Protocol for Suicide Risk Assessment and Management

Version No. 1

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Definitions

١. Suicide:

Is the act of intentionally causing one's own death.

٢. Death Wishes:

Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and don't wake up.

٣. Non-Specific Active Suicidal Ideation:

General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

٤. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose, but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."

٥. Active Suicidal Ideation with Some Intent to Act, without Specific Plan:

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."

٦. Active Suicidal Ideation with Specific Plan and Intent:

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

٧. Actual Attempt:

A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as a method to kill oneself. Intent

does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. Injury or harm is not mandatory; just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident, so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

٨. Interrupted Attempt:

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, an actual attempt would have occurred).

Examples; Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge.

Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

٩. Aborted or Self-Interrupted Attempt:

When a person begins to take steps toward making a suicide attempt, but stops himself/herself before he actually has engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

١٠. Preparatory Acts or Behaviors:

Acts or preparations towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

١١. Deliberate self-harm (DSH):

Self-injurious behavior both with and without suicidal intent that has non-fatal outcomes.

١٢. Non-suicidal self-injury (NSSI):

The deliberate damage to one's own body tissue without suicidal intent.

١٣. Parasuicide:

An apparent attempt at suicide, commonly called a suicidal gesture, in which someone mimics the acts of suicide without the intent to kill him-self/her-self, e.g., a sub-lethal drug overdose, or wrist slash. Previous parasuicide is a predictor of suicide.

١٤. Seclusion Room:

Safety room used in the treatment and management of disruptive and violent behaviors where most outside stimuli are eliminated, allowing an individual to "reset" and feel calm for containing a clinical situation that may result in a state of emergency.

Introduction

Suicide (International Perspective):

Suicide is a tragic and distressing phenomenon. Each suicide is a tragedy that takes the life of an individual prematurely and has a continuing effect that dramatically affects the lives of families, friends, communities, provinces and entire countries (1).

Suicide is the act of killing oneself; it is not a diagnosis or a disorder, but a behavior. It is not a mental illness in itself, but a potential consequence of many mental disorders. Suicide is one of the leading causes of premature death and is considered a public health and social problem worldwide (2).

Every year, more than 800.000 people die by suicide (one person every 40 seconds). Suicide is the second leading cause of death among those aged 15 to 29 years. Considering the relevance of this problem, the World Health Organization has considered suicide prevention as a global imperative, and countries should consider suicide prevention as a high priority health care program (1).

The overall global age-standardized suicide rate was 10.5 per 100 000 populations in 2016; 13.7 and 7.5 per 100 000 for males and females, respectively (3).

The numbers differ between countries, but low and middle income countries bear most of the global suicide burden, with an estimated 75% of all suicides occurring in these countries (1).

Suicide arises from a complex interaction between many risk factors and triggers in a person's life. However, suicide can also be influenced by social and economic circumstances and differences between cultures and individuals' experiences in society. It is not easy to understand what compels a person to take their own life, especially for those who have never experienced such overwhelming feelings. To determine accurate information about suicide, it is

important to identify those who may need more support and have clarity about common myths and facts about suicide (4).

Reducing stigma related to suicide and broadening awareness are only a part of our collective responsibility, and we should talk more openly about suicide and reduce the stigma that persists around mental illness. But another, perhaps more crucial imperative is to work toward an understanding of suicidal thoughts and actions (5).

Regarding the association between mental disorders and suicide, it was found that individuals with a mental disorder had a nearly eight-fold increased risk of suicide compared with those without a mental disorder (6).

In their systematic review on psychological risk factors of suicide attempts, YariGvion et.al. (2018) concluded that mental pain, communication difficulties, decision-making impulsivity, aggression, as well as several demographic variables were found to be major risk factors for suicide attempts (7).

The best available evidence for effective treatment of those at risk for committing suicide is communication among people and trying to understand the nature of the problem or the view of the patient as a person who exists in an interpersonal, social, and cultural context as well as medical and psychiatric contexts(3).

So, we have to work towards better and full understanding of suicide and suicidal behavior to uncover the best ways to reach and treat those who struggle with suicide while providing an evidence based interventions that elevates the issue beyond awareness and moves us toward actions in dealing with this potentially preventable phenomenon

Suicide (National Perspective)

The Saudi reports of sentinel events of suicide in inpatient units as well as suicide of staff, visitors and watchers anywhere in MOH properties in Kingdom of Saudi Arabia (KSA) revealed that the most common inpatient's suicide occurs

in General Hospitals, indicating the need to educate the staff for the assessment of high-risk psychiatric and suicidal patients.

Figure (1): Suicide in Inpatient Units and Suicide of Staff, Visitors, Watchers in anywhere in MOH properties in the past 10 Years (N=46)
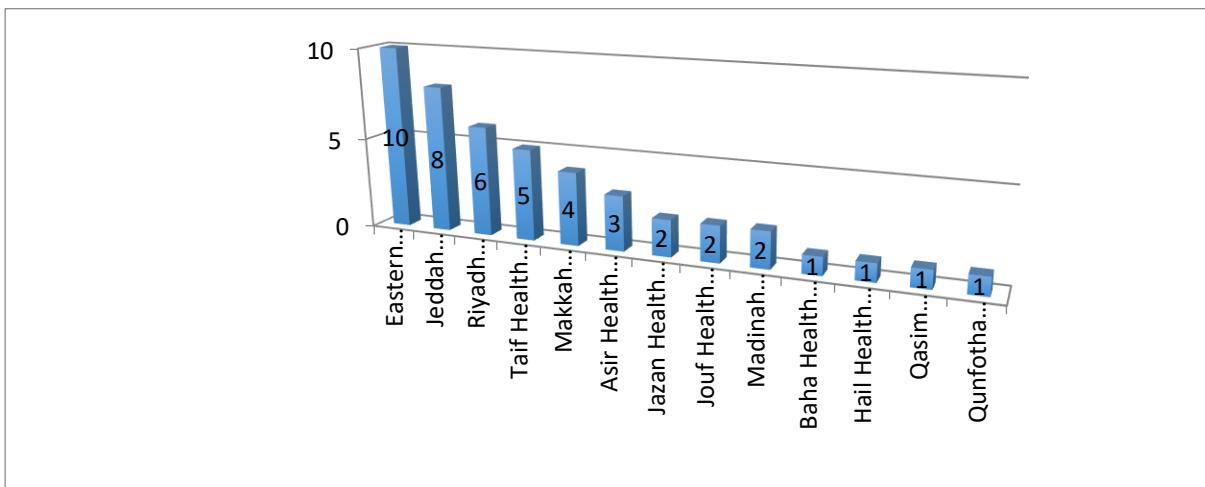
Figure (1) represents the rates of suicide in different regions of the kingdom in the past 10 years where eastern region had the highest suicidal rates in KSA (10 suicide cases), followed by Jeddah (8), Riyadh (6), Taif (5), Makkah (4), Asir (3), Jazan (2), Jouf (2), Madinah (2) and finally one case of suicide in Baha, Hail, Qasim and Qunfotha). It is worth noting that the total suicide number was 46 suicides, among them 41 inpatient suicides, and 5 suicides were in staff, visitors and watchers (2 in Riyadh, 1 in Eastern region, Baha and Asir).

Figure (2): Trends of Suicide in Inpatient Units over the past 10 years (N=46)
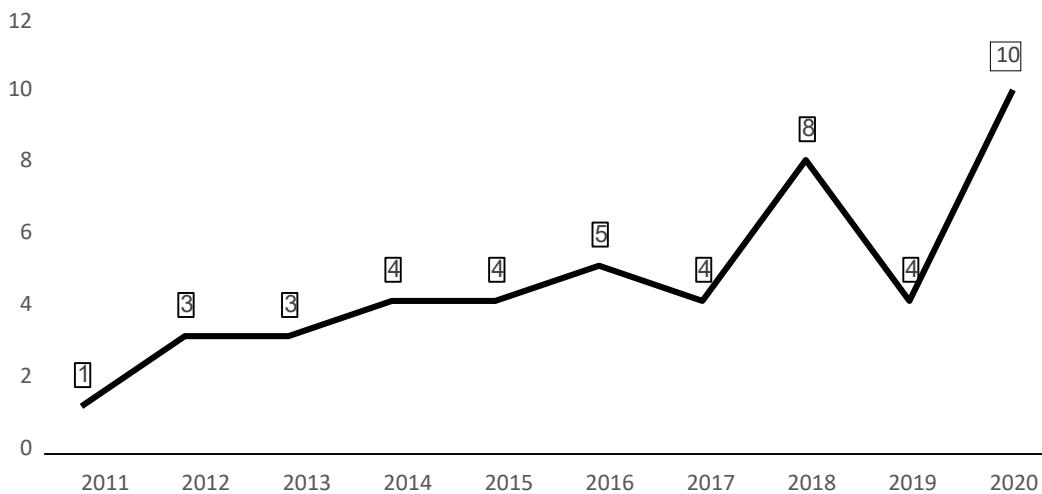
Figure (2) represents trends in Suicide rates in inpatient units in KSA overtime from 2011-2020. The trend shows a step-wise increase in rates of suicide overtime reaching the peak in 2020 with 10 folds of suicide rates when compared to rates in 2011. We have to put in mind that the proportion of reported cases represents the ice-berg of the problem.

Regarding gender differences, males represented 71% while females represented 29% of cases of completed suicide (Fig 4).

Figure (4): Gender differences in cases of completed suicide

Males (71%)
Females (29%)

MOH Protocol for Suicide Risk
Assessment and Management in MOH Facilities
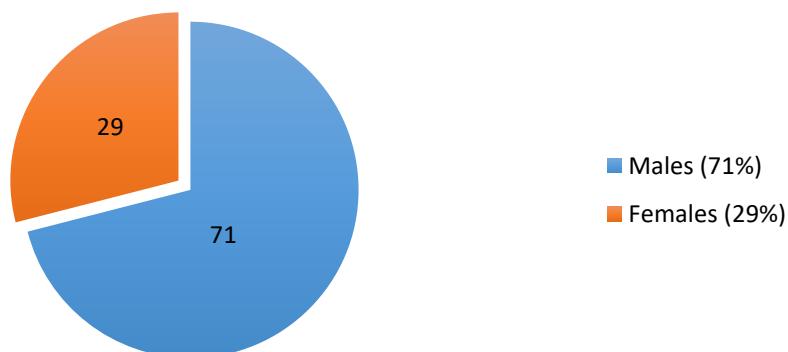
Hanging was the most common method of suicide (60%), followed by jumping from windows (27%) and lastly being cut by sharp objects (13%) (Fig 5).

Figure (5): Method of Suicide
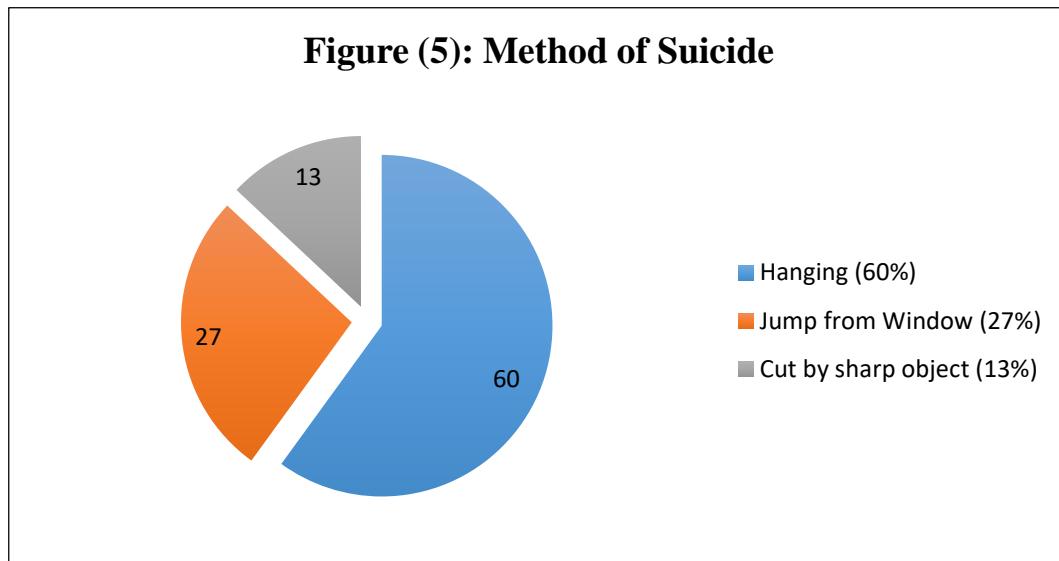
Despite the assumption that most suicidal attempts occur in psychiatric patient, it was found that seventy-four percent of cases of reported completed suicide occurred in general hospitals in comparison to only 26% in mental hospitals where health-care providers lack proper training and experience in dealing with such emergencies (Fig:6).

Figure (6): Rates of Suicide in General versus Psychiatric Hospitals
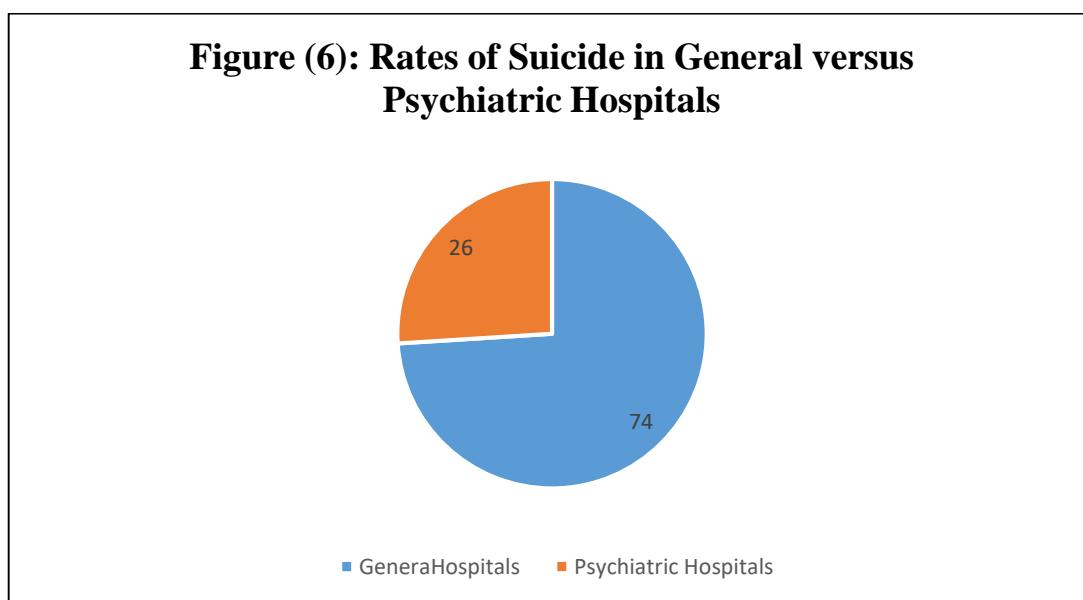
As regards the time when suicide occurred, 59% of cases occurred in the critical time of evening and night shifts, while 41% of cases occurred during morning shifts (Fig 7)

Figure (7): Common time of Suicide occurrence

- AM (41%)
- PM (59%)
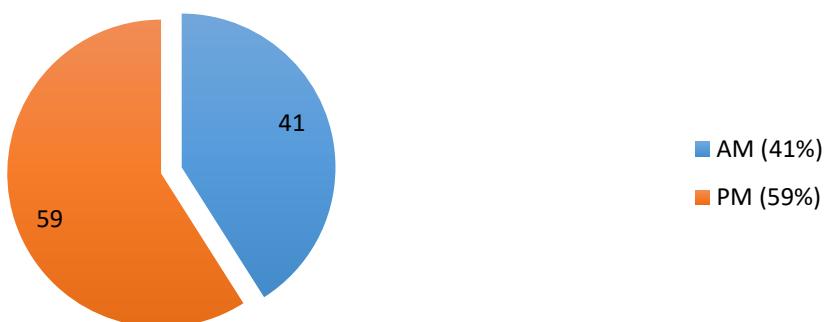
Causes/Contributing Factors for Suicide:

Information from Saudi MOH Root Cause Analyses regarding contributing factors in suicide occurrence, revealed that organizational factors (lack of provision of service and unsuitable layout of rooms and bathrooms) together with competency factors (poor competency for suicide risk assessment) were the most commonly reported factors followed by factors related to policies, procedures and working load.

Table 1: Causes/Contributory Factors for Suicide in KSA

Main Theme	Frequency of Occurrence	Root Causes / Contributory factors
Organizational	5	Lack of service provision
		The room and bathroom layout are not suitable
Competency factors	5	Poor competency in assessing the high-risk patient for suicide in general and mental hospital
Policies, procedure and guideline	4	Required policy not available
		Outdated policy
Working load factor	4	Low staff to patient ratio

Purpose

The purpose of this guide is to ensure an effective method for suicidal assessment, monitoring and treatment of patients at risk for suicide attending MOH facilities.

This guide describes the process for assessing for suicide risk, provides suicidal precautions, and outlines management of patients who are at risk for inflicting direct harm on themselves in MOH institutions.

These prevention techniques will be accomplished by a comprehensive approach that identifies and mitigates process and system-level issues contained within the environment of health-care facilities that contribute to suicide attempts.

Suicide and attempted suicide are prevalent in medical and mental health practice, and they are commonly associated with psychiatric disorders. A thorough grasp of environmental, psychological, as well as pharmacological treatment is required for optimal management. There is a clear need to create a MOH protocol for suicide risk assessment and management due to highly variable practice. As a result of an initiative of the Ministry of Health of the Kingdom of Saudi Arabia, a group of expert psychiatrists reviewed multiple published protocols for suicide risk assessment and management that aim to facilitate standardized care so that all patients with suicide risk receive optimal treatment that is evidence-based and creates adapted protocols for the health care providers.

Aim & scope

This protocol aims to identify clients at risk for suicide attending MOH facilities and delivers evidence-based recommendations on the assessment and management of patients with suicide risk.

The protocol describes the process for assessing for suicide risk, provides suicidal precautions, and outlines management of patients who are at risk for inflicting direct harm on themselves.

This protocol also aims to assist clinicians in all areas to make assessment and care decisions regarding patients who present with suicidal ideation or provide reason to believe that there is a cause for concern.

Targets

This protocol is intended to be a practical protocol and ready reference for health professionals who work in settings where they will be caring for patients at risk of suicide. It provides an overview of fundamental principles and practical resources for less experienced employees, which they may implement and discuss with their supervisors. Multidisciplinary teams can utilize it as a shared reference point to aid in coordinated treatment, and more experienced professionals can use it as a refresher or training resource. The protocol should be applied within a framework of local policies and procedures.

Setting

MOH Facilities including:

- Eradah Complex for Mental Health Hospitals /Psychiatric Hospitals
- Emergency department /Psychiatric department / Clinics in General Hospitals.
- Primary Health-care Centers.

End Users

Psychiatry Consultants, Specialists and Residents, non-psychiatric physician, primary care physicians, Nurses, psychologists and /or social workers.

Primary Care Physician's Role:

- Initially, primary care physician assesses the case for suicide risk, if he /she provisionally diagnoses that the case has no suicide risk, he/she should manage the case in primary care setting.
- If the primary care physician assesses a new case and finds the patient to have a suicide risk, he/she should take precautions to guarantee safety of the

patient and refer the case to specialized psychiatrist. However, some cases with mild / chronic suicidal risk may still continue follow-up in primary care service, especially if this primary care service works in collaboration with mental health service utilizing the collaborative care model.

- After the case with acute suicide risk has been stabilized, and proper care was provided by the treating psychiatrist, who can either continue to manage /follow up the case or refer back the case to primary care physician for regular follow up and continuing the Management plan according to patient's condition.

- During follow up of a known suicidal patient in the primary care clinic, once the case showed any signs or symptoms or any safety issues (e.g. suicidality or homicidally), primary care physician should refer the case to specialized psychiatry care for stabilization and management after application of related articles of the Saudi Mental Health Law regarding forced admission.

General Hospital Physician's Role:

- Initially, primary care physician assesses the case for suicide risk, if he /she provisionally diagnoses that the case has no suicide risk, he/she should manage the case in the General Hospital.

- If the case has been identified with acute suicide risk, he/she should refer/consult the case to Psychiatrist after application of related articles of the Saudi Mental Health Law regarding forced admission.

- After the case with suicide risk has been stabilized, and proper care was provided by the treating psychiatrist, who can either continue to manage /follow up the case or refer back the case to the primary physician for regular follow up and continuing the Management plan according to patient's condition.

- During follow up by the primary treating physician, once the case showed any signs or symptoms or any safety issues (e.g. suicidality or homicidally), the physician should refer/consult the case to Psychiatrist for stabilization

and management after application of related articles of the Saudi Mental Health Law regarding forced admission

Methodology

This is the first version of the Saudi practical protocol on the assessment and management of patients with suicide risk in agreement with Saudi mental health law regulations. This protocol development is completed through 2 phases:

Phase 1: literature review, and the review of multiple published protocols by a team composed of a group of psychiatric consultants were the published protocols were evaluated.

Phase 2: The protocol was sent to a group of experts in psychiatry to put in their input and provide their review. Their inputs were collected, followed by further meetings and assessment of the feedback by the committee.

Suicide Risk Assessment Applicability and Considerations for Tool Selection:

The suicide risk assessment tools aim to identify (1) specific symptoms or conditions known to be related to risk factors or warning signs for suicide (i.e., symptom assessment), and (2) resilience or protective factors that assess a person's motivation or determination to live or die.

Such tools can be administered through self-report measures or via clinical-administered interviews or observations. They can be administered orally, with pencil and paper, and/or electronically, either independently (as a screening measure) or as part of more comprehensive health or behavioral health assessment.

The team reviewed all available self-report and clinician rated tools measuring risk of suicide according to recommendations from suicide risk assessment toolkit: a resource for healthcare workers and organizations published by the Canadian Patient Safety Institute and Mental Health Commission of Canada and after extensive study of pros and cons as well as characteristics of these tools the **Scale for Impact of Suicidality - Management, Assessment and Planning of**

Care (SIS-MAP- brief scanner) has been chosen as it is available for free and has proper reliability and validity and because it can be used in both outpatient and inpatient settings in general as well as psychiatric hospitals(8).

Updating

The first version of this protocol was created in 2022 (1444 H). The protocol will be updated every two years or if any changes or updates are released by international/national protocols.

Conflict of Interest

This protocol was developed based on valid scientific evidence. No financial relationships with any company.

Funding

No funds were provided.

DISCLAIMER

This clinical protocol is an evidence-based decision-making tool for managing health conditions. It is based on the best information that is available at the time of publication, and is to be updated regularly. This protocol is not intended to be followed as a rigid treatment protocol. It is also not meant to replace the clinical judgment of practicing physicians but is only a tool to help manage patients with suicide risk. Decisions must always be made on an individual basis, and physicians must customize care and tailor management to patients' unique situations and health histories. This resource guide is for general information only and should be utilized by each health care organization in a manner that is tailored to its circumstances.

Nobody will be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.

PROTOCOL OVERVIEW (SUMMARY)

Patient Visits Healthcare Organization for Care

Is Patient Visiting Mental Hospital

No → **Patient is Visiting PHC/General Hospital**

Yes

Screen by Patient Safety Screener3

Screen by Patient Safety Screener3

Is patient positive for suicide

Is patient positive for suicide?

No → **Manage The Case as Usual**

No → **Manage The Case as Usual**

Yes

Yes

Suicide Risk Stratification by Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner)

- **In PHC Refer the case to psychiatrist**
- **In General Hospital either to Mange in psychiatric ward or refer to Psychiatric Hospital**

Low Suicide Risk Scores ≤ 6

Moderate Suicide Risk Scores 7 - 8

High Suicide Risk Scores ≥ 9

- **Outpatient treatment is highly recommended,** but in case of admission because of any other indication, the following interventions should be fulfilled:
- Assess patient's medical stability.
- Body/belongings search and remove those items which are deemed hazardous to the patient.
- Family engagement.
- Safety plan/move patient as close to nurse's station as possible.
- Assess physical environment.
- Room checked for harmful objects daily and after visitors depart and remove any hazardous items.
- Providing social care service.
- Patient is accompanied by staff for any off unit activities.
- Perform daily round, review Plan of Care.
- **The physician will conduct a suicide risk reassessment** within one month (in case the patient is treated on outpatient bases) or within one week after discharge from an in-patient unit and if the patient's condition changes.
- **Observation Type (Standard Observation):** Conduct routine checks and documentation.

- **Clinical judgment to determine the place and level of care required.** For admitted patients, the following interventions should be fulfilled:
- Assess patient medical stability.
- Body/belonging search and remove those items deemed hazardous to the patient.
- Family engagement.
- Safety plan/move patient as close to nurse's station as possible.
- Assess physical environment.
- Room checked for harmful objects daily and after visitors depart, and remove any hazardous items.
- Remove patient belongings.
- Arrange for plastic dinnerware.
- Confiscate sharp objects.
- Search visitor belongings.
- Providing social care service.
- Patient is accompanied by staff on a 1 to 1 basis for any off unit activities.
- Psychiatrist performs daily round, review Plan of Care.
- **The physician will conduct a suicide risk reassessment** once weekly or if a patient's condition changes.
- **Observation Type (Line of Sight Observation):** Assess and document at 15-minute intervals.

- **Patient at a serious risk of suicide and should be admitted to a psychiatric unit/ facility.** The following interventions should be fulfilled:
- Assess patient medical stability.
- Body/belonging search and remove those items which are deemed hazardous to the patient.
- Family engagement.
- Safety plan/move patient as close to nurse's station as possible.
- Assess physical environment.
- Room checked for harmful objects daily and after visitors depart, and remove any hazardous items.
- Remove patient belongings.
- Arrange for plastic dinnerware.
- Confiscate sharp objects.
- Search visitor belongings.
- Providing social care service.
- Patient is accompanied by staff on a 1 to 1 basis for any off unit activities.
- Psychiatrist performs daily round, review Plan of Care.
- **The physician will conduct a suicide risk reassessment** every 24 hours or if patients condition changes.
- **Observation Type (One to One Observation):** staff member constantly with the patient, not more than an arm's length away, and documents at 15-minute intervals
- **Special Precautions include:**
  - Activities of Daily Living (ADLs) and toileting are to be closely monitored.
  - Bathroom and shower doors must remain open, providing uninterrupted direct observation of patients.
  - Nursing staff member will accompany the patient when medical treatment requires the patient to leave the unit leave the unit.
  - Direct continuous 1:1 observation with documentation every 15 minutes.

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                    │       Provision of Care        │◄──┐
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                          ╱   Is Patient Fit  ╲──────────┘
                          ╲   for Discharge?  ╱
                            ╲               ╱
                              ╲───────────╱
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                              Yes   ▼
                    ┌───────────────────────────────┐
                    │     Preparing for Discharge    │
                    └───────────────────────────────┘
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                                    ▼
                          ╱───────────────────╲
                        ╱  Discharge + Follow Up  ╲
                        │  1st Week After Discharge │
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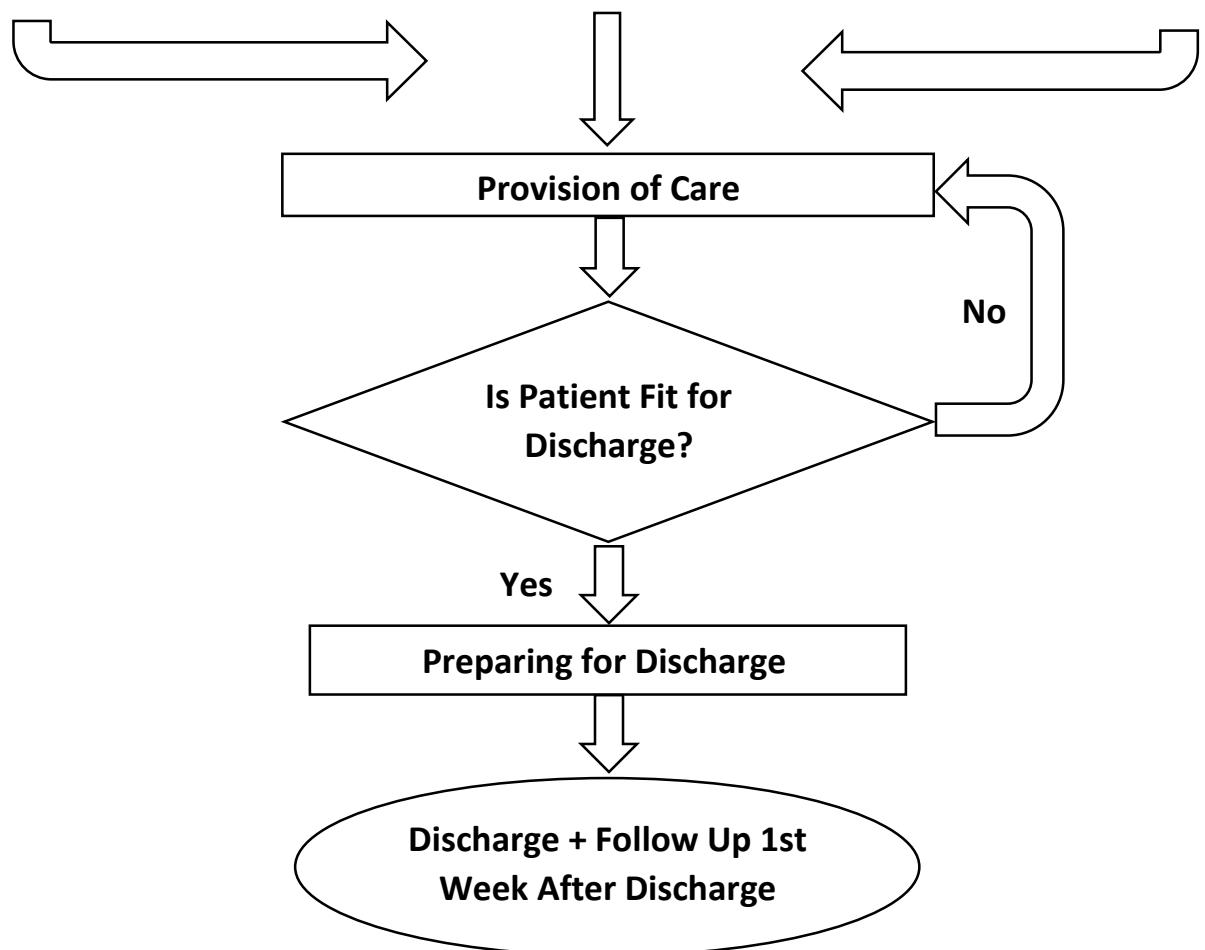
General Principles in Assessment and Management of suicide risk

The Content of Suicide Risk Assessment includes, Identifying and evaluating warnings signs as well as risk and protective factors.

A suicide risk screening /assessment will be completed on all patients entering for care in the Emergency Departments/PHCs or admitted to the Hospital by the Physician, and upon any change in condition.

The Patient Safety Screener will be used during the Triage in PHC, General and psychiatric hospitals, and any positive screen for Suicide Risk will necessitate further evaluation by **Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner)** (8).

Anyone who talks about suicide needs to be taken seriously. Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated.

While suicide risk assessment tools are important to the assessment process, they should be used to inform, not replace, clinical judgment, and to provide additional information and corroboration to inform clinical decision-making about suicide risk and treatment planning. Suicide assessment should be conducted in a way that allows the person privacy when disclosing sensitive material.

A patient who is suspected of self-harm but is unconscious, comatose or unresponsive due to his or her medical condition requires frequent assessments by the Registered Nurse for change in level of consciousness. As soon as the patient regains consciousness, the patient will be screened for suicidal risk and, if appropriate, assessed for level of risk and appropriate level of suicide precaution.

Address the patient's immediate safety needs and most appropriate setting for treatment. Patients may be placed on suicide precautions by a physician's written or verbal order (according to the institution's local policies and

procedures) or as a result of a clinical assessment. The Registered Nurse (RN) may place a patient on suicide precautions, inform the physician of the patient's behavior until a complete suicidal risk assessment is completed by the physician in order to continue or discontinue the initial order.

Inpatient unit staff need to be vigilant, particularly when the person is not well-known and for the first week after admission. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Treatment (both psychopharmacological and psychological) of underlying mental illness should be initiated as early as possible.

Observation: The use of levels of observation that provide each patient with an optimal level of safety in the least restrictive manner. All patients will be routinely observed in compliance with physician orders and prescribed protocols.

Three levels of staff monitoring are provided:

١. **Standard Observation**: (Conduct routine checks and documentation) - Minimal level of observation used for low suicidal risk as measured by SIS_MAP brief scanner (Score ≤ 6).

٢. **Line of Sight Observation**: (assess and document at 15-minute intervals): A level of observation wherein the patient remains in staff view at all times. A specific staff member is assigned, and the line of sight observation is maintained by staff in person or through video monitoring, used for moderate suicidal risk as measured by SIS_MAP brief scanner (Score 7 – 8).

٣. **One-to One Observation**: (staff member constantly with the patient, not more than arm's length away, and documents at 15-minute intervals). Consists of one to one staff observation with a patient never farther away than arm's length. The patient remains within arm's length of a staff member at all times, used for high suicidal risk as measured by SIS_MAP brief scanner (Score ≥ 9).

The nursing staff will use the environmental patient safety checklist to ensure that the patient has been provided as safe environment

The patient's environment is secured using the Environment Patient Safety Checklist for every shift. The Suicide Precaution Once initiated, only a psychiatric specialist/consultant may discontinue or reduce suicide precautions.

The physician will reassess the patient according to the suicide risk stratification by Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner). for continuation / Modification of suicide precautions.

A brief evaluation summary will be documented. The summary may include warning signs, risk indicators, protective factors, access to lethal mean, collateral sources used, and relevant information, specific assessment data that supports risk determination and rationale for actions taken and not taken.

Clinical status of the patient will be documented along with changes in physical or emotional condition on behavior/close observation flow sheet and environment suicidal patient safety checklist.

When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information to his/ her family and in case of LAMA/elopement/Absconded, inform the police.

ASSESSMENT AND INTERVENTIONS

The Patient Safety Screener will be used during the Triage in PHC, General and Mental Hospitals. Ask all three screening questions; ask all questions exactly as worded by the patient's language (use Arabic or English forms); do not bundle or re-word questions, and treat the patient with empathy (9).

The three screening questions are about Depression, Suicidal ideation, and Suicide attempts. The three screening questions are:

١. **Depression**; Over the past 2 weeks, have you felt down, depressed, or hopeless?

٢. **Suicidal ideation**; Over the past 2 weeks, have you had thoughts of killing yourself?

٣. **Suicide attempt**; Have you ever attempted to kill yourself?

If Yes to item 3, ask: when did this last happen?

- Within the past 24 hours (including today)?
- Within the last month (but not today)?
- Between 1 and 6 months ago?
- More than 6 months ago?

"Yes" to Item 1= positive screen for Depression.

"Yes" to Item 2 OR "last 6 months" to Item 3= positive screen for Suicide Risk, and consider further evaluation by Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner).

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor as specifically predictive of suicide or other suicidal behavior."

Suicide Risk Stratification Includes:

High Suicide Risk: A score of ≥ 9 on suicide risk assessment by Scale for impact of suicidality-management, assessment and planning of care (SIS-MAP brief scanner).

Moderate Suicide Risk: A score from 7 to 8 on suicide risk assessment by Scale for impact of suicidality-management, assessment and planning of care (SIS-MAP brief scanner).

Low Suicide Risk: A score of ≤ 6 on suicide risk assessment by Scale for impact of suicidality-management, assessment and planning of care (SIS-MAP brief scanner).

Document the risk level: High Suicide Risk /Moderate Suicide Risk / Low Suicide Risk.

Consider to do Brief Evaluation Summary and restatement of main points, as a conclusion which include: Warning Signs, Risk Indicators, Protective Factors, Access to Lethal Means, Collateral Sources Used and Relevant Information Obtained, Specific Assessment Data to Support Risk Determination and Rationale for Actions Taken and Not Taken.

Levels of Risk and Interventions:

١. Low Suicide Risk Interventions:

A score of ≤ 6 on suicide risk assessment by Scale for impact of suicidality-management, assessment and planning of care (SIS-MAP brief scanner). Outpatient treatment is highly recommended, but in case of admission because of any other indication, the following interventions should be fulfilled:

- Interventions as shown in PROTOCOL OVERVIEW (SUMMARY).

- Observation Type (Standard Observation): Conduct routine checks and documentation.
  - The staff member will observe and check in with the patients at routine checks and document the patient's location and status at each interval.
  - Assigned staff will make direct visual contact with patients and confirm they are in no danger or distress.
  - Observations may not be completed standing in a doorway or at a distance particularly for patients who are sleeping. It is expected that staff will enter the room, approach the patient and check their identity, respirations, and ensure they are not in any distress.
  - Staff will provide interventions as appropriate and notify Change RN of any change in patients' condition or location.
  - Documentation of routine checks rounds is to occur at the time of assigned patient rounds and not in advance.
  - While making patient rounds, the staff member observes the environment for unsafe conditions.

- Significant behavioral observations of patients and environmental problems are reviewed and reported to the Charge Nurse immediately.
- Once patients are prepared for bed time, the doors are left open at staff discretion so as not to hinder the patient's privacy.
- The staff member must enter the room to observe the condition of the patient, chest rising, and respirations to ensure the patient is not in any distress.
- Flashlights may be used during the night rounds, taking care not to flash the light in the patient's face, but allowing staff to verify the patient is in his/her bed and breathing normally.
- The Charge RN should review and sign the observation board at a minimum the end of shift to ensure completion as assigned.

٢. **Moderate Suicide Risk Interventions:**

Scores between 7 and 8 require clinical judgment to determine the level of care required. in the case of admission, the following interventions should be fulfilled:

- Interventions as shown in PROTOCOL OVERVIEW (SUMMARY)
- Observation Type (Line of Sight Observation):
  - A staff member will keep the patient within line of sight/constantly video monitoring of the patient at all times and document the patients' location and status a minimum of 15 minutes.
  - When patients' shower, change clothes, or use the bathroom, the staff will remain outside the door with the door slightly opened and visually check the patient. Staff will endeavor to maintain the patient's privacy as much as possible; however, the safety of the patient is the first concern.
  - Staff will provide interventions as appropriate and notify Change RN of any change in patients' condition or location.
  - Observations may not be completed standing in a doorway or at a distance, particularly for patients who are sleeping. It is expected that staff

will enter the room, approach the patient and check their identity, respirations, and ensure they are not in any distress.

- Staff will provide interventions as appropriate and notify Change RN of any change in patients' condition or location.

- Documentation of checks is to occur at the time of assigned patient rounds and not in advance.

- While making patient rounds, the staff member observes the environment for unsafe conditions.

- Significant behavioral observations of patients and environmental problems are reviewed and reported to the Charge Nurse immediately.

- Once patients are prepared for bed time, the doors are left open at staff discretion so as not to hinder the patient's privacy.

- The staff member must properly observe the condition of the patient and insure that the chest is rising, and respirations regular and the patient is not in any distress.

- Flashlights may be used during the night rounds, taking care not to flash the light in the patient's face, but allowing staff to verify the patient is in his/her bed and breathing normally.

٣. High Suicide Risk Interventions:

Individuals who score ≥ 9 on the SIS-MAP brief scanner are at a serious risk of suicide and should be admitted to a psychiatric unit/ facility. The following interventions should be fulfilled:

• Interventions as shown in PROTOCOL OVERVIEW (SUMMARY)

• Observation Type (One-to-One Observation):

- The patient is assigned a constant one to one staff member within close proximity. The staff member continuously assesses the patient's status and documents at least every 15 minutes.

- When patients' shower, change clothes, or use the bathroom, the staff will remain with the patient. Staff will endeavor to maintain the patient's privacy as much as possible; however, the safety of the patient is the first concern.
- Staff will provide interventions as appropriate and notify Change RN of any change in patients' condition or location

- Special Precautions Include:
  - Activities of Daily Living (ADLs) and toileting are to be closely monitored.
  - Bathroom and shower doors must remain open, providing uninterrupted direct observation of patients.
  - A nursing staff member will accompany the patient when medical treatment requires the patient to leave the unit (17) (18).

Immediate Actions and Interventions

Immediate actions and interventions depend on the level of suicide risk:

- **In case of high risk of suicide**: Maintaining direct observational control of the patient, limiting access to lethal means, and Immediate transfer with escort to Urgent/ED care setting for hospitalization.

- **In cases of moderate risk of suicide**: it is indicated to refer the patient with escort to a psychiatrist for complete evaluation and interventions and limit access to lethal means.

- **In case of low risk of suicide**: consider consultation with mental health provider to determine the need for referral and treatment, treating presenting problems, addressing safety issues, and documenting the rationale for actions

Preparing for Discharge

Prepare patient for discharge by providing suicide prevention information and highlighting how and where to obtain help.

For any Patient with suicidal risk leaving the hospital to be closely followed by social worker staff and frequently monitor in the first week post- discharge.

Proper documentation of the level of suicidal ideation (death wishes, non-specific active suicidal ideation, active suicidal ideation with any methods (not plan) without intent to act, active suicidal ideation with some intent to act without specific plan, active suicidal ideation with specific plan and intent) and documentation of the level of suicidal behavior (actual attempt, interrupted attempt, aborted or self-interrupted attempt, preparatory acts or behaviors, deliberate self-harm, non-suicidal self-injury or parasuicide) should be registered at the discharge note to help for categorization and registration of suicide at national level

Patient's Discharge:

- Guidelines for planning a safe discharge of a suicidal patient include:
    - A comprehensive suicide risk assessment has been conducted, score of **Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner)** less than 9 and an appropriate out-patient treatment plan is in place.
    - The person is medically stable and has adequate social supports.
    - The person has agreed to return to the mental health service if their suicidal intent returns.
    - The person, their caregiver and family have been provided with written copies of their treatment plan, including details of any medications, ways to deal with symptoms and distress, dates of follow-up appointments, and contact numbers for times of crisis.
    - All attempts have been made to remove potentially lethal means of self-harm.
    - Treatment of any underlying psychiatric diagnoses has been arranged.
    - Appropriate steps have been taken to address psychosocial precipitating factors.

- Follow-up with the person will be conducted as soon as possible, ideally within 7 days.

- The Treatment Plan Agreement (Applied to All ER discharged Patients):
  - It is an easy-to-use Arabic template for a treatment plan agreement that includes aspects of the Commitment to Treatment Statement (CTS), the Safety Planning Intervention (SPI), and restricting access to lethal means by family intervention should be applied to all discharged patients from ER.
  - The form will be filled out by the clinician and signed by both the clinician and the patient to emphasize the collaborative nature of the agreement. This intervention is effective evidence based strategy used in Saudi Arabia (10), easy to use in the emergency setting to help address clinicians' need for brief suicide interventions that includes recognizing warning signs of an imminent suicidal crisis, utilizing adaptive coping strategies, reaching out to settings which maximize safety and distract from suicidal thoughts, utilizing family members or friends to help resolve the crisis, and contacting mental health professionals or agencies.

Support for Second Victims

Emotional distress is likely when Healthcare Professional is involved in any error or adverse event, regardless of severity. Providing support for Second Victims, Support for Healthcare Professionals Involved in Errors and Adverse Events related to suicide/attempted suicide by relieve them of immediate patient care duties for a brief period; provide one-on-one peer support, professional review, and collegial feedback, as well as access to patient safety experts and risk managers; and offer crisis support, referral to Quality of life employee health clinic and Psychiatry referral when needed.

Enhancement of Suicide Prevention

Suicide is a tragedy worldwide and each suicide results in the suffering of more than 135 persons who know the deceased person. So, MOH facilities should not

only be concerned with the management of suicide, but they should also contribute to suicide prevention programs through:

- Awareness programs to educate society about the magnitude of the problem and how they can help their beloved ones, especially on the International day of suicide prevention on the 10th of September every year.

- Enhancing life skills and resilience by helping people to build skills like critical thinking, stress management, coping with the challenges in life, especially for teenagers in the local community.

- Providing self-help materials easily available in corridors and waiting areas in healthcare facilities.

Training of healthcare workers for Suicide management

- Suicide, attempted suicide, or self-harm that results in severe, temporary harm, permanent harm, or death while being cared for in a healthcare setting or within 72 hours of discharge, including the emergency department are considered sentinel events.

- Staff should receive a minimum of 4 hours of education on National suicide management strategies specific to the patient population they are serving by the National Taskforce for Suicidal Prevention & Management.

- All staff who work or interact with patients at risk of suicide receive a structure training and orientation to all policies, practices, and protocols.

- Staff is required to demonstrate competency and know the protocol for observation requirements for patients at high risk.

- Staff training and competency is done at least annually and includes (demonstrate/teach-back).

- Nurses receive competency testing for 1:1 observation, de-escalation techniques, rapid response, and understanding of policies and protocols for working with mental health populations.

Legal Perspectives for protecting individuals at risk of suicide

Management of patients with suicide risk should be in accordance with Articles eleventh, twelfth and thirteen of the last Executive Regulations of the Mental Health Care System in KSA, health-care professionals have a duty of responsibility to take the necessary actions to guarantee the safety of individuals who are found to:

- Have clear indications that he/she has a severe mental disorder, the symptoms of which represent a danger or potential danger to him or others at the time of his examination.

- The admission of the patient is necessary to manage his/her illness, improve his condition, or stop its deterioration.

- The patient should be admitted to maintain his safety and to provide the necessary treatment, and the reasons are explained to the patient's family according to the mandatory entry form Number one.

- In the event of a grievance by the patient or his legal representative, this is done according to the complaint / grievance form of a psychiatric patient number four to the psychiatric/ treatment facility, and the procedures stipulated in the Executive Regulations of the Mental Health Care System are adhered to.

Media Reporting of Suicide

The notion of copycat suicide developed from research indicates that suicide can be "contagious". Exposure to suicidal behavior can influence others to copy these behaviors.

Copycat suicide refers to two or more cases of suicide that occur in close temporal proximity and are presumably related.

Sensational reporting of suicide can trigger:

- Imitative suicidal behaviors (Copycat)
- Usage of similar method of suicide

- Occurrence within two days to two weeks.

- Influence more on youngsters.

- Large impact on Depressed/ suggestible persons.

- Followers/ fans (celebrity suicide).

Best Practices and Recommendations for Reporting on Suicide (21):

Media Should Avoid:

- Describing or depicting the method and location of the incident.

- Sharing the content of a suicide note.

- Describing personal details about the person who died.

- Presenting suicide as a common or acceptable response to hardship.

- Repeating the story many times.

- Speculating on the reason for the suicide.

- Sensationalizing details in the headline.

- Glamorizing or romanticizing suicide.

- Prominent placement of stories related to a suicide death in media.

- Showing photograph or video footage of a suicidal scene.

Media Should:

- Keep information generic.

- Report that a note was found and is under review (if suicide note was found).

- Keep information about the person general.

- If there is a police investigation going on, avoid media trial.

- Utilize this opportunity to educate the public on suicide.

- Encourage people to seek help.

- Educate about suicide warning signs and risk factors (e.g., mental illness, relationship problems).

- Providing tips to coping with difficulties, support, and availability of treatment.

- Be sensitive to the grieving family.

- Provide helping numbers.

- Counter-perception that the suicide was tied to heroism, honor or loyalty to an individual or group.

- Place a print article inside the paper or magazine and later in a newscast.

- Bust myths about suicide in general.

- Educate the people about Mental Health Care System (11).

ENVIRONMENTAL SAFETY GUIDE FOR SUICIDE PREVENTION

A. Zero Suicide Concept

B. Safe Environment Through Proper Screening, Assessment, Reassessment, Care Planning, Observation &Staffing Plan

C. The Organization-Wide Physical Environmental Risk Assessment

D. Physical Environmental Safety Recommendations

E. Patient's Environmental Safety

F. Patient's Environmental Search

G. Patient's Body Search

A. ZERO SUICIDE CONCEPT

The seven essential elements of Zero Suicide to adopt:

- Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care.
- Train – Develop a competent, confident, and caring workforce.
- Identify – Systematically identify and assess suicide risk among people receiving care.
- Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Including collaborative safety planning and restriction of lethal means.
- Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- Transition – Provide continuous contact and support, especially after acute care.
- Improve – Apply a data-driven quality improvement approach to inform system changes including Environment that will lead to improved patient outcomes and better care for those at risk (12).

B. SAFE ENVIRONMENT THROUGH PROPER SCREENING, ASSESSMENT, REASSESSMENT, CARE PLANNING, OBSERVATION &STFFING PLAN

١. Screening, Assessment and Reassessment

- A process is in place to screen all patients for suicide using a validated screening/assessment tool upon admission.
- Trained, qualified and competent clinician performs suicide risk screenings /assessments.
- The assessment includes asking patients about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

- Patients on an inpatient psychiatric hospital units and psychiatric units in general hospitals or those at risk for suicide/ self-harm are screened no less than once per day.

- There is a process in place to escalate interventions to a psychiatrist when patients who are showing signs of suicidal ideation or self-harm.

- Nurses are empowered to implement a 1:1 observation for a patient until the risk can be validated by a psychiatrist.

- Hospital staff obtains ALL past social, medical, and mental health treatment records.

٢. **Observation/Monitoring**

- There is a policy, procedure and checklist of staff roles and responsibilities in performing patient observations.

- The organization has established clear instructions for 1:1 monitoring.

- There is a clear intervention plan that staff follow when providing 1:1 or 2:1 observation.

- An observation plan is created and communicated to all staff interacting with a patient on increased monitoring (1:1, 2:1, etc.) (Medical record notes, communication board). Communication includes a reason for the plan, what the behaviors are, and ensuring staff understands the plan.

- Before staff provide care or interact with a patient on increased observation, they review the observation plan. I.e., what to look for in the room and patient behaviors.

- Staff do not perform 1:1 observation for more than four consecutive hours - i.e., staff are rotated out. And may be improved gradually till reach to level that the Staff does not perform 1:1 observation for more than two consecutive hours.

- There is a procedure with steps to take in keeping high-risk patients safe when moving them off the unit or to a new area within a unit, i.e., a safety

sweep is conducted to identify and remove items that can be swallowed or used for self-harm.

- Nurses have authority to initiate a restraint and/or seclusion-based established criteria of behaviors to self or others, prior to obtaining the order from a psychiatric clinician.

- A psychiatric clinician is contacted before discontinuing restraint and seclusion.

٣. Plan of Care (POC)

- The treatment plan includes interventions to mitigate suicide risk.

- A licensed psychiatrist leads the interdisciplinary team in developing all treatment plans.

- There is a policy and procedure for updating the plan of care (POC) when the patient's condition changes.

- Ensuring safe handover communication.

- At discharge, patients are given a suicide safety plan intervention (SPI) that includes what to do if symptoms return.

٤. Staffing Level, Training and Competency

- Avoid Lower staff-to-patient ratios that challenge the ability of the hospital to maintain safety.

- Staff training and competency is done at least annually and includes (demonstrate/teach-back).

- Staff are required to demonstrate competency and know the protocol for observation requirements for patients at high risk.

- All staff who work or interact with inpatient psychiatric patients receive a structure training and orientation to all policies, practices, and protocols.

- Staff receive a minimum of 4 hours of education on mental illness specific to the patient population they are serving.

- Nurses receive competency testing for 1:1 observation, de-escalation techniques, rapid response, and understanding of policies and protocols for working with mental health populations.
- Drills are performed to evaluate and improve staff interventions to prevent self-harm.

C. THE ORGANIZATION-WIDE PHYSICAL ENVIRONMENTAL RISK ASSESSMENT

- The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s).
- psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
- For non-psychiatric units in general hospitals that are not required to be ligature-resistant, the focus should be on rigorous implementation of protocols to keep patients safe. The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital (13).

Self-Harm Prevention

- Administrative, clinical, and medical staff are involved in conducting environmental assessments.
- Environmental rounds at each change of shift are conducted to detect unsafe conditions in the psychiatric hospitals and psychiatric units in general hospitals and any area these patients receive care in.

- An organizational-wide environmental risk assessment is used in psychiatric hospitals and psychiatric units in general hospitals to identify ligature points and items that can be used for self-harm.

- The organization performs quarterly environmental rounds in psychiatric hospitals and psychiatric units in general hospitals to identify ligature risks and ensure any found have been mitigated.

- For environmental assessments, the organization may obtain a second opinion (for example, staff from other programs/services or outside assistance) on the environmental risks (13).

D. PHYSICAL ENVIRONMENTAL SAFETY RECOMMENDATIONS

The purpose is to minimize fixtures that can facilitate strangulation and other high risk aspects within the hospital environment which is important element in the prevention of suicide.

Risk factors associated with the physical environment of the inpatient at suicidal risk, cited as the most common root cause of inpatient suicide.

١. PATIENT ROOMS

- Patient's clothing should be removed and patient provided with clothing that does not have any strings and cannot be easily torn into pieces. Use gowns with buttons, remove shoe laces, belts, necklaces, and piercings (including earrings).

- Store duffel bags/backpacks out of patient room (handles can be removed and used for hanging).

- Upon admission, identify and secure all patient medications outside the patient room.

- Consider replacing glass windows with Plexiglas or shatter proof glass.

- Only use heavy furniture in patient rooms so it cannot be thrown.

- If televisions are present, they should be mounted high up on the ceiling, bolted down and have all power cords wired up into the ceiling and not accessible to patients.

- Remove all call-light cords/TV cords and use call buttons/remotes.

- Garbage cans should not have plastic bags.

- Limit or restrict access to certain items in patient rooms:

- Pens and other writing utensils.

- Combs (teeth can be removed and used for cutting).

- Any type of eating utensils (plastic or metal)

- WORK TO ELIMINATE:

- "Pinch points" or hinges on doors and door frames.

- Consider "soft doors".

- Beds with posts or any other areas that a patient could attach something to.

- For high risk patients, consider placing mattress on the floor without bedframe, or a "captain's bed" style frame.

- Pillow cases on pillows.

- Removable bed sheets.

- Door handles that could be used as an attachment point (including door, closet door, bathroom, etc.).

- Hangers/hooks and clothing rods in closets.

٢. BATHROOMS

- Use breakaway fixtures in showers/bath tubs and sinks.

- Use breakaway shower curtains (if shower curtains are present).

- Modify faucets to minimize hanging risk.

- Remove all locks from bathroom doors.

- Build safety features around plumbing fixtures, such as a stainless steel box that removes hanging risk • Add "plates" to grab bars that permit functionality but minimize hanging risk.

٣. EMERGENCY DEPARTMENTS

- If patient presents with suicidal thoughts, ensure they are placed in a room immediately and not left in waiting room.
- After placing patient in room, consider removing sheets and pillow case from bed.
- Patient should be monitored at an increased frequency while in Emergency Department.
- Remove IV pump/tubing and any oxygen tubing from room.
- Ensure all sharps are locked.
- Cover or remove all call-light cords.
- Patient's clothing should be removed and patient provided with clothing that does not have any strings and cannot be easily torn into pieces.
- Garbage cans should not have plastic bags.
- If televisions/screens are present, they should be high up on the ceiling, bolted down and have any power cords wired up into the ceiling and not accessible to patients

٤. SECLUSION ROOMS

- Ensure adequate seclusion environments. Seclusion room design should focus equally on safety and functionality, ensuring that the room protects the patient at all times.

٥. OTHER AREAS (HALLWAYS, COMMON AREAS, NURSING STATIONS….)

- Lock all linen closets that are in common areas.
- Patients at high risk for suicide should not be given plastic utensils for meals, give ordering choices that can be eaten without utensils (e.g. hamburgers, sandwiches, etc…).

- Consider the use of half-dome security mirrors at nursing stations to provide increased visualization (14).

E. SUICIDAL PRECAUTIONS & PATIENT'S ENVIRONMENTAL SAFETY FOR AT RISK PATIENTS

- The Purposes is to maintain patient safety & provide suicidal precautions throughout hospitalization, and to address the patient's immediate safety needs and most appropriate setting for treatment.

- The nursing staff will use the Nursing Environmental Patient Safety Checklist to ensure that at-risk patients have been provided a safe environment.

- The order for 1:1 observation should be written in physician's order form, not just verbally.

- The nursing staff will place the patient on close observation and use the behavior/ close observation flow sheet to document observation every 15 minutes/randomly.

- Nurse observing a patient on suicidal precautions will remain constantly vigilant and alert for impulsive/unexpected behavior and be in apposition to intervene promptly and appropriately.

- Inpatient unit staff need to be vigilant, particularly when the person is not well-known and for the first week after admission.

- Patients on suicide precautions may be cohorted to facilitate patient monitoring.

- The hospital assesses the patient's need for continuing care, treatment, and services after discharge or transfer.

- When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information to the individual and his/ her family and in case of LAMA/elopement, inform the police.

A Behavior/Close Observation Flow-sheet

- Is required for at-risk patients and the frequency of documentation will be dictated by the level of risk.

- The nursing staff will use the Environment Patient Safety Checklist and Behavior/Close Observation Flow-sheet with the patient until the assessment is complete.

- When a patient is determined to be at risk for suicide through screening, regardless of the level of risk, the patient's safety is maintained by the following:

  - The patient's environment is secured using the Nursing Environment Patient Safety Checklist every shift.

  - The rationale and plan for establishing safety is explained to the patient.

  - In the event that a gun or other deadly weapon is discovered during the search of a patient, Hospital Security will be called immediately to assist and secure the weapon.

- A patient who is suspected of self-harm but is unconscious, comatose or unresponsive due to his or her medical condition requires frequent assessments by the Registered Nurse for change in level of consciousness. As soon as the patient regains consciousness, the patient will be screened for suicidal risk and, if appropriate, assessed for level of risk and appropriate level of suicide precaution.

- **Suicide/ self-harm behavior management and interventions**
  - Recommended interventions based on level of risk as assessed.

One-to-one (1: 1) observation (close observation) for high suicidal risk patients

- All standard procedures for general one-to-one observation apply.

- Nurse must remain within arm's length of patient at all times.

- All nurse must be acutely aware of all possible dangers, i.e. knives, blades, scissors, light bulbs, fluorescent tubes, Perspex exit signs, windows, glass door, electric sockets, matches, lighters, emergency light glass, other patients

medicine, drugs, air vent strips, insecticides, paper clips, flip top from drink cans, cleaning agents and many more.

- Special care should be made while patient is sleeping or, Observation must continue as he is feigning.

- Nurse must search patient's bed to ensure there are no danger things.

- Patient should be bathed independently and shaved by nurse or barber. Ensure all blades are accounted for.

- Fresh clothing should be checked before issuing.

- All meals should be cut up (bite size) to avoid choking and only plastic spoons, Styrofoam plates, and paper cups should be used. No cans or glassware are permitted.

- Count for all clothes and bed linens during each shift.

- Search the patient's belongings, clothing, luggage, and packages at the time precautions are instituted. Tell your patient of your concern for safety and the reason for the search.

- Monitor items brought onto the unit by visitors. Remove any item considered unsafe and return it to the visitor when they leave the unit.

- Stay with the patient while he is taking prescribed medication to make sure he/she swallows the medications.

- Restrict patients on Suicide Precautions to the unit unless it's absolutely necessary to leave the unit for testing or procedures that cannot be delayed.

- Never let the patient out of sight.

- The nursing staff ensures that the patient is provided a safe environment all the time.

- The nursing staff will place the patient on and use the behavior/ close observation flow sheet to document observation every 15 minutes.

Follow Up of Patient at Risk of Suicide

- If a patient with suicidal risk leaves the hospital, inform the Critical Mental Patient Team (CMPT)/ assigned person or a team can be closely followed and frequently monitor in the first week post- discharge.

F. PATIENT'S ENVIRONMENTAL SEARCH

THE PURPOSE is to maximize environmental safety for patient and to prevent the patient from harming self. To maintain patient safety & provide suicidal precautions throughout hospitalization, and Address the patient's immediate safety needs and most appropriate setting for treatment.

DEFINITIONS:

Environmental Assessment: Observation and inspection of all areas of the unit with open access to patients by the assigned nurse.

Room Search: A room search is a thorough search of patient's room for potentially dangerous things.

Restricted items/ Contraband items – are items that pose a potential risk of harm to self or others and include, but are not limited to the following:

- All medications, illegal drugs, alcohol, and toxic substances.
- Matches, lighters, cigarettes and other smoking materials.
- Shampoo, hair care products, aerosol products and razors.
- Hair dryers, curling irons, and other electric appliances.
- Guns, knives, and other items that readily lend themselves to use as weapons.
- Mirrors, bottles, and other items made out of glass.
- Scissors nail files, cutlery, sewing kits, and other sharp objects.
- Shoe laces, ties, string, straps, cords, belts, drawstrings, and other items that present a potential strangulation hazard.
- Electric cords, telephone cords, bed cords (if detachable) and window blind cords.
- Oxygen tubing, Flowmeter (unless required for continuous use).

- Plastic bags.

- Keys.

- Hooded garments.

- Perishable food when it is in a patient's room.

- Jewelry that could pose a strangulation or cutting hazard.

- Any other item that, within the discretion of staff, poses a potential risk of harm to self or others. Or any other item that in the environment of the patient (e.g., bedsheet, curtain, gown, window/door rubber etc.) poses a potential risk of harm to self or others.

PATIENT'S ENVIRONMENTAL SEARCH RECOMMENDATIONS:

- The nursing staff must perform environmental search ton in-patients at risk for suicide every eight (8) hours.

- Inpatient areas may be searched at any time by nursing / security staff if there is reasonable suspicion that illegal substances/ non-therapeutic items are present.

- All equipment, furniture, patient belongings and surroundings of the unit will be searched.

- Search will be coordinated by the unit head nurse.

- Regular inspection round must be made for the general environment and all relevant events documented.

- Repeat search of patient's belongings in the event that the patient is transferred.

- Stay with the patient while he/she is taking prescribed medication to make sure he/she swallows the medication (check mouth for checking of medications).

- Send drugs / medications found to Pharmacy for identification.

- Request Hospital Police/Police to dispose of illicit drugs (including alcohol) and /or store any weapon.

- Complete incident report if suspected contraband is found.
- Send patient valuables home with family or keep it in a safe cabinet with the patient's
- Affairs department. Document disposition on appropriate nursing record and place in
- Patient's chart.
- Notify nursing supervisor for any questions / problems that occur during the room search.

PATIENT'S ENVIRONMENTAL SEARCH PROCEDURES:

- The nursing staff will use the Nursing Environmental Suicidal Patient Safety Checklist every eight (8) hours to ensure that the patient at risk for suicide has been provided a safe environment.
- Explain to the patient, and family if available, the need to search belongings and remove potentially harmful to him/herself.
- Assist the patient to change into hospital-provided gown, robe, and slippers with a staff nurse in constant attendance.
- Perform a body search ton the patients before allowing them to move freely inside the unit.
- In General environment searching, check the following areas which include but not limited to:
  - Patient's rooms.
  - The patient comfort room/ bathroom.
  - Games room.
  - TV room / prayer room.
  - Dining room.
  - Garden.
  - And other areas accessible to patient.

- Ask the patient in a polite manner to leave their rooms and stay in a designated area.
- Provide seating for the patient outside the room, during the search with a staff member in constant attendance.
- Check for:
  - Contrabands/ Forbidden items.
  - Items or situations that is hazardous to patients and staff.
  - Condition and status of patients.
- Document all personnel items removed and place in bag / box for safekeeping.
- Verify the list of items removed by the patient by obtaining his signature and that of one witness.
- Allow patient to return to his/her room, once the room search is completed, with personnel in attendance as ordered.
- Head nurse / in-charge nurse of shift ensures that anything unusual which is directly related to patients is documented in their progress notes.
- Document in progress note:
  - Date and time room search occurred.
  - Personal involved
  - Significant items removed from the patient room
  - Describe the physical appearance of illicit drugs including alcohol.
  - Do not attempt to name the substance.
- Appropriate action should be taken whenever anything unusual is reported by the assigned nurse.
- An incident form must be completed for any unusual substance found (15,16).

G. PATIENTS' BODY SEARCH & PATIENT'S ROOM SEARCH TO MAINTAIN A SAFE ENVIRONMENT

THE PURPOSE:

To provide guidelines in searching patients admitted to psychiatric hospitals /psychiatric units in general hospitals /Non psychiatric units in general hospitals who are at risk for suicide to maintain a safe environment.

PATIENTS' BODY SEARCH

Searching patients admitted to the hospital; returning to their units from off-unit, off-hospital activities; returning from home (out on pass or medical leave) or returning from another hospital by the nursing staff, in the presence of a security officer.

- All patients admitted or returned to psychiatric hospital units /psychiatric units in general hospitals /Non psychiatric units in general hospitals who are at risk for suicide must have a body search performed.

- An unannounced random search conducted in all inpatient areas twice a week or at any time by Nurse, if there is reasonable suspicion, and providing a clear need.

- The search of the patient should be the last activity performed before the patient is taken directly to his/her in-patient unit.

- Patient search must be performed in the designated search room (close room) in the presence of a security officer.

- The patient's privacy must be maintained throughout and standard procedure followed.

- Unit physician, head nurse or charge nurse may order the body search.

- The nurse in-charge must make sure that enough staff are available to carry out the task (nurses and security staff).

- Nurse must document the procedure in the nurses' progress notes and if any remark was found in patient body should be documented in patient electronic file record.

- Nurse shall report in case of finding any contraband, with the Head nurse or Nursing Supervisor on duty as a witness and must inform physician on duty before bringing patient to the unit and initiating OVR.

- The patient's privacy must be maintained throughout and standard procedure followed.

- Unit physician, head nurse or charge nurse may order the body search.

- The nurse in-charge must make sure that enough staff are available to carry out the task (nurses and security staff).

- Nurse must document the procedure in the nurses' progress notes and if any remark was found in patient body should be documented in patient electronic file record.

- Nurse shall report in case of finding any contraband, with the Head nurse or Nursing Supervisor on duty as a witness and must inform physician on duty before bringing patient to the unit and initiating OVR.

PATIENT'S BODY SEARCH PROCEDURES

- Prepare all the necessary items needed for the search.

- Request a security officer to be present.

- Bring the patient to the search room.

- Request the patient to remove his clothing, layer-by-layer from head to toe, searching each layer, or ask one nurse to help the patient remove his clothing, keeping the clothing in a plastic bag.

A. Searching patient Admitted to the hospital:
  - Prepare the materials needed:
    - Hospital gown of right size and color.
    - Slipper.
    - Two plastic bags labeled with patient's name and medical record number.
  - Explain the procedure to the patient as a matter of policy.

- Wear gloves.
- Perform a full body search on the patient.
  - Run hand through the patient's hair on the head and the back of the ear areas.
  - Look into both ears of the patient.
  - Look into patient's mouth. Ask him/her to raise his/her tongue.
  - Ask patients to remove his gown and singlet (pants and shirt), search for any hidden contraband, and then put in the plastic bag, to be sent to the Laundry Department.
  - Visibly examine the back and frontal area of the patient.
  - Then run hand through the patient's leg and between the thighs.
  - Ask patient to raise both arms and then run hand through the patient's armpit.
  - Ask patient to remove his socks if any (slippers/sandals/shoes) and out in other labeled plastic bag, then check the patient's feet, especially the soles and between the fingers area.
  - Provide patient with hospital slippers.
  - Ask patient to put on the appropriate unit gown.
  - Ask the patient to remove his underpants and let the patient squat three times. Anything that patient may hide in the anal area would fall down.
  - Search patient's underclothes for any illicit substances.
- Once search is completed and nothing considered contraband was found, escort patient or ask another nurse to escort patient directly to his in-patient unit.
- Wash hands.
- Where applicable, the suspicious substance and chemicals are sent to Security Officer.
- If patient refused, ask help from the security of the hospital/ police.

- Nurse must document the procedure in the progress notes and complete the search form.
- Nurse writes incident report in case he/she finds any contraband, with the security officer as a witness and must inform nursing supervisor and physician on duty before bringing patient to the unit.

B. Searching for Inpatient Returning to Their Units from Off-Unit Activities:
- A full pat-down search of the body is carried out.
- If there is still a strong suspicion that the patient is harboring illicit substances on his body, assistance may be called and a full body search may be performed in a private area. (Follow procedure on full body search of patient).
- Any suspicious substances found should be sent to the Security Officer.
- A critical/unusual occurrence report must be completed for any suspicious substances found.

C. Body Search of In-patients:
- The patient must show reasonable indication that a body search is required.
- Confirm order for body search from the physician/head nurse or charge nurse.
- Assess patient's behavior.
- Perform a body search in a private place e.g., inside the patient's room with the door closed.
- Starts body search:
  - Explain the procedure to the patient.
  - Wear gloves.
  - Ask patient to stand with legs apart.
  - Run hands through patient's hair, armpit, back and frontal areas of the body; the thigh and legs. Give emphasis on the garter area of patient's underwear.

- Search patient pockets and head gear (if any).
- Ask patient to open his/her mouth and raise his/her tongue, and then inspect.

- When the body search is finished, ask the patient to step out of the room.

D. Perform Search of Patient's Room:
- Patient's belongings, bed, pillows, the comfort room and the surroundings of the room.
  - After searching, keep patients belonging in its original place.
- In the case of finding contrabands:
  - Any personnel belongings such as money, cellphone and cigarettes except chemicals should be given to the Patient's Affair personnel and be kept on the vault and patient's property form should be filled and completed with signatures on both parties the patient or his relatives who accompanied him and Patient Affairs Personnel.
  - An incident report must be submitted for any suspicious substance found during the search.
  - Any suspicious substance found during the search must be brought to the immediate attention of Nursing Supervisor on duty and physician for counter-checking.
  - If the patient refused, ask help from the police/security of the hospital.
- Document the procedure and findings in the nurses' progress notes of patient's electronic file record (HIS).
- Any contraband found from the patient, an OVR must be initiated and forwarded to Patient's Affair to keep in the vault or condemn if needed, inform the related department to take action, e.g. Hospital Administration or Security and Safety Officer (16).

APPENDICES

Patient Safety Screener (PSS-3)

استمارة فحص سلامة المريض/المريضة يمكن أن ستخدم في الفحص الأولي للمرضى في أقسام الطوارئ والمرضى في العيادات الخارجية.
اطرح جميع أسئلة الفرز الثلاثة. لا تتخطى أي سؤال.

المقدمة "الآن سأطرح عليك بعض الأسئلة التي نطرحها على كل شخص يتم التعامل معه هنا ، بغض النظر عن المشكلة التي قدموا من أجلها. إنه جزء من سياسة المستشفى، ويساعدنا على التأكد من عدم فقدان أي معلومات مهمة خاصة بك.

الاكتئاب 1 خلال الأسبوعين الماضيين ، هل شعرت بانخفاض في المزاج أو الاكتئاب أو اليأس؟

نعم ☐   لا ☐   رفض الإجابة ☐   المريض/المريضة غير قادر على الإكمال ☐

التفكير في الانتحار 2 على مدار الأسبوعين الماضيين ، هل راودتك أفكار بقتل نفسك؟

نعم ☐   لا ☐   رفض الإجابة ☐   المريض/المريضة غير قادر على الإكمال ☐

3 محاولة الانتحار هل سبق لك أن حاولت قتل نفسك؟

نعم ☐   لا ☐   رفض الإجابة ☐   المريض/المريضة غير قادر على الإكمال ☐

أ. إذا كانت الإجابة بنعم للبند 3 ، اسأل: متى حدث هذا آخر مرة؟ . . . .
- ➤ خلال الـ 24 ساعة الماضية (بما في ذلك اليوم) ☐
- ➤ خلال الشهر الماضي (لكن ليس اليوم) ☐
- ➤ أكثر من شهر وأقل من 6 أشهر ☐
- ➤ منذ أكثر من 6 أشهر ☐
- ➤ رفض الإجابة ☐   المريض/المريضة غير قادر على الإكمال ☐

"نعم" للسؤال 1 = نتيجة إيجابية للاكتئاب.

"نعم" للسؤال 2 أو "آخر 6 أشهر" للسؤال 3 = نتيجة إيجابية لمخاطر الانتحار.

قم بتطبيق بروتوكول المنشأة الخاصة بالتعامل مع النتائج الايجابية.

نصائح
- ➤ اطرح جميع الأسئلة كما صيغت بالضبط
- ➤ لا تقم بتجميع الأسئلة أو إعادة صياغتها
- ➤ عامل المريض بتعاطف

استمارة فحص سلامة المريض/المريضة (3)

Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner – English Version)

PATENT NAME: _____ DATE: _____

1. Demographics

Score

Inpatient or outpatient (circle)　　　　　*Score 1 for inpatient*　　➔　　_____

Subtotal for Demographics section 1:　_____

2. Psychological Domain

Item Scores (right column = 1)

Ideation:

　　　　　　　　　　　　　　　　　　　　0　　　　1

I.

	0		1	
Do you think you would be better off dead?	No	_	Yes	_
Do you feel you are vulnerable to hurting yourself?	No	_	Yes	_
Do you often hurt yourself by cutting or overdose of pills?	No	_	Yes	_

Subtotal for section 2 I:　_____

Item Scores (right column = 1)

Management of ideation:

M　　　　　　　　　　　　　_____

Do you wish to die?	No	_	Yes	_
Can you control these (ideation) thoughts?	No	_	Yes	_
Do you fear losing control and attempting suicide?	No	_	Yes	_

Subtotal for section 2 M:　_____
(right column = 1)

Assessment of current state of suicidality (consider current thought processes and/or recent attempt)

A. Do you currently feel suicidal?	No	_	Yes	_
Do you feel helpless?	No	_	Yes	_
Have you attempted to kill yourself?	No	_	Yes	_

Subtotal for section 2 A:　_____
(right column = 1)

Planning for subsequent attempt:

P.

Do you think you will attempt suicide in the future?	No	_	Yes	_

Subtotal for section 2 A:　_____
(right column = 1)

3. Comorbidities (check all that apply)

Drug abuse	_	History of	_	Current
Alcohol abuse or dependence	_	History of	_	Current
Sexual abuse	_	History of	_	Current

4. Family History (including siblings, parents, or grandparents Mental illness *(family member)* __

Subtotal for Family History (Score 1 for Yes in this section):

5. Protective factors for suicide risk

Is your family practically supportive of your problems and your recovery? No ☐   Yes ☐
Do you have good self-esteem? (believe that you are a worthwhile person) No ☐   Yes ☐
Do you savour life's satisfying moments?   No ☐   Yes ☐

Subtotal for Protective factors: _____
(Right column = 1)

6. Clinical ratings/Observation

Is there evidence of a personality disorder or issues related to personality?   No ☐   Yes ☐
Is there presence of psychosis?   No ☐   Yes ☐
Would you consider client vulnerable due to any of the following?
     A dysfunctional or chaotic home environment   No ☐   Yes ☐
     Existential issues (i.e. no meaning in life)   No ☐   Yes ☐

Subtotal for Clinical ratings/observations (Score 1 for each Yes in this section): _____

7. Psychosocial and Environmental Problems

Score 1 for every problem named in this section
Check:
___Problems with primary support group (*specify*): _____
___Problems with access to health care services (*specify*): _____

Subtotal for Psychosocial/Environmental (count all check marks): _____

SIS-MAP brief scanner Clinical Profile:

I-MAP subscales		Demographics:	
2I- Ideation:	_____	Psychological Domain:	_____
2M- Management	_____	Comorbidities:	_____
2A- Assessment	_____	Family History:	_____
2P- Planning	_____	Clinical ratings/observations :	_____
		Psychosocial/Environmental:	_____
		Total of all above sections:	_____
		Protective Factors: (subtract):	_____

SIS-MAP brief scanner Risk Index: _____

Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP brief scanner – Arabic Version)

اسم المريض: التاريخ :

1- <u>البيانات الشخصية:</u>

الدرجة

- مريض منوم أو عيادات خارجية: _____ الدرجة (1) للمريض الداخلي (المنوم) ←— ——

المجموع الفرعي لقسم البيانات الشخصية (المعلومات السكانية): 1 _____

2- <u>الأبعاد النفسية:</u>

2.1 التفكير درجات العناصر (العمود الأيمن = 1)

    0   **1**

- هل تعتقد أنك ستكون أفضل حالاً لو كنت ميت   نعم _____   لا _____
- هل تواجه أي "موقف" قد تؤذي نفسك فيه   نعم _____   لا _____
- هل تؤذي نفسك غالباً بجرح جلدك أو تناول جرعة زائدة من الأدوية   نعم _____   لا _____

المجموع الفرعي لقسم التفكير 2.1 _____

2.2 إدارة التفكير درجات العناصر (العمود الأيمن = 1)

- هل تتمنى الموت (أن تموت)   نعم _____   لا _____
- هل يمكنك التعامل مع الأفكار المؤلمة عن الانتحار   لا _____   نعم _____
- هل تخشى فقدان السيطرة والإقدام على الانتحار   نعم _____   لا _____

المجموع الفرعي لقسم إدارة التفكير 2.2 _____

2.3 تقييم الحالة الحالية للانتحار

(ضع في اعتبارك عمليات التفكير الحالية أو المحاولات الحديثة) درجات العناصر (العمود الأيمن = 1)

- هل حاولت قتل نفسك   نعم _____   لا _____
- هل تشعر بالعجز   نعم _____   لا _____
- هل تشعر حالياً برغبة في الانتحار   نعم _____   لا _____

المجموع الفرعي لقسم تقييم الحالة الحالية للانتحار 2.3 _____

2.4 التخطيط لمحاولة لاحقة درجات العناصر (العمود الأيمن = 1)

- هل تعتقد أنك ستقدم على الانتحار في المستقبل   نعم _____   لا _____

المجموع الفرعي لقسم التخطيط لمحاولة لاحقة 2.4 _____

المجموع الفرعي لجميع أقسام الأبعاد النفسية قسم (2.1 + 2.2 + 2.3 + 2.4) _____

3- <u>الأمراض المصاحبة:</u> **(حدد كل ما ينطبق)**

- تعاطي المواد المخدرة   تاريخ سابق للاستخدام ☐   استخدام حالي ☐
- تاريخ استخدام الكحول أو الاعتمادية عليه   تاريخ سابق للاستخدام ☐   استخدام حالي ☐
- الاعتداء الجنسي   تاريخ سابق ☐   حالياً ☐

الأمراض المصاحبة (عد جميع الحقول المؤشرة) _____

4- التاريخ الأسري: (متضمناً الأشقاء والآباء والأجداد)

- المرض النفسي (أحد أفراد الأسرة)   نعم ☐   لا ☐

المجموع الفرعي لقسم التاريخ الأسري (الدرجة (1) لنعم في هذا القسم) _____

5- عوامل الحماية من مخاطر الانتحار

- هل لديك احترام جيد لذاتك (تعتقد أنك شخص ذو قيمة)   نعم ☐   لا ☐
- هل تدعمك عائلتك في حل مشاكلك وتشافيك بصورة فعلية   نعم ☐   لا ☐
- هل تستمع بلحظات الحياة المرضية   نعم ☐   لا ☐

المجموع الفرعي لقسم عوامل الحماية من مخاطر الانتحار (العمود الأيمن = (1)) _____

6- التقييم الإكلينيكي / الملاحظة: **درجات العناصر (العمود الأيمن = 1)**

- هل يوجد دليل على اضطراب في الشخصية أو مشاكل تتعلق بالشخصية؟   نعم ☐   لا ☐
- هل يعاني المراجع من الذهان؟   نعم ☐   لا ☐
- هل تعتبر العميل عرضة للخطر بسبب أي مما يلي:
  ❖ بيئة منزلية مختلة أو فوضوية   نعم ☐   لا ☐
  ❖ القضايا الوجودية (عدم وجود معنى في الحياة)   نعم ☐   لا ☐

المجموع الفرعي لقسم التقييم الإكلينيكي / الملاحظة (العمود الأيمن = (1)) _____

7- المشكلات النفسية والاجتماعية والبيئية: **الدرجة (1) لكل مشكلة مذكورة في هذا القسم**

☐ مشاكل مع مجموعة الدعم الأساسية (حدد) _____

☐ مشكلات الوصول إلى خدمات الرعاية الصحية (حدد) _____

المجموع الفرعي لقسم المشكلات النفسية والاجتماعية والبيئية (عد جميع الحقول المؤشرة) _____

التقييم الكلي: SIS-MAP

الدرجة الكلية	الأبعاد المقاسة	
	البيانات الشخصية	1
	الأبعاد النفسية	2
	الأمراض المصاحبة	3
	التاريخ الأسري	4
	التقييم الإكلينيكي / الملاحظة	6
	المشكلات النفسية والاجتماعية والبيئية	7
	مجموع الأقسام أعلاه	
	اطرح من المجمع أعلاه نتيجة: عوامل الحماية من مخاطر الانتحار	5
	مؤشر الخطورة : SIS-MAP brief scanner	

Treatment Plan Agreement Form

	Kingdom of Saudi Arabia Ministry of Health **General Administration of Mental Health and Social Service** المملكة العربية السعودية وزارة الصحة الإدارة العامة للصحة النفسية والخدمة الاجتماعية	MRN: ☐ ☐ ☐ ☐ ☐ NAME: .... AGE: .... SEX: M ☐ F ☐ NATIONALITY: .... DEPARTMENT: .... CONSULTANT IN-CHARGE: ....

اتفاقية الخطة العلاجية

ينص هذا الاتفاق على أهمية كلٍ من المعالج والمراجع في تخطي الأزمات الحالية أو ما قد يحدث مستقبلًا.

يتم ذلك بإيضاح أدوار الطرفين في الخطة العلاجية:

❖ **خطة المتابعة:**
_____
_____
(يتم تفصيل مواعيد المتابعة)

❖ **خطة العلاج الدوائي:**
_____
_____
(يتم ذكر الأدوية بجرعاتها ومواعيدها)

❖ **خطة العلاج بالجلسات:**
_____
_____
(يتم تفصيل مواعيد الجلسات)

❖ **خطة الحد من الوصول لوسائل الأذى:**
_____
_____
(يتم ذكر وسائل الأذى و تحديد طرق الحد
من الوصول لها)

يتم أيضًا إيضاح الطرق الآمنة للتعامل مع الأزمات المستقبلية:

١. **التعرّف على علامات الأزمة:**
_____
_____
(الأفكار، المشاعر، السلوكيات ..إلخ)

٢. **طرق التكيف الذاتية:**
_____
_____
(الاسترخاء، الأنشطة البدنية ..إلخ)

٣. **المواضع التي تقلل من أثر الأزمة:**
_____
_____
(أماكن أو أشخاص)

٤. **الأشخاص الذين يمكنهم المساعدة:**
_____
_____
(أفراد عائلة أو أصدقاء، مع ذكر ارقام
التواصل معهم)

توقيع المعالج/ـة: _____ توقيع المراجع/ـة: _____

توقيع قريب أو صديق: _____

Body Search Checklist

<table>
<tr><td rowspan="6">**Kingdom of Saudi Arabia**
Ministry of Health
General Administration of Mental Health and Social Service

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للصحة النفسية والخدمة الاجتماعية

Ministry of Health</td><td>MRN: ☐ ☐ ☐ ☐ ☐ ☐</td></tr>
<tr><td>NAME: ....</td></tr>
<tr><td>AGE: .... SEX: M ☐ F ☐</td></tr>
<tr><td>NATIONALITY: ....</td></tr>
<tr><td>DEPARTMENT: ....</td></tr>
<tr><td>CONSULTANT IN-CHARGE: ....</td></tr>
</table>

BODY SEARCH CHECKLIST			استمارة تفتيش مريض		
Appearance: المظهر	**Free/ Clear** (√)	**Anything Unnecessary Found Document Accordingly**	**Personal Items:** أغراض شخصية	**Free/ Clear** (√)	**Anything Unnecessary Found Document Accordingly**
Hair الشعر			Cellphone / Radio تلفون / راديو		
			Watch الساعة		
Nose الانف			Shaving Gear الة الحلاقة		
			Tubes (e.g. Toothpaste)/Bottles انابيب معجون الاسنان		
Mouth الفم			Handkerchief المناديل		
			Cigarettes السجاير		
Body الجسم			Suitcase الحقيبة		
			Musical Instrument الآلات الموسيقية		
Toes القدم			Books /Magazines كتب / مجلات		

Clothing		Free/ Clear (√)		Anything Unnecessary Found Document Accordingly
Hat	اغطية الرأس	Fold & Brim	Linings/Seams	
Thobes	الثوب	Pockets	Linings/Seams	
Underwear	ملابس داخلية	Pockets	Linings/Seams	
T-Shirt/Shirts	القميص	Pockets	Linings/Seams	
Shorts	السراويل	Pockets	Linings/Seams	
Pants	السراويل	Pockets	Linings/Seams	
Jackets	جاكيت	Pockets	Linings/Seams	
Pull-Over/Sweaters	سويتر	Pockets	Linings/Seams	
Sweatshirts	الرداء الشتوي	Pockets	Linings/Seams	
Sweatpants	البنطلون	Pockets	Linings/Seams	
Socks	الشرابات	Pockets	Linings/Seams	
Sandals/Shoes	الاحذية	Pockets	Linings/Seams	

Note: Any Patient Admitted With Suspect Plaster (POP) Must Be Subject To X-Ray

Name of Searcher: اسم المفتش	Signature: التوقيع	Date &Time: التاريخ / الوقت
Name of Co-Searcher: اسم المفتش المدقق	Signature: التوقيع	Date &Time: التاريخ / الوقت

Nursing Environment Suicidal Patient Safety Checklist

<table>
<tr>
<td>

Kingdom of Saudi Arabia
Ministry of Health
General Administration of Mental Health and Social Service

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للصحة النفسية والخدمة الاجتماعية

Ministry of Health
</td>
<td>

MRN: ☐ ☐ ☐ ☐ ☐ ☐

NAME: ....

AGE: SEX: M ☐ F ☐

NATIONALITY: ....

DEPARTMENT: ....

CONSULTANT IN-CHARGE: ....
</td>
</tr>
</table>

NURSING ENVIRONMENT SUICIDAL PATIENT SAFETY CHECKLIST

Items Checked *Checklist must be completed at the beginning of every shift for all patients at risk for suicide*	Date: AM	PM	NOC
Complete approved Suicide Assessment to " Score" levels of risk and the interventions to be implemented if patient triggers on screening questions.			
Room inspection completed at beginning of each shift.			
Communicate initiation of Suicide Precautions and Level of Observation to other Care Team Members.			
Place the patient in a treatment area, which provides the best observation and protection. Never leave patient unattended behind a closed curtain. Keep curtain open at all times.			
Remove in-room sharps container or use locked containers.			
Remove ALL sharp objects (needles, scalpels, knives, scissors, nail files, coat hangers, cutlery, glass items, etc.).			
Remove all detachable/removable hanging risk items, if possible and unless medically necessary: • Suction Tubing • Electric cords/ telephone cords / bed cords/ (if detachable) / window blind cords. • Oxygen tubing / Flowmeter (unless required for continuous use). • Monitoring Equipment (BP/EKG cables) unless items are required for continuous monitoring/care. • Excess IV tubing • Nurse call light in room and bathroom (provide bell as needed).			
Remove garbage container, linen container and all plastic bags.			
Remove extra linen (sheets, towels, pillowcases, gowns).			
Visually inspect room and bathroom and remove/reduce risk of potentially harmful object as best possible: • Shower curtain • Note shower heads for hanging risks and observe patient closely when using shower • Remove any hanging curtains • Secure windows • Lock all cabinets • Remove any items that are dangerous if ingested • Disable bathroom door lock			
Inspect patient belongings, initiate Patient Belongings Record: remove potentially harmful objects or contraband from patient and environment. This includes: *patient medications, glass or sharp items, toiletry items containing alcohol, matches or lighter, aerosol spray cans, curling iron, hair dryer, razor, belts, straps, ties, shoe laces, dental floss and jewelry.* Remove items from patient room and place in a secured location or send home with family. Allowable items: Cordless electric razor, eyeglasses, and non-breakable toiletries.			
Provide patient gown with snaps and no strings. No clothing with any type of strings/drawstrings.			
Request disposable cups, plates and utensils from dietary (count before and after meals) or serve finger foods only.			
Stay with the patient while he/she is taking prescribed medication to make sure he/she swallows the medication (check mouth for checking of medications).			
Ask patient if there is a family member or friend he/she wants involved in care. Inform family/ visitors the level of observation/suicide precautions of patient, the associated restrictions, and rationale.			
Monitor ay item(s) brought in by visitors. Remove an item considered unsafe and return it to the visitor when they leave			
If patient is being admitted, report is given to the admitting nurse. Included in the report should be the initiation of Suicide Precautions.			
Nurse On Duty Stamp & Signature			

Patient's Behavior /One To One Observation Flow Sheet

<table>
<tr><td rowspan="2">[Ministry of Health logo]
وزارة الصحة
Ministry of Health</td><td>Kingdom of Saudi Arabia
Ministry of Health
General Administration of Mental Health and Social Service

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للصحة النفسية والخدمة الاجتماعية</td><td>MRN: ☐ ☐ ☐ ☐ ☐ ☐

NAME: ....
AGE: SEX: M ☐ F ☐
NATIONALITY: ....
DEPARTMENT: ....
CONSULTANT IN-CHARGE: ....</td></tr>
</table>

PATIENT'S BEHAVIOR /ONE TO ONE OBSERVATION FLOW SHEET

Date: **Department:**

Time	Comment/ Code	Initial	Time	Comment/ Code	Initial	Time	Comment/ Code	Initial	Time	Comment/ Code	Initial
0:00			6:00			12:00			18:00		
0:15			6:15			12:15			18:15		
0:30			6:30			12:30			18:30		
0:45			6:45			12:45			18:45		
1:00			7:00			13:00			19:00		
1:15			7:15			13:15			19:15		
1:30			7:30			13:30			19:30		
1:45			7:45			13:45			19:45		
2:00			8:00			14:00			20:00		
2:15			8:15			14:15			20:15		
2:30			8:30			14:30			20:30		
2:45			8:45			14:45			20:45		
3:00			9:00			15:00			21:00		
3:15			9:15			15:15			21:15		
3:30			9:30			15:30			21:30		
3:45			9:45			15:45			21:45		
4:00			10:00			16:00			22:00		
4:15			10:15			16:15			22:15		
4:30			10:30			16:30			22:30		
4:45			10:45			16:45			22:45		
5:00			11:00			17:00			23:00		
5:15			11:15			17:15			23:15		
5:30			11:30			17:30			23:30		
5:45			11:45			17:45			23:45		

AM SHIFT SIGNATURE/STAMP	PM SHIFT SIGNATURE/STAMP	NIGHT SHIFT SIGNATURE/STAMP	Type of Monitoring for Suicidal Patient	Observation Level
			☐ Low Risk: Every 1 hr.	☐ General Observation Routine Monitoring

			☐ Moderate Risk:
			   Every 15 minutes
				☐ Constant Observation
				     Within eyesight

			☐ High Risk:
			   Every 15 minutes
				☐ Close Observation
				     Within arm's length

			☐ Other types of monitoring:	

Behavior / Activity Codes		Activity Codes		Location Codes
CC= Calm & Cooperative **U**= Uncooperative **Ag**= Agitated **R**= Restless **C**= Confused	**Tt**= Tearful **Nv**= Nonverbal **VO**=Verbal Outbursts **DB**= Destructive Behavior (Self-harm, throwing, Kicking, Biting)	**A**= Awake **S**= Sleeping **V**=Visitor **BR**= Bedrest **Chr**= Up in chair **M**= Eating Meal	**T**= Telephone **Re1**= Restraint 1:1 **Re**= Restraint **Assist**= Assisted with ADL's	**R**= Bedroom **OF**= Off Unit **BR**= Bathroom **SA**= Smoking Area **K**= Kitchen **PA**= Play area **H**= Hallway

NOTE: Report any significant change in behavior or condition to doctor immediately.

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نسعد باستقبال ملاحظاتكم ومقترحاتكم التي
من شأنها تحسين وتطوير مستوى الأداء في مجال
الخدمات النفسية وعلاج الإدمان عبر الإيميل

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