responsible owner for the governance of this alert?** | |
| **What do you want the staff to do when they see the alert on the patient record?** | |
| **Who will communicate that this alert is now available for front end users to select as appropriate? Who will communicate what the staff are expected to do when they see the alert?** | |

**Appendix 2**

# Oasis – Alert Expiration or Merger Form

| | |
|---|---|
| **Name of proposer** | |
| **Job Role** | |
| **Speciality/Department** | |
| **Contact telephone/email** | |

| | |
|---|---|
| **Proposed Alert to be removed or merged** | |
| **Sub-grouping of alert** | |

| | |
|---|---|
| **What has prompted this request?** | |
| **Are there any anticipated risks to patients or the Trust caused by removing or merging this alert?** | |
| **If merger proposed with which alert should merger take place?** | |
| **Do patients with the alert attached need to be notified before removing or merging the alert?** | |

**Supporting Document 1 - Equality Impact Assessment Tool**

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.
Please complete assessment form on next page;

**Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form**
**Please read EIA guidelines when completing this form**

**Section 1 - Name of Organisation** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Herefordshire & Worcestershire STP | | Herefordshire Council | | Herefordshire CCG | |
| Worcestershire Acute Hospitals NHS Trust | x | Worcestershire County Council | | Worcestershire CCGs | |
| Worcestershire Health and Care NHS Trust | | Wye Valley NHS Trust | | Other (please state) | |

| | |
|---|---|
| **Name of Lead for Activity** | Matthew Thurland, Health Records Manager |

| | | | |
|---|---|---|---|
| **Details of individuals completing this assessment** | **Name** | **Job title** | **e-mail contact** |
| | Teya Morris | Data Quality Officer | teya.morris@nhs.net |
| | Matthew Thurland | Health Records Manager | matthew.thurland@nhs.net |
| | Hayley Wharton | Data Quality Manager | hayley.wharton@nhs.net |
| **Date assessment completed** | 7 September 2020 | | |

**Section 2**

| | | | | |
|---|---|---|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | Patient Alerts Policy | | | |
| What is the aim, purpose and/or intended outcomes of this Activity? | This policy describes how electronic patient alerts will be managed at Worcestershire Acute Hospitals NHS Trust. It will outline how alerts are governed, key responsibilities and the process for updating and making changes. | | | |
| Who will be affected by the development & implementation of this activity? | ❑<br>❑x<br>❑<br>❑ | Service User<br>Patient<br>Carers<br>Visitors | ❑x<br>❑<br>❑<br>❑ | Staff<br>Communities<br>Other _____ |

| | |
|---|---|
| Is this: | x❑ Review of an existing activity<br>❑ New activity<br>❑ Planning to withdraw or reduce a service, activity or presence? |
| What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc. | The policy has been widely circulated and discussed across staff groups to ensure that patients with particular needs are recognised. Professional leads have been allocated to lead on sub-groups to ensure that the alerts are appropriately governed. |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | The policy has been widely circulated across staff groups. |
| Summary of relevant findings | |

**Section 3**

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Age** | N/A | N/A | N/A | |
| **Disability** | Yes | N/A | N/A | The policy makes provision for highlighting patients with particular disabilities to ensure that staff are able to put the appropriate measures in place (such as patients with a learning disability, visual or hearing impairment). |
| **Gender Reassignment** | Yes | N/A | N/A | The policy makes provision for highlighting patients who have had gender reassignment to ensure that particular needs are recognised (subject to patient consent). |
| **Marriage & Civil Partnerships** | N/A | N/A | N/A | |
| **Pregnancy & Maternity** | Yes | N/A | N/A | The policy makes provision for highlighting patients with specific pregnancy-related conditions to ensure that staff are able to provide the appropriate clinical treatment (e.g. |

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| | | | | Group B Strep; Gestational Diabetes). |
| **Race including Traveling Communities** | N/A | N/A | N/A | |
| **Religion & Belief** | | | | The policy makes provision for highlighting patients who are Jehovah's Witness to ensure that staff are able to provide clinical treatment in line with these beliefs. |
| **Sex** | N/A | N/A | N/A | |
| **Sexual Orientation** | N/A | N/A | N/A | |
| **Other Vulnerable and Disadvantaged Groups** (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.) | Yes | N/A | N/A | The policy makes provision for highlighting patients who require safeguarding intervention to ensure that staff are able to put the appropriate measures in place. |
| **Health Inequalities** (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies) | N/A | N/A | N/A | |

**Section 4**

| What actions will you take to mitigate any potential negative impacts? | Risk identified | Actions required to reduce / eliminate negative impact | Who will lead on the action? | Timeframe |
|---|---|---|---|---|
| | N/A | N/A | N/A | N/A |
| | | | | |
| | | | | |
| **How will you monitor these actions?** | | | | |

| | |
|---|---|
| **When will you review this EIA?** (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation) | At the point of policy renewal. |

**Section 5 -** Please read and agree to the following Equality Statement

**1. Equality Statement**

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

| | |
|---|---|
| **Signature of person completing EIA** | Matthew Thurland |
| **Date signed** | 7 September 2020 |
| **Comments:** | |
| **Signature of person the Leader Person for this activity** | Matthew Thurland |
| **Date signed** | 7 September 2020 |
| **Comments:** | |

NHS Worcestershire Acute Hospitals NHS Trust · NHS Herefordshire Clinical Commissioning Group · NHS Redditch and Bromsgrove Clinical Commissioning Group · NHS South Worcestershire Clinical Commissioning Group · NHS Wyre Forest Clinical Commissioning Group · NHS Wye Valley NHS Trust

NHS Worcestershire Health and Care NHS Trust · 2gether NHS Foundation Trust · NHS · Taurus Healthcare · worcestershire county council · Herefordshire Council

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval