Ministry of Health

Al Masarra Hospital

Guideline of Emergency Psychiatric Department

Document Title	Guideline of Emergency Psychiatric Department
Document Type	Guideline
Directorate/Institution	Al Masarra Hospital
Targeted Group	Al Masarra Hospital employees
Document Author	Task Force from different specialties
Designation	Different Specialties
Document Reviewer	Task Force from different specialties
Designation	Different Specialties
Release Date	March 2025
Review Frequency	Every 3 years

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Date	March 2025	Date	March 2025

Acknowledgement

The Emergency Psychiatric Guidelines represent a significant step forward in Al Massara Hospital to provide effective and compassionate care to individuals facing psychiatric emergencies. The emergency department would like to take this opportunity to thank the team responsible for developing these guidelines.

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Acronyms

AMRH	Al Masarra Hospital
ED	Emergency Department
ONSET	Oman National System for Emergency Triage
LWBS	Left Without Being Seen
BVC	Broset Violence Score
LAMA	Left Against Medical Advice
AWS	Alcohol Withdrawal Scale
COWS	Clinical Opiate Withdrawal Scale
PRO	Public Relation Officer
RHTFCA	Regional Hospital Task force of Child Abuse
ATS	Australian Triage Scale
EPS	Extrapyramidal Symptoms
NMS	Neuroleptic malignant syndrome
HOD	Head of the Department
RTC	Round The Clock

Definition

- **Triage**: The process of prioritizing patients based on the severity and urgency of their condition.
- **Emergency:** a dangerous or serious situation, such as an accident, that happens suddenly or unexpectedly and needs immediate action
- **Medical Response**: medical treatment administered in response to a Medical Emergency that of necessity requires immediate emergency medical intervention.
- **Emergency Psychiatric Situation**: A mental health crisis that requires immediate professional intervention to prevent harm to the individual or others.

CHAPTER ONE

- **Introduction**

  Al Masarra Hospital (AMRH) is a tertiary hospital specializing in providing psychiatric care, starting from the Emergency department where patients will receive high-quality care. The emergency psychiatric guidelines and procedures for psychiatry patients are of the highest importance in Al-Masarra Hospital as they enable quick and accurate identification, evaluation, and priority of people in need of psychiatric care in the emergency department.

- **Purpose**

  1. To provide clear guidelines for the emergency psychiatric department.
  2. To ensure a coordinated and compassionate response and facilitate smooth collaboration among healthcare workers and facilities involved with the emergency department.
  3. To develop a systematic and adequate triage procedure for emergency psychiatric situations and medical situations, encompassing evaluation, prioritizing, and appropriate resource allocation.
  4. To provide a quick guideline for emergency medical situations.

- **Scope**

  This guideline applies to all Al Masarra Hospital (AMRH) healthcare professionals, staff, and facilities involved in emergency psychiatric care.

- **Structure**

  This guideline is the first version, and it consists of three chapters. Chapter One entails the introduction, purpose and scope. The second chapter contains the guidelines and procedure. Chapter three includes the responsibilities of all health workers who are required to work in the emergency department.

CHAPTER TWO

Guidelines / Procedures

1. Initial Assessment: (psychiatric patient):

1.1. Once a patient arrives, a trained and qualified staff nurse must evaluate the patient for an emergency psychiatric condition.

1.2. Triage assessment notes should include a patient's medical history, including any co-morbidities or ongoing medical conditions.

1.3. For the medical conditions, comorbidity, the triage nurse must ensure the stability of the patient, including checking the hemodynamic vital signs.

1.4. Triage should be done for all patients who attend the emergency department.

1.5. A brief physical examination, focusing on signs of acute distress, intoxication, withdrawal, or medical emergencies.

1.6. The examination must consider elements including:

- Suicidality.
- violence risk.
- substance misuse.
- psychosis.
- and acute distress for psychiatric patients.
- Risk of fall.

1.7. To compile pertinent patient history and condition data, triage Nurses should use a standardized assessment technique using a triage registration form from the Al-Shifa system.

1.8. The triage nurse should determine the urgency of the situation and record it in the emergency triage registration form.

1.9. The triage nurse must notify the infection control department if a patient requires isolation.

1.10. In case of proxy for medication, the medical record Staff will open a walk-in visit, and if there are three previous proxy visits in the emergency department; a decision will be made by triage/on-call doctor whether to give medication and appointment if routine case or to bring the patient if needs to be examined.

1.11. **Patients with Forensic Cases:**

1.11.1 presenting psychiatric life-threatening can be seen in the emergency department, triage category according to patient condition, admission decision should be arranged first with the forensic department.

1.11.2 If the case is stable, early discussion to be facilitated with the forensic department for further management.

1.11.3 If the case presents booked admission as prisons, the treating team will do full assessment during morning in working days (depends on arrangement between triage doctor and treating team), and on-call will do full assessment after working hours and during weekends. However, patients should be medically cleared prior to admission. If patients still having unstable medical condition should be returned after full assessment from the doctor.

1.12. **Child Patient Cases:**

1.12.1 For Any patient presenting with emergency child abuse the PRO must be informed immediately to contact RHTFCA, further management should be done according to the doctor's order, however, any witness of the event can contact child protection.

1.12.2 If the child presents a new case with a referral, medical record staff should check if the appointment was given, or the doctor replied in the referral. OR if the child came without a referral should determine the urgency of the condition and management should be done in accordance with the condition and discussion with child team if expert opinion needed During working hours.

1.12.3 If the child presents a routine referral for medication only, medication will be written by emergency triage doctors (preferably during OPD days will be in child clinic).

1.12.4 If the child attends a routine old case without referral and the last visit in OPD exceeds more than one year or the child referred to another hospital should bring the referral, and an appointment will be given from the medical record with the treating team.

1.12.5 If the child is old case and the last visit in OPD exceeds more than two years, then referral will be requested, and appointment will be given as a new case in child psychiatry.

1.12.6 If a child is present for an assessment, first degree or the main care giver should be involved (legal guardian).

1.12.7 If a child decided for admission from the ED (14yrs, old and above,) otherwise patient can be referred to SQUH for further management, psychoeducation should be provided what has been done.

1.12.8 Child Admission consent must be filled by first degree, or the main care giver (legal guardian). (see appendix 9)

1.13. **Geriatric Patients Cases:**

1.13.1 For Geriatric patients presenting as new cases with a referral should check if the appointment was given or the doctor replied by medical record staff.

1.13.2 If the patient came without a referral, should determine the urgency of the condition and management should be done in accordance to the condition and discussion with the geriatric team if expert opinion needed during working hours and after working hours second on-call should be discussed with the third on-call and forth on-call.

1.13.3 Geriatric patients attend as a routine old case without a referral and the last visit in OPD exceeds more than one year should bring a referral letter from the local Centre and an appointment will be given according to the arrangement from the medical record department.

1.13.4 For the case new or old with substance misuse patient (routine) case appointment should be given. If the case is overdose, stabilize the case and should be discharged after the stability of the patient and an appointment should be given or referred to another institution.

1.14. **Substance Missuses Patient:**

1.14.1 In the case of admission treating team should be informed during working hours and after working hours second on-call should be discussed with the third on-call and fourth on-call.

1.14.2 For any old substance misuse patient (D unit) case visit less than seven years consider follow-up with the treating team. If it exceeds more than seven years, consider a new case. (see annex 2) (refer to policy and procedure of referrals to the Addiction Department).

1.15. For all cases with old routine adult psychiatric and the last visit in OPD exceeds more than one year consider bringing a referral letter and an appointment will be given with the treating team, if it exceeds more than five years consider bringing a referral letter and an appointment will be given as new case with new distribution in the unit.

1.16. If the patient decides to be referred to another hospital, prior discussion with another hospital should be done. Urgent and Immediate referral will be managed by the physician. staff should wait for release by receiving team, however waiting time should not exceed two hours if assessment or procedures will take more than FOUR hours. If any concern the staff nurse must inform the shift supervisor.

1.17. Distribution of new cases of adult psychiatric for admission only from emergency should be in the emergency department with one file for all the days (emergency distribution file), it will be distributed by turn as A B C for both during working hours and after working hours. If the patient went LAMA should not be distributed and they will have an appointment with a medical record department.

1.18. If the patient came with an emergency or urgent condition with or without referral and the doctor decided for the nearest appointment, a medical record Staff will give an appointment if a new case, if an old case appointment will be given by a doctor.

1.19. Patients who were seen in triage as referred cases from other institutes should be referred to their regional psychiatrist after discharge from ED and not to be given an appointment in AMH.

1.20. If the referred case from other health institution accepted by third on-call to be seen in emergency department should be for assessment and evaluation. Therefore, the decision of admission must be taken according to triage doctor during working hours, and after working hours, the on-call team will decide for admission if

needed. However, the escorting staff should wait until doctor will finish the assessment.

2. Triage Categories:

2.1. Patients will be categorized into different triage levels based on the severity and urgency of their condition.

2.2. A qualified nurse professional should make triage decisions.

2.3. Triage category can be done using a numerical scale (1 to 5), which is in the triage registration form, and should be done according to the Australian mental health triage scale which is classified according to patient behavioral conditions as follows:

2.3.1 Triage Category 1: Immediate

- possession of weapons
- Self-destruction in ED
- Altered mental status
- Hemodynamic instability
- Extreme agitation or restlessness
- Bizarre/ disoriented behavior.
- Suicidal/ Homicidal ideation with clear plan and means.
- Require restrain or SOS IMMEDATLY.
- Reported verbal commands to do harm to self or others (command hallucination).
- Recent violent behavior.

2.3.2 Triage Category 2: emergency (less than 10 min):

- Extreme agitation/ restlessness
- Psychically/verbally aggressive
- Confused/ unable to cooperate.
- Hallucination. Delusion, paranoia
- Require restraint or SOS.
- High risk of absconding and not willing for treatment
- Attempt at self-harm/ threat of self-harm or others.
- Unable to wait safely.

- Sign of Delirium
- Lithium toxicity
- NMS
- Overdose drug
- Serotonin Syndrome
- Hypertensive crisis

2.3.3 Triage Category 3: urgent (less than 30 min):

- Agitation, restless
- Instructive behavior
- Confused
- Ambivalence about treatment
- Suicidal ideation
- Situation crises
- Not likely to wait for treatment due to risk.
- Presence of psychotic symptoms: hallucination, delusions, paranoid ideas, thought disordered, bizarre/ agitated behavior.
- Presence of mood disturbance: sever symptoms of depression, withdrawn/uncommunicative and or anxiety.
- Elevated or irritable mood
- EPS

2.3.4 Triage Category 4: semi-urgent (less than 60 min):

- No agitation/restlessness
- Irritable without aggression
- Cooperative
- Gives coherent history.
- Presence of psychotic symptoms: per-existing mental health disorder, symptoms of anxiety or depression

2.3.5 Triage Category 5: routine (less than 120min):

- Co-operative.
- Communicative and able to engage in developing management plans.
- Able to discuss concerns.
- Complaint with instructions.
- Known patient with chronic psychotic symptoms.
- Pre-existing non-acute mental health disorder.
- Known patient with chronic unexplained somatic symptoms.
- Request for medication
- Minor adverse effect of medication
- Financial, social, accommodation, or relationship problems.

Triage decisions should consider available resources and the facility's capacity to provide appropriate care. *(Refer to Appendix 3)*

3. Risk Assessment:

3.1. Utilize a standardized suicide risk assessment tool to evaluate the patient's risk of self-harm or suicide (SAD PERSON Scale) and the triage nurse should use the SAFE 5T assessment tool in triaging the patient.

3.2. Assess the patient's risk of harm to others or any potential indications of violence, staff need to use the BVC score to detect the violence scale, and it should be attached to the patient file if admitted, in a Kardex note Staff must mention the scale result and the type of violence.

3.3. Maintain the Alcohol Withdrawal Scale (AWS), and Clinical Opiate Withdrawal Scale (COWS) if needed.

3.4. Identify the patient's weaknesses, such as any cognitive issues, age-related issues, or weakened decision-making abilities.

3.5. A brief risk assessment screening tool is incorporated into the triage document. Possible risk factors include:

- Significant history of risk

- Recent thoughts, plans, and symptoms indicating risk
- Recent behaviors suggest risk.
- Concern from others about risk
- Current problems with alcohol or substance misuse
- Major mental illness or disorder
- At-risk mental state:
  - Deterioration due to untreated illness
  - Non-adherence to treatment
  - Lack of family support
  - Emergence of early warning signs
- Unrecognized acute medical illness presenting as delirium.
- Significant circumstances that create volatile behaviors
- Concern that a child or young person is being abused or neglected.
- Refugee experience, migration and acculturation stressors, minority ethnic status, intergenerational conflict, and concerns with multiple identity issues.

For further information, please *refer to the Policy and Procedure of Suicide Risk Assessment and Management* AMRH/ADMIN/P&P/008/Vers.02

4. Mental Health Assessment:

- Triage Nurse should conduct mental health assessments based on clinical criteria of Appearance, affect, behavior, conversation and mood.

4.1 Appearance:

What does the patient looks like?

- Are they disheveled, unkempt, or well presented
- Are they wearing clothing appropriate for the weather
- Do they look malnourished or dehydrated
- Are they showing any visible injuries?
- Do they appear intoxicated, flushed, with dilated pinpoint pupils?

- Are they tense, slumped over, displaying bizarre posture of facial grimaces

4.2 Affect:

- What is your observation of the patient's current emotional state?
- are they flat, downcast, tearful, distressed or anxious?
- is their expression of emotion changing rapidly?
- is their emotion inconsistent with what they are talking about?
- are they excessively happy?

4.3 Behavior

- How is the patient behaving?
- are they restless, agitated, hyperventilating, or tremulous?
- are they displaying bizarre, odd, or unpredictable actions?
- are they oriented?
- How is the patient reacting?
- are they angry, hostile, uncooperative, over-familiar, suspicious, guarded, withdrawn, inappropriate or fearful?
- are they responding to unheard voices or sounds, unseen people or objects?
- are they attentive or refusing to talk?

4.5 Conversation

- How is the patient talking?
- Does their conversation make sense?
- Is their speech rapid, repetitive, slow, uninterruptible?
- Is it loud, quiet, a whisper, clear or slurred?
- Are they angry or using obscene language?
- do they stop in the middle of a sentence because they are hearing voices?
- Do they know what day and time it is and how they got to the ED?

4.6 Mood

- How does the patient describe their mood? Do they say they feel:
- Down, worthless, depressed or sad?
- Angry, or irritable?
- Anxious, fearful or scared?
- Sad, happy or high?
- Like they cannot stop crying all the time?

5. **Initial Assessment Medical Emergency**:

Assessment of the patient will depend on the triage category according to ONSET:

5.1. Level 1 (Resuscitation): Requires immediate medical attention to avoid loss of life. A delay in initial evaluation could be harmful to the patient. The ED Consultant or ED Physician should be notified immediately upon the patient's arrival. Level 1 patients will require 1:1 nurse care or greater, initially (for example cardiac arrest, respiratory failure, coma, multiple traumas, heat stroke, drowning, etc.).

5.2. Level 2(Emergency): Conditions are potentially life-threatening. Observation room placement and initial nursing assessment should be maintained. The ED Physician should be notified promptly once the initial nursing assessment is completed. Reassessment will be performed based on the patient's condition and response to treatment. An ED physician must see the patient within 10 minutes of arrival (for example typical ischemic chest pain, respiratory distress, new onset stroke etc.). ED physicians must evaluate the case; if resources are available; management should be done according to patient needs and then referred to another hospital for further management and evaluation. If the resources are not available, an emergency referral should be done, and patients should be escort to another hospital by physician and staff nurse.

5.3. Level 3 (Urgent): are potentially serious, but not life-threatening. Upon completion of the initial nursing assessment, periodic reassessment for less than 30 minutes will be performed by the nurse until evaluated by a physician. (For

example, acute febrile illness, severe nausea and vomiting, minor alteration in vital signs, abdominal painful crisis etc.). Urgent referrals should be done after stabilization for further evaluation and treatment. Staff only with one medical orderly should escort the patient to another hospital if needed.

5.4. Level 4 (Less urgent): Periodic reassessment for less than 90 minutes will be performed by the nurse until evaluated by a physician. (For example, mild dehydration). If the case is stable should be returned to follow in the local health center

5.5. Level 5 (Non-Urgent): Conditions that may be acute non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to a nearby health care facility / Primary Health Care (PHC) (for example Upper Respiratory Tract Infection (URTI) mild headache without neurological findings. If the case is stable should be returned to follow in the local health center.

Victims of trauma should be allocated a triage category according to their objective clinical urgency according to ONSET. As with other clinical situations, this will include consideration of high-risk history and complete physical examination.

6. Prioritization and Decision-Making:

6.1. Assign a triage level based on the urgency and severity of the patient's condition.

6.2. Develop an appropriate care plan based on the triage level.

6.3. If necessary, Consult the second opinion from the shift in charge in triage to validate and confirm the triage decision.

6.4. Patients with severe and life-threatening conditions should receive immediate treatment and intervention.

6.5. Patients with non-life-threatening conditions should receive prompt intervention based on their triage level.

6.6. Patients in triage levels 3 and 4 should be adequately monitored and reassessed to ensure their condition doesn't deteriorate.

6.7. Patients with drug overdose, lithium toxicity, delirium, NMS, EPS, serotonin syndrome and hypertensive crises should be referred to a physician immediately and fast intervention should be done.

6.8. Patient with routine D unit please refer to *Opioid use disorder management* guideline *AMRH/AP/GUD/002/vers.01*

7. Isolation cases:

7.1. Triage Nurse must notify the infection control department if the patient requires isolation

7.2. Standard precautions should be maintained for All patients, especially MRSA patients.

7.3. If the patient is for re-admission and requires isolation should notify the infection control department.

7.4. If a patient has previously been admitted to another hospital within 6 months, the triage nurse should notify the infection control department and isolate the patient. MRSA testing should be performed in the emergency department if no bed is available inside the hospital, or in the isolation room if a bed is available.

7.5. Staff must use surgical masks for droplet precautions and N95 masks for air precautions.

8. Observation process:

8.1. Patients, if decided for observation for psychiatric care should stay only **maximum for 6 hours** if old case and need to review by triage doctor during working hours and by the on-call doctor during after working hours. If the case is new observation should be for 24hr then to be reviewed by the triage doctor during working hours and by the on-call doctor after working hours. *(Refer to Appendix 8)*

8.2. Preferably two patients can be kept for observation in the emergency room with relatives.

8.3. The patient if decided for observation for medical care should stay only a **maximum for four hours to stabilize the case or depending on physician's plan** and need to be reviewed by a physician, the case should be discussed with another hospital for further investigation if needed.

9. Admission process:

9.1. please refer to the Guideline of Adult Psychiatry Admission.

9.2. The maximum number of patients for temporary admission in the emergency department due to the unavailability of a bed inside the hospital is only 3 patients: 2 males, and 1 female, Maximum days allowed to stay 3 days only.

9.3. If the patient is admitted to the emergency department due to the unavailability of a bed inside the hospital, on the first day should be seen by a triage doctor and starting from the second day treating team should come and see the patient.

9.4. Emergency Nurses staff should complete the full admission process including the admission checklist, required scales, ID band, and admission consent and notes. And should inform the doctor if medicolegal needs to be done.

10. Redirection of low acuity patients:

According to ONSET. Redirection can be conducted based on resource availability, ED capacity, proximity to primary care facilities, and triage nurse experience.
If the patient needs medical care for levels 3, 4, and 5, they should be directed to the local health facility.
If a patient is low risk and triages category 4 or 5, and does not require emergency care, he or she should be defeated to an appointment and given psychoeducation.

11. LWBS:

11.1. If the case is emergency or urgent and the patient left without being seen, patient Kardex should be maintained, the time should be mentioned when calling the patient, an incident report should be written, PRO should inform Dispose of the name in category LWBS.

11.2. If the cases are semi-urgent or routine and the patient left without being seen and the file was open, patient Kardex should be maintained, the time should be mentioned when calling the patient, Dispose of the name in the category LWBS.

12. LAMA:

12.1. If the case is from the child unit and the relative refuses to be admitted, the continuation of care in another hospital form needs to be filled and the child unit must be informed. PRO needs to be involved and full documentation must be done with triage Nurse, Paper should be kept in the LAMA folder in the reception room.

12.2. If the case is from the psychiatric unit, one close relative should fill LAMA form and the ID band should be attached with paper, PRO needs to be involved and full documentation must be done with the triage Nurse, Paper should be kept in the LAMA folder in the reception room.

If the case is from the drug unit, they can sign LAMA by themselves and the ID band should be attached to the paper, PRO needs to be involved and full documentation must be done with the triage Nurse, Paper should be kept in the LAMA folder in the reception room.
Refer to Policy & Procedure for patient refusing Intervention Against Medical Advice AMRH/PSY/P&P/026/Vers.01

13. **Triage in Crisis and disaster situations:**

Refer to Guideline for Disaster & Emergency Management (AMRH/ADMIN/GUD/001/Vers. 01)

14 Dispose:

Dispose of the file after the patient leaves the hospital immediately.
Refer to the triage flow chart (appendix 1)

CHAPTER THREE

Responsibilities:

1. **Triage Nurse Shall:**

1.1. Perform initial assessments of incoming patients by writing in triage emergency assessments in the Al-Shifa system, focusing on their mental and emotional state by completing a mental status examination.
1.2. Vital signs must be taken for all patients coming to the triage room.
1.3. Collect pertinent medical and psychiatric histories from patients and their relatives.
1.4. Assess the severity and urgency of patients' illnesses using the numerical scale in triage notes.
1.5. Allocate appropriate resources and staff to address the varied needs of patients.

1.6. Implement procedures according to doctor orders on patient's file (ex: ECG, LAB…)
1.7. Initiate necessary medical interventions, such as stabilizing patients in crisis.
1.8. Communicate effectively with other members of the healthcare team, including psychiatrists, social workers, and physicians.
1.9. Monitor and reassess patients to ensure their condition is stable or improving.
1.10. Provide proper handover reports to the shift-in-charge nurse regarding the status of patients and any critical developments.
1.11. Maintain full documentation in nursing Kardex, nursing procedures, and patient reading.

2. Shift In-charge Shall:

2.1. Supervise the triage nurse and other healthcare workers during the shift.
2.2. Ensure proper allocation of resources, including staff assignments and equipment, based on patient needs.
2.3. Report any issues or concerns that arise during the shift, coordinating with the ward in-charge nurse as needed.
2.4. Monitor and ensure adherence to established triage protocols and procedures.
2.5. Provide guidance and support to triage nurse and other team members.
2.6. Ensure that all documentation is complete and accurate.
2.7. Be prepared to respond to critical incidents or escalations in the triage area.
2.8. Collaborate with the ward in-charge nurse, supervisor, and other healthcare providers in emergency situations.
2.9. Coordinate with security staff if necessary to maintain a safe environment.
2.10. Facilitate communication between the triage nurse, ward in-charge nurse, and other healthcare team members.
2.11. Act as a point of contact for queries or concerns from staff or patients.

3. Ward In-Charge Nurse Shall:

3.1. Oversee the admission and discharge processes for patients entering or leaving the triage.

3.2. Ensure that all necessary documentation is completed accurately.

3.3. Allocate staff and resources to meet patient needs.

3.4. Coordinate with the shift-in-charge nurse to ensure a smooth transition of care from the triage area to the ward.

3.5. Supervise nursing care provided to patients in the ward, including medication administration and therapeutic interventions.

3.6. Monitor patient safety and ensure that the environment remains secure and conducive to healing.

3.7. Provide support and guidance to nursing staff.

3.8. Offer training and education as needed to maintain the highest quality of care.

3.9. Address any staffing issues or concerns in collaboration with area manager and hospital administration.

4. Supervised Triage Doctor Shall:

4.1. Supervised all issues related to the emergency department.

4.2. Implementing regulations and ensuring high quality patient care.

4.3. Efficiency running a health care facility and improving communication.

4.4. Stay updated medical trends.

4.5. Assisting with training and continuing education.

4.6. Examining activities and coordinating the emergency department activities.

4.7. Establish emergency protocols.

4.8. Follow up administrative issues.

5. Triage Doctor Shall:

5.1. Obtain full medical and psychiatric history from the patient and the attendee.

5.2. Perform psychiatric assessment including risk assessment and MSE.

5.3. Order complete lab investigation and ECG for patients who require these procedures according to medication taking and relapsed cases who take a prolonged 3 months.

5.4 Contact with other health workers for further management:

5.4.1. Contact a general physician for physical assessment and medical review.

5.4.2. Contact with the treating team if the patient requires expert consult.

5.4.3. Contact the bed manager during working hours if the patient is for admission.

5.4.4. Hand over to the first/ second on-call doctor if the working time has been finished and there are pending issues for the patients.

5.5 A rapid tranquilizer (SOS medication and restrain) should be ordered as soon as possible in case the patient have risky behavior.

5.6 The medico-legal form should be filled in the emergency department before the patient enters the ward if the patient has any bruises scratches or beating marks

5.7 Clinical rounds should be done for the patients who are waiting for admission and no bed available on the first day, and to inform the treating team regarding patient condition and should be seen by the treating team next day.

5.8 Formulating the management plan with HOD ED Doctor in working hours.

5.9 No sick leave will be issued if the triage doctor does not see the patient.

6. First On-call Doctor Shall:

6.1. Assess all the patients in the emergency department.

6.2. Verify all clinical findings with second on-call doctors.

6.3. Refer the needs cases to the general physician to cleared medically.

6.4. Contact the shift supervisor if the patient is for admission to clarify for the bed status.

7. Second On-call Doctor Shall:

7.1. Supervising the first on-call doctor.

7.2. Any new case should be attended with first on-call to see the cases.

7.3. Discussing patients' cases with third on-call (specialist psychiatric or senior specialist) after working hours and public holidays.

7.4. Any case referred from outside hospital should be informed by third on-call to the fourth on-call.

8. Third On-call Doctor Shall:

8.1. Receiving calls from outside hospital who required transfer to the hospital.

8.2. All the cases and referrals (including E-referrals and by phones) from outside should be discussed first prior sending the patient.

8.3. Discussed all the cases who required admission with fourth on-call prior admission procedure.

8.4. In critical crises cases should be attended in the hospitals.

8.5. During weekends and public holidays rounds should be done for newly admitted patients.

9. Fourth On-call Doctor Shall:

9.1. Received a call from a third on-call to clarify for the final decision regarding patient condition and admission confirmation.

10. Physician Shall:

Refer to the policies and procedures of the Department of Medicine.

11. Clinical Pharmacy Shall:

11.1. Answer drug-related queries from a triage doctor and other healthcare professionals during working hours.

12. Medical Orderly Shall:

Refer to job description of medical orderly

13. Health Information and Statistics Department Staff Shall:

13.1. Receiving patients and visitors who came to the emergency department.

13.2. Register patients, update data and collect registration fees.

13.3. Opening visits to patients and coordinating with nursing for those in need of medications without seeing the doctor as walk in-visit (proxy).

13.4. Opening a visit for patients examined by nursing (ED visit).

13.5. Coordinating appointments for new cases with the Appointments Section during official working hours and after official working hours, coordinating with the Appointments Section through WhatsApp. And the patient or the relatives

should also be informed to send a message through WhatsApp to get an appointment. *(refer to appendix 2)*

13.6. Collecting laboratory and pharmacy fees for expatriate patients.

13.7. Collection of fees in cases of hospitalization for expatriate patients.

14. Nursing supervisor Shall:

14.1. Take account in the provision of administrative and clinical leadership in area of responsibility.

14.2. Co-ordinate the provision of the human and material resources required in the department to meet the patients' needs.

14.3. Take account the reviews and follow the experience of the front-line staff nurses and other nurse's services users.

14.4. Co-ordinate with units' nurses, wards in charges, and other service providers with regard to patients' activities.

14.5. Assume the accountability for staff education, training, guiding and involvement in the development programs.

14.6. Plan, organize and leads nursing services provision for the units or departments.

14.7. Communicate effectively within the multidisciplinary team, to provide accurate and timely information.

14.8. Provides clinical supervision and support and reviews patterns of care delivery and develops strategies to address patient care problems and other related issues.

14.9. Act as an advisor and role model person for the delivery of expert nursing care to patients with complex health related problems.

14.10. Responsible for the reviewing of patients care management protocols and critical paths and patient care outcomes.

14.11. Rapidly assess situations and determine the provision of safe patients care delivery.

14.12. Nursing shift duty supervisor is responsible to notify each shift-in charge who will assess the status of their wards and staff to maintain normal operation.

14.13. Round The clock (RTC) Nurse Supervisor responsible to Notifies, Coordinates and works with all concerned departments:

- *CSSD*
- *Laboratory*
- *X-ray Dep*
- *Laundry Dep*
- *Engineering and bio-medical engineer*
- *Housekeeping*
- *Shift in-charges of the wards*

14.14 The RTC Nurse supervisor shall take accountabilities to:

- Control patients flow in and throughout the hospital.
- Coordinate with PRO to arrange and make any necessary plan.
- Check the availability of beds.
- Ensure safety of all patients, health workers, visitors and attendants.

14.15 Document any information and report any problems or concerns to the Head of Departments (HODs).

15 Infection Control Staff Shall:

15.1. Ensure that emergency department employees follow infection control policies and guidelines. Conduct routine audits and evaluations to ensure compliance and provide comments.

15.2. Ensure that all emergency staff maintain standard percussion and proper hand hygiene.

15.3. Implement strategies for isolating patients with infectious illnesses in the emergency department to avoid infection transmission.

16 **Ambulance driver Shall:**

Please refer to job description from the local side.

17 Public Relation Officer (PRO) Shall:

17.1. Collaborate with other multidisciplinary team members regarding any administrative issue.

17.2. Contact police from the forensic department for any issue related to patients (e.g.: breaking the rules and regulations of the hospital, position of weapon, alcoholic intoxicated patients, drug possession).

17.3. Ensure appropriate involvement of family member/ concerned agency if needed.

17.4. Contact with police and relatives in case the psychiatric patient went LAMA or left without being seen or absconded and he/she has any risky behaviors.

17.5. Contact with relatives if the patient from D unit went lama.

18. Security staff Shall:

18.1. Checking the patient and relative by metal detector before entering the triage and Before admission.

18.2. Provide full security for the department.

Documentation and Communication:

- All triage decisions and subsequent interventions should be clearly documented in the patient's medical record.
- Effective communication should be maintained between all healthcare professionals involved in the triage and treatment of the patient.

Compliance: All healthcare professionals, staff, and facilities involved in emergency psychiatric care must adhere to this policy. Failure to comply with the policy may result in disciplinary action.

Review: This guideline will be routinely reviewed [FEB, 2027] to ensure its effectiveness, relevance, and compliance with applicable laws and regulations.

CHAPTER FOUR:

Document History and version control Table

Version	Description	Review Date
1	**Initial Release**	**March 2025**
2		

References:

Gilboy N, Tanabe T, Travers D, Rosenau AM. Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4. Implementation Handbook 2012 Edition. AHRQ Publication No. 12-0014. Rockville, MD. Agency for Healthcare Research and Quality. November 2011.

Definition of triage. (2023, December 6). Merriam-Webster: America's Most Trusted Dictionary. https://www.merriam-webster.com/dictionary/triage

Mental health for emergency departments – A reference guide - Resources. (n.d.). NSW Health. https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mental-health-ed-guide.aspx

Ministry of health, Oman. (2019, June). *Policy of Oman National System for Emergency Triage (ONSET) In Hospitals*. https://www.moh.gov.om/documents/17733/121232/Oman+National+System+for+Emergency+Triage+%28ONSET%29/2ebf4465-80d8-1e77-71be-83bdfc899917

Emergency Medical Education: From First Aid to First Pitch: How ..., https://fastercapital.com/content/Emergency-Medical-Education--From-First-Aid-to-First-Pitch--How-Emergency-Medical-Training-Can-Shape-Startup-Success.html.

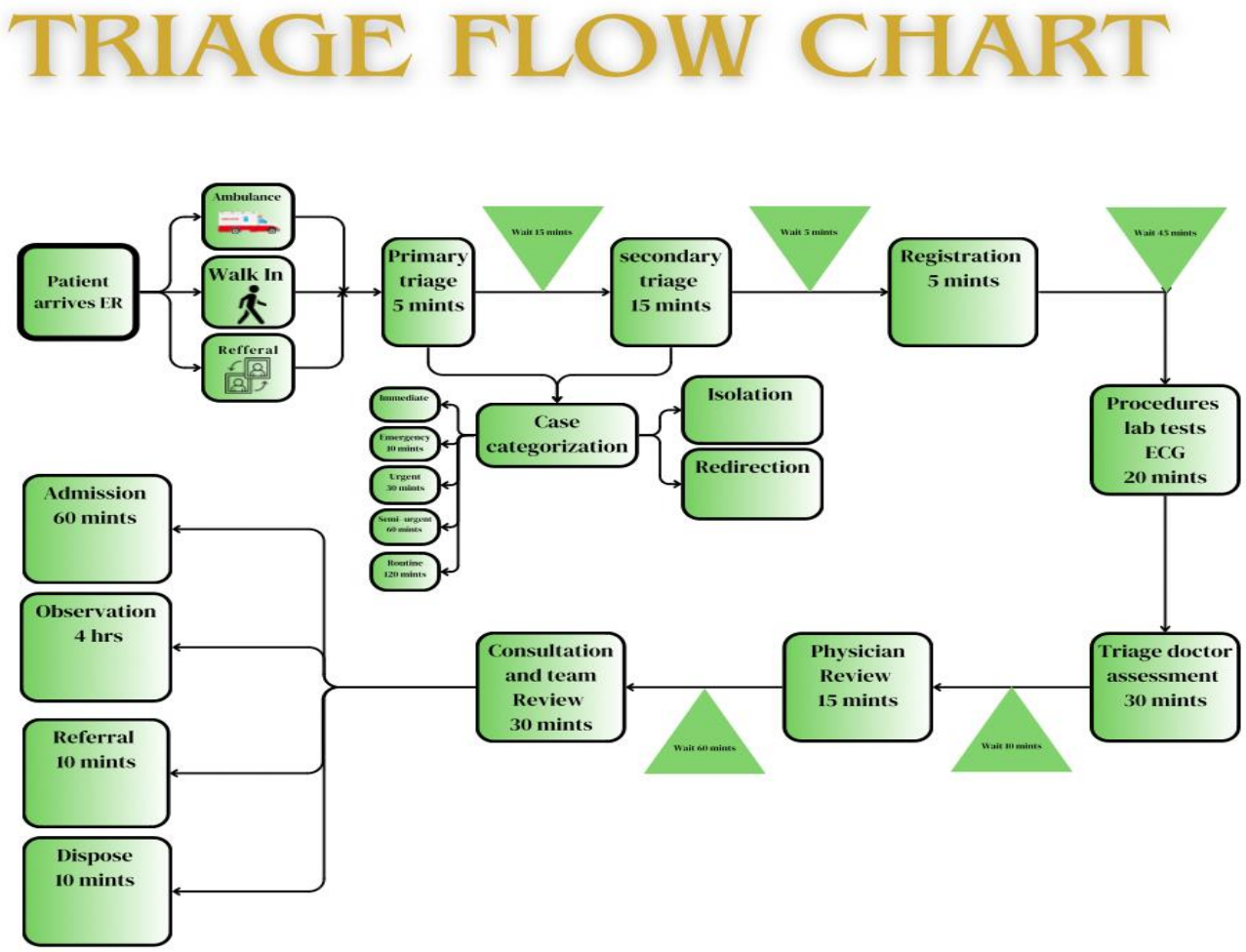
Department of Health | Mental health triage tool, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-mh.

Scales of Emergency Response (Itch#1) | by Beth Sanders | Medium, https://bethsandersca.medium.com/scales-of-emergency-response-69c9cbf5c409.

Benefit Terms and Conditions - Two Mountains, https://www.twomountains.co.za/benefit-terms-and-conditions/.

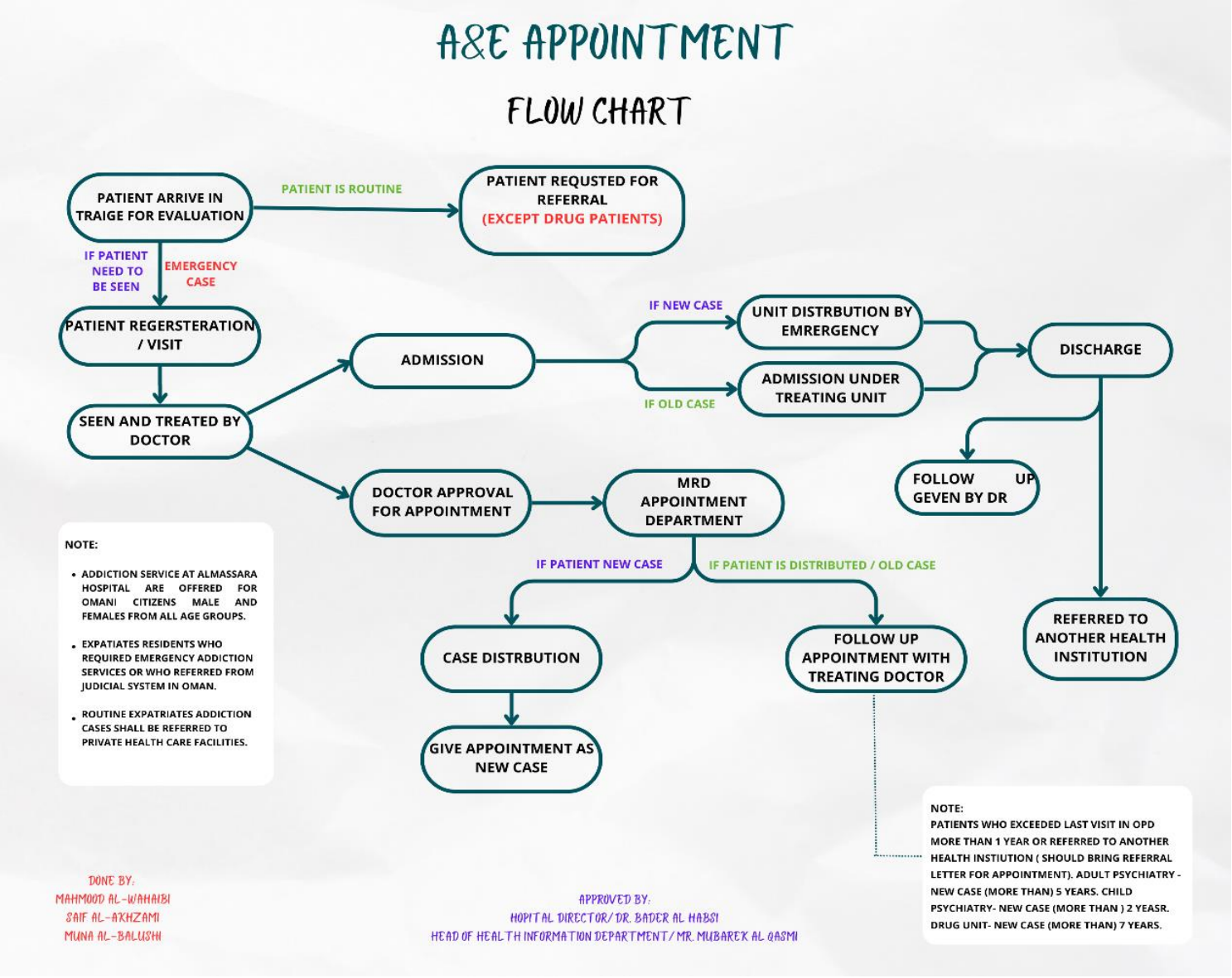
Annexes

Appendix 1. Triage Flow Chart.



Appendix 2.

A&E Appointment Flow Chart



Appendix 3.

Triage Code for Psychiatric Patient (according to Australian Triage Scale for mental Health)

Triage code	*Treatment acuity*	*Description*	*Presentation*	*General management*
1	immediate	There is a clear danger to self or others. The Australasian Triage Scale identifies severe behavioral disorders with an immediate threat of hazardous violence.	**Observed:** • Violent behavior • Possession of weapon • Self-harm in ED • Displays extreme agitation or restlessness • Bizarre/disoriented behavior **Reported:** • Verbal commands to harm self or others that the person is unable to resist (command hallucinations) • Recent violent behavior	**Observation:** intermittent observation, or 2:1 constant observation *(please refer to policy and procedure of patient observation)* **Action:** • Alert the triage doctor or on-call doctor immediately • Provide a safe environment for patients and others • Ensure adequate personnel to provide restraint. **Consider** • Calling security +/– police if staff or patient safety is compromised. • May require several staff to contain patient • Intoxication by drugs and alcohol may cause an escalation in behavior that requires management.

Triage code	**Treatment acuity**	**Description**	**Presentation**	**General management**
2 	Emergency Within 10min	If there is a risk of harm to oneself or others, and/or the client is physically restrained in an emergency department. AND/OR Severe behavioral disturbance. *The Australasian Triage Scale states:* Violent or aggressive: • Immediate threat to self or others • Requires or has required restraint • Severe agitation or aggression	**Observed:** • Extreme agitation/ restlessness • Physically/verbally aggressive • Confused/unable to cooperate • Hallucinations/delusions/ paranoia • Requires restraint/ containment • High risk of absconding • Sign of Delerium • Lithium toxicity • NMS • Overdose drug • Serotonin Syndrome • Hypertensive crisis **Reported:** • Attempt at self-harm/ threat of self-harm • Threat of harm to others • Unable to wait safely	**Observation:** intermittent observation, or 2:1 constant observation *(please refer to policy and procedure of patient observation)* **Action:** • Alert the triage doctor or on-call doctor. • Use de-escalation technique • Provide a safe environment for patients and others • Ensure adequate staff each shift to provide restraint.

Triage code	**Treatment acuity**	**Description**	**Presentation**	**General management**
3 Within 30min	Urgent	**Possible danger to self or others** • Moderate behavioral disturbance • Severe distress *Australasian Triage Scale states:* • Very distressed, risk of self-harm • Acutely psychotic or thought disordered • Situational crisis, deliberate self-harm • Agitated/ withdrawn	**Observed** • Agitated/restless Intrusive behavior • Confused • Ambivalence about treatment • EPS **Reported** • Suicidal ideation • Situational crisis **Presence of psychotic symptoms** • Hallucinations Delusions • Paranoid ideas • Thought disordered • Bizarre/agitated behavior **Presence of mood disturbance** • Severe symptoms of depression • Withdrawn/ uncommunicative • And/or anxiety • Elevated or irritable mood	**Observation:** Close proximity observation, or 2:1 constant observation *(please refer to policy and procedure of patient observation)* **Action** • Alert the triage doctor or on-call doctor. Ensure safe environment for patient and others **Consider** Re-triage if evidence of increasing behavioral disturbance i.e. • Restlessness • Intrusiveness • Agitation • Aggressiveness • Increasing distress (May require to Use de-escalation technique / or restrain)

Triage code	**Treatment acuity**	**Description**	**Presentation**	**General management**
4	Semi-urgent Within 60min	**Moderate distress/ mild restless** No risky behavior *Australasian Triage Scale states:* • Semi-urgent mental health problem • Under observation and/ or no immediate risk to self or others	**Observed** • No agitation/restlessness Irritable without aggression Cooperative • Gives coherent and clear history **Reported** • History of mental health disorder • Symptoms of anxiety or depression without suicidal ideation • Willing to wait	**Observation:** General Observation *(please refer to policy and procedure of patient observation)* **Action** Consult triage doctor or on-call doctor for further management **Consider** Re-triage if evidence of increasing behavioral disturbance, i.e. • Restlessness • Intrusiveness • Agitation • Aggressiveness • Increasing distress

Triage code	*Treatment acuity*	*Description*	*Presentation*	*General management*
5 ☐	Routine Within 120min	**No risky behavior** No acute distress No behavioural disturbance *Australasian Triage Scale states:* • Known patient with chronic symptoms • Social crisis, clinically well patient	**Observed** • Cooperative, manageable and • Able to discuss concerns • Compliant with instructions Reported • Known patient with chronic psychotic symptoms • Previous non-acute mental health disorder • Known patient with chronic unexplained somatic symptoms • Request for medication • Minor adverse effect of medication	**Observation:** General Observation *(please refer to policy and procedure of patient observation)* **Action** Discuss with triage doctor or on-call doctor Redirection to local service if needed

Appendix 4.

SAD PERSONS SCALE

SULTANATE OF OMAN **MINISTRY OF HEALTH** **DOCUMENT CODE:** AMRH/NSG/002/Vers.01 **DATE CREATED:** 17/03/2013 **DATE TO BE REVIEWED:** 22/05/2021 Rev:22/05/2019 **DEVOLOPED BY:** CNII **APPROVED BY:** NSG AFFAIRS DEPT.	**AL MASARRA HOSPITAL** **NURSING AFFAIRS DEPARTMENT** SUICIDE RISK ASSESSMENT CHECKLIST **(SAD PERSONS SCALE)**	**PATIENT STICKER**
PATIENT'S DIAGNOSIS:	**DATE:**	**TIME:**

	RISK FACTORS	CRITERIA	POINTS ASSIGNED	ASSESSMENT SCORE
S	Sex	Male	1	
A	Age	< 20years; > 45 years	1	
D	Depression	Major (e.g. depression)	1	
P	Psychiatric History	Previous suicidal attempt	1	
E	Excessive Alcohol/Drug Misuse	Ethanol/excessive alcohol or drug abuse	1	
R	Rational Thinking loss	Psychosis; Organic Brain Disorder	1	
S	Separation	Separated/Divorced/Widowed	1	
O	Organized Plan	Determined suicide plan/serious attempt	1	
N	No Social Support	Isolated or no community back up	1	
S	Sickness	Terminal/Chronic illness, debilitating, severe: e.g. non-localized cancer, AIDS	1	
			10	

SCORE	INTERPRETATION
0-2	Little Risk
3-4	Close Monitoring for Patient
5-6	Strongly consider hospitalization
7-10	Very High Risk Hospitalization for further assessment
Signature of Assigned Staff	
Signature of Shift in Charge	

Note: Regardless of the score obtained, overall clinical assessment is still paramount and the primary care doctor/Psychiatrist must perform a separate assessment to patient and observe necessary precautions. This serves as a nursing clinical guide and teaching reference. Reference: ***Patterson WM, Dohn HH, Bird J, et al. Evaluation of suicidal patients: the SAD PERSONS Scale. Psychosomatics 1983***

Appendix 5.

Alcohol Withdrawal Scale

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: NSS - 20 DATE CREATED: 20/11/2011 DATE REVIEWED: 18/05/2016 DEVOLOPED BY: CNI APPROVED BY : NSG AFFAIRS DEPT	AL- MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT ALCOHOL WITHDRAWAL SCALE	PATIENT STICKER

SYMPTOMS	0	1	2	3	4
Perspiration	No sweating	Barely perceptible sweating, Moist palms	Moist palms & localized beads of sweat on face and chest.	Whole body wet with perspiration	Profuse sweating, Patients clothes and bed linen completely wet.
Anxiety	Calm	Mildly anxious	Moderately anxious or guarded so anxiety is inferred	Anxious and fearful and difficult to control/calm down	Uncontrolled anxiety including panic attacks
Tremors	No tremors	Positional hand tremor only	Constant slight tremor of hands	Constant marked tremor of hands	Tremors observed even with arms not extended
Agitation	Normal activity	Slight restlessness, unable to remain in one place & unable to sleep.	Tense, moves constantly, but obeys requests/instruction.	Constantly restless, unable to remain on bed and unable to sleep disturbing other clients.	Highly excited
Hallucination	No evidence of hallucination	Distorted by existing objects but aware of it	Verbalizes appearance of totally new objects or false perception. But accepts not real if pointed out	Believes that hallucinations are real.	Hallucinations with no meaningful contact with reality.
Orientation	Fully oriented to time place and person.	Oriented to person but not sure of time and place	Oriented to per son but disoriented to time and place	Disoriented to time and place & patchy in person	Totally disoriented, no meaningful contact can be established.
Temperature	37.0 C	37.1 to 37.5 C	37.6 to 38.0 C	38.1 to 38.5 C	Above 38.5 C

Scoring keys:
0 to 4: Mild
5 to 9: Moderate
10 to 14 Severe

Appendix 6.

Clinical Opioid Withdrawal Scale

MINISTRY OF HEALTH SULTANATE OF OMAN DOCUMENT CODE:NSS-27 DATE CREATED: 12/12/2013 DATE TO BE REVIEWED: 12/12/2015 DEVELOPED BY: NSS APPROVED BY: NSG AFFAIRS	**AL MASARRA HOSPITAL** **NURSING AFFAIRS DEPARTMENT** **CLINICAL NURSING SERVICES SECTION** **CLINICAL OPIATE WITHDRAWAL SCALE (COWS)**	**PATIENT STICKER**

Flow Sheet for Measuring Opioids Withdrawal Symptoms over a Period of Time

For each item, write in the number that best describes the patient's signs and symptoms. Rate just the apparent relationship to opioids withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* **0** pulse rate 80 or below **1** pulse rate 81-100 **2** pulse rate 101-120 **4** pulse rate greater than 120	**GI Upset**: *over last ½ hour* **0** no GI symptoms **1** stomach cramps **2** nausea **3** vomiting **5** Multiple episodes of diarrhea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* **0** no report of chills or flushing **1** subjective report of chills or flushing **2** flushed or observable moistness on face **3** beads of sweat on brow or face **4** sweat streaming off face	**Tremor** *observation of outstretched hands* **0** No tremor **1** tremor can be felt, but not observed **2** slight tremor observable **4** gross tremor or muscle twitching
Restlessness *Observation during assessment* **0** able to sit still **1** reports difficulty sitting still, but is able to do so **3** frequent shifting or extraneous movements of legs/arms **5** Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* **0** no yawning **1** yawning once or twice during assessment **2** yawning three or more times during assessment **4** yawning several times/minute
Pupil Size **0** pupils pinned or normal size for room light **1** pupils possibly larger than normal for room light **2** pupils moderately dilated **5** pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** **0** none **1** patient reports increasing irritability or anxiousness **2** patient obviously irritable anxious **4** patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* **0** not present **1** mild diffuse discomfort **2** patient reports severe diffuse aching of joints/ muscles **4** patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh Skin** **0** skin is smooth **3** piloerrection of skin can be felt or hairs standing up on arms **5** prominent piloerrection
Runny Nose or Tearing *Not accounted for by cold symptoms or allergies* **0** not present **1** nasal stuffiness or unusually moist eyes **2** nose running or tearing **4** nose constantly running or tears streaming down cheeks	**SCORE:** **Mild = 5-12** **Moderate = 13-24** **Moderately Severe = 25-36** **Severe Withdrawal = more than 36**

Appendix 7.

BRØSET VIOLENCE CHEKLIST (BVC)

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: NSS -25 DATE CREATED:27/01/2013 Rev:09/05/19 DATE TO BE REVIEWED: 09/05/21 DEVOLOPED BY: CNI APPROVED BY : NSG AFFAIRS DEPT	AL MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT CODE WHITE RESPONSE FORM WITH BRØSET VIOLENCE CHEKLIST (BVC)	PATIENT STICKER

DATE		**LOCATION OF INCIDENT**	
TIME		**OTHER CLIENT INVOLVED**	
TRIGGER OF INCIDENT			

BRØSET VIOLENCE CHECKLIST (BVC)
(Please put a tick √ mark if the behavior is present then count the total score)

										Score Interpretation with Suggested Management
Date										
Time										**0 = THE RISK FOR VIOLENCE IS LOW**
Confused										
Irritable										**1-2 =THE RISK OF VIOLENCE IS MODERATE Preventative Measures should be taken (e.g. Verbal De-escalation, Diversion technique, Quiet Room)**
Boisterous										
Verbal threats										
Physical threats										**>2 = THE RISK OF VIOLENCE IS HIGH Preventative Measures should be taken, Plan should be developed to manage potential violence (e.g. Verbal De-escalation, SOS, Seclusion, Restraint)**
Attacking objects										
TOTAL										

Additional Observed Behavior:

Confused: Appears obviously confused and disorientated. May be unaware of time, place or person.	**Verbal threats:** A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a grumbling aggressive manner.
Irritable: Easily annoyed or angered. Unable to tolerate the presence of others.	**Physical threats:** Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Boisterous: Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.	**Attacking objects**: An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; Kicking, banging or head-butting an object; or the smashing of furniture.

INTERVENTIONS RENDERED (Please put a tick √ mark in the box listed below)

1	**Doctor Notified**		8	**Physical Restraint**	
2	**Psychotherapy**			**Specify type of restraint used:**	
3	**Diversion Technique**		9	**Chemical Restraint (SOS medication Administered)**	
4	**Verbal De-escalation Technique**		10	**Debriefing Rendered**	
5	**Escorted Client**		11	**Constant Observation**	
6	**Provided low environmental stimuli (Quiet Room)**		12	**QA Event Reporting and Documentation**	
7	**Seclusion Room**		13	**Others pls. specify:**	

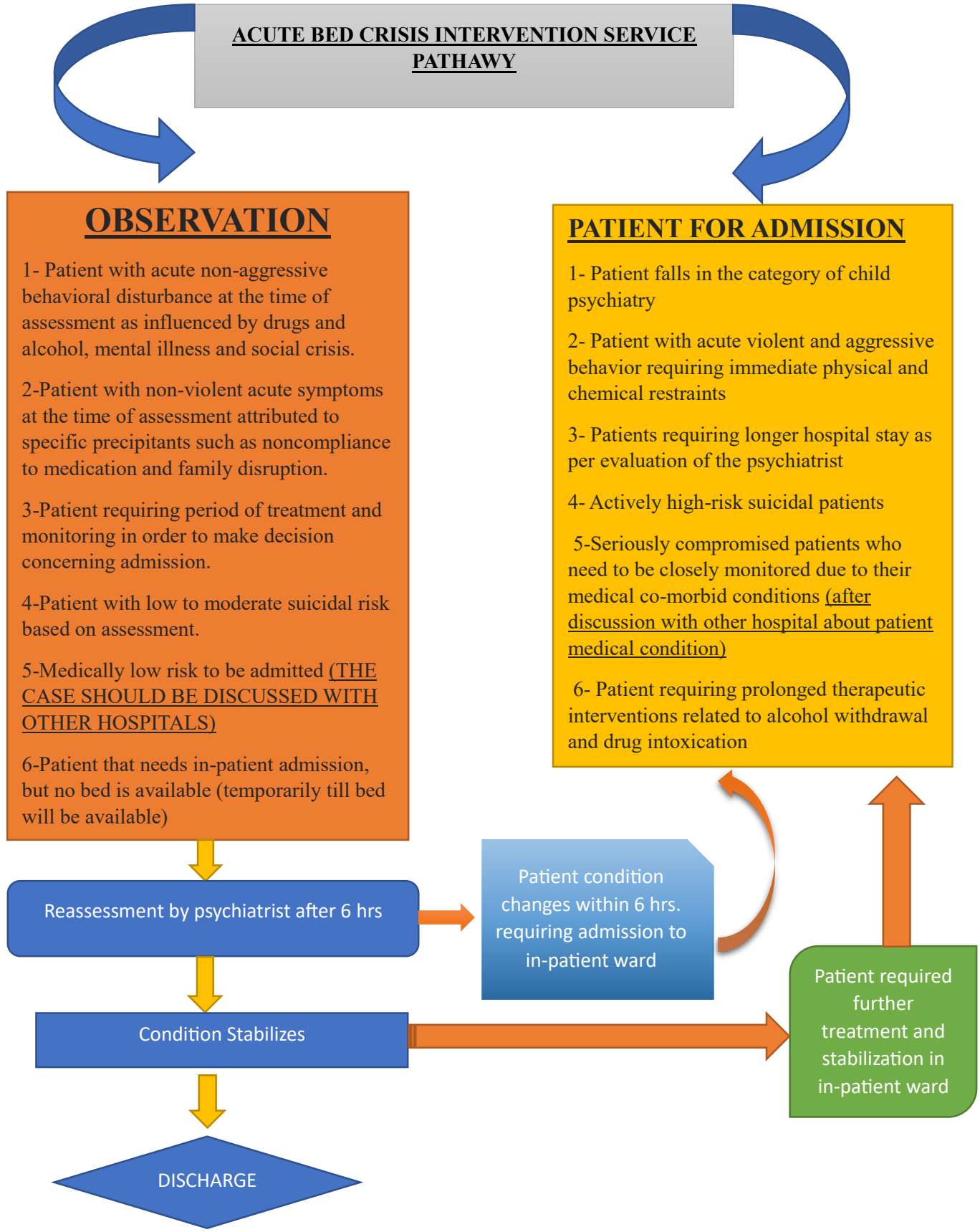
SOS MEDICATION ADMINISTERED

NAME OF MEDICATION	DOSAGE	ROUTE	FREQUENCY	TIME
CLIENT EVALUATION				

TEAM MEMBERS AND OTHER RESPONDERS

NO.	NAME	TASK PERFORMED	SIGNATURE
1.			
2.			
3.			
4.			
CODE WHITE LEADER			
NURSING SUPERVISOR/ WARD IN CHARGE			

Appendix 8.


ACUTE BED CRISIS INTERVENTION SERVICE PATHAWY
OBSERVATION
1- Patient with acute non-aggressive behavioral disturbance at the time of assessment as influenced by drugs and alcohol, mental illness and social crisis.
2-Patient with non-violent acute symptoms at the time of assessment attributed to specific precipitants such as noncompliance to medication and family disruption.
3-Patient requiring period of treatment and monitoring in order to make decision concerning admission.
4-Patient with low to moderate suicidal risk based on assessment.
5-Medically low risk to be admitted (THE CASE SHOULD BE DISCUSSED WITH OTHER HOSPITALS)
6-Patient that needs in-patient admission, but no bed is available (temporarily till bed will be available)
PATIENT FOR ADMISSION
1- Patient falls in the category of child psychiatry
2- Patient with acute violent and aggressive behavior requiring immediate physical and chemical restraints
3- Patients requiring longer hospital stay as per evaluation of the psychiatrist
4- Actively high-risk suicidal patients
5-Seriously compromised patients who need to be closely monitored due to their medical co-morbid conditions (after discussion with other hospital about patient medical condition)
6- Patient requiring prolonged therapeutic interventions related to alcohol withdrawal and drug intoxication
Reassessment by psychiatrist after 6 hrs
Patient condition changes within 6 hrs. requiring admission to in-patient ward
Condition Stabilizes
Patient required further treatment and stabilization in in-patient ward
DISCHARGE

Appendix 9.

Admission Consent Form for Youth in Al Masarra Hospital

Department Name:
Admission Date:
Patient Name:
Date of Birth:
ID/Residence Number:

I, the undersigned,

Name: [Parent/Guardian Name]
ID/Residence Number:
Relationship to the Patient:

Hereby consent to the admission of my son/daughter/minor under my care, [Patient Name], to Al Masarra Hospital for the purpose of receiving necessary treatment as per the medical diagnosis and therapeutic recommendations provided by the specialized medical team.

I also agree to:
1. Conduct the necessary medical and psychological evaluations and assessments.
2. Follow the therapeutic plans, including medication, behavioral therapy, and counseling sessions as needed.
3. Comply with the hospital's rules and regulations to ensure the safety of the patient and all residents.

I acknowledge that I have understood all the therapeutic procedures, that the patient's rights and obligations have been explained to me, and I take full legal responsibility regarding my consent.

Signature:
[Parent/Guardian Signature]
Date:

Treating Physician's Signature:
[Physician Name and Signature]
Date:

Please note that all provided information will be treated with complete confidentiality in accordance with applicable laws and regulations.

Appendix 10. Audit Tool

Department: _____

Date: _____

Auditor's Name: _____

#	Criteria	YES	No	N/A	Remarks
Knowledge of the Guideline/procedure/protocol (interview)					
1	Is/ are the staff/ doctors aware of the content of the document?				
2	Is/ are the staff/ doctors aware of the guidelines and procedures of the emergency Department?				
3	Is/ are the staff aware of the Triage System Guidelines?				
Training or (Document Review & Interview)					
4	Is there training conducted?				
5	Are the doctors/ staff following recommended guidelines for the emergency Department				
6	Are the triage nurses documenting triage information including assessment, correct category, vital signs, Level of consciousness and MSE?				
Observation					
7	Are the triage nurses assessing and identifying clients at risk for suicide using triage risk assessment (SAD) or risk of violence using BVC Checklist?				
8	Are the triage nurses assessing the risk of fall for all patients?				
9	The patient was identified according to the urgency of the condition and appropriate care was provided by the staff				

Appendix 11: Document Request Form

Document Request Form			
Section A: To be completed by Document Writer			
Writer Details			
Name	Muna Abdullah Al Balushi	Date of Request	*March 2024*
Institution	*Al Masarra Hospital*	Contact information	*96656866*
Department	Emergency Department		
Purpose of Request: ☒ **Develop new document** ☐ Modify existing document ☐ Cancel existing document			
Document Information			
Document title (for new & existing documents)	Guideline of Emergency Psychiatric Department		
Document code (for existing documents)	AMRH/ED/GUD/001/Vers. 01		
Required Amendments	---		
Reasons	New Document		
Section B: To be completed by **Document Section of Quality Management and Patient Safety**			
☒ Approved ☐ Rejected ☐ Cancelled			
Comment and Recommendation: Proceed with the work			
Name and Title	Kunooz Al Balushi Document Manager	Date	April 2024

Appendix 12: Document Validation Checklist

Document Validation Checklist					
Document Title: Guideline of Emergency Psychiatric Department		**Document Code:** AMRH/ED/GUD/001/Vers. 01			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Footer complete	✓			
1.3	Involved departments contributed	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
3.	**Well defined procedures and steps**				
3.1	Procedures/methods in orderly manner	✓			
3.2	Procedure/methods define personnel to carry out step	✓			
3.3	Procedures/methods define the use of relevant forms	✓			
3.4	Procedures/methods to define flowchart	✓			
3.5	Responsibilities/Requirements are clearly defined	✓			
3.6	Necessary forms/checklist and equipment are listed	✓			
3.7	Forms/Checklist are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Procedures/methods are adherent to MOH rules and regulations	✓			
4.2	Procedures/methods are within hospital/department scope	✓			
4.3	Relevant central policies are reviewed	✓			
4.4	Used of approved font type and size	✓			
4.5	Language is clear, understood and well structured	✓			
Reviewed by: **Kunooz Al Balushi**