Ministry of Health

Al Masarra Hospital

Guideline of Adult Psychiatry Admission

(Administration Department)

Document Title	Guideline of Adult Psychiatry Admission
Document Type	Guideline
Directorate/Institution	Al Masarra Hospital
Targeted Group	Clinical Nursing Staff; Healthcare Provider
Document Author	Taskforce
Designation	Taskforce
Document Reviewer	Taskforce
Designation	Taskforce
Release Date	September 2023
Review Frequency	Three years

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Date	October 2022	Date	October 2022

Acknowledgement:

The team acknowledges the whole team, the writers, the reviewers, and all contributors who shared endeavors towards completion of this document.

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Acronyms

AMRH	Al Masarra Hospital
HOD	Head of Department
ED	Emergency department
OPD	Outpatient department
PRO	Public Relation officer
BVC	Broset Violence Score
AWS	Alcohol withdrawal scale
COWS	Clinical Opiate Withdrawal Scale

Definitions

- Admission of a patient means allowing and facilitating a patient to stay in the hospital ward for observation, investigation or treatment of the disease.
- Hospitalization in Mental Health Facility is indicated when the person is severely depressed and suicidal, severely psychotic, experiencing alcohol or drug withdrawal, or exhibiting behaviors that require close supervision in a safe and supportive environment.
- Voluntary or self-admission: it means that the patient is having the capacity to make decisions about his/her mental healthcare and treatment. Decision making capacity depends on several elements. For instance, level of understanding, insight, evaluation, reasoning and abilities related to making a choice and communication. The independent patient can ask to leave the hospital at any time and can do so without asking for consent as well. Involvement of PRO is needed to inform the concerned first degree relative about the admission.
- Involuntary or supported admission: it means the patient does not have the capacity to decide about his/her mental healthcare and treatment. Involuntary admission can be given to patients who have a serious psychiatric disorder with a risk of harming self or others.
- Routine admission: it means the patient is admitted in a planned period for specific investigation, diagnostic test or making an alteration in the psychiatric treatment.
- Acute admission: this is when the patient needs urgent psychiatric help. It also known as an emergency admission to an acute psychiatry unit. The aim of this kind of hospitalization is to control the symptoms and ensure the safety of the patients and the people around them.

CHAPTER ONE:

Introduction:

Al Masarra Hospital (AMRH) is a tertiary hospital specialized in providing psychiatric care for mentally ill clients through using curative and preventative measures. The hospital is divided into main sub-departments, the outpatient departments and the inpatient departments. The outpatient departments include both the Out Patient Department (OPD) and Emergency Departments (ED). Both departments play an important role in the first phase of admission cycle.
This document discusses the guideline of admitting adult client into psychiatric wards and the required intervention and procedures when the client has been already decided for admission in the hospital. In addition, it highlights the role of various multidisciplinary personnel when the patient is going through the admission procedure and their responsibilities in this regard. A flowchart is attached in the Annexes section to simplify the vital steps and to offer a clear picture for the whole process.

Purpose:

- To ensure appropriate admission procedure and maintain accurate data for all admitted male and female psychiatric patients.
- To provide proper and effective guidelines to all the ward staff with regard to safe and standard admission procedure.
- To provide an organized admission services for all patients by meeting individuals needs and establish a plan of ongoing care.
- To ensure psychiatric patients receive comprehensive and holistic care through proper assessment.

Scope

Psychiatric Admission Policy applies to all multidisciplinary treating team members in Al-Masarra Hospital (AMRH) who works directly with the patients and the policy scope covers adult psychiatric patients only, who are above 18 years old. For patients under 17.5 years old (*Refer Policy & Procedure of Child admission)*

Structure

This is the first version of this guideline and it consists of three chapters. Chapter one entails the Introduction, Purpose and Scope. Second chapter contains the Guidelines and Procedure of Adult Psychiatry Admission in Ambulatory Areas covering male and female patients. Chapter three includes the responsibilities of staff nurses, shift in charges, the ward in charges, clinical instructors and supervisors in relation with this guideline.

CHAPTER TWO:

Guideline

1. Acute psychiatric inpatient hospitalization is a highly structured level of care designed to meet the needs of individuals who have emotional and behavioral manifestations that put them at risk of harming self or others, or otherwise render them unable to care for themselves.

2. The client has a psychiatric diagnosis or provisional psychiatric diagnosis.

3. The psychiatric patient with medical conditions that require a high level of care in critical care units will not be admitted in the hospital due to the unavailability of critical care facility. Therefore, all patients before being admitted will be medically cleared by the physician and physically examined to exclude any serious medical conditions that need an urgent referral to other healthcare facilities.

4. Male/female clients who are 17.5 years old and above can be admitted in the adult Male/Female psychiatric wards. For patients under 17.5 years old, the Policy & Procedures of Child and Adolescent in Patient Services, the criteria for admission, will be followed. *(Refer to Child & Adolescent in Patient Services, Admission Policy & Procedure, AMRH/CAPD/P&P/001/Vers.01)*

5. Admission is decided after full and clear assessment from psychiatrist or concern specialized treating doctor. The purpose of admission, expected duration and therapies vary by conditions. The admitting doctor can give estimated duration of admission according to patient's diagnosis, chief complains and document it clearly in the treatment plan.

6. The purpose of admission and management plan should be explained by the admitting doctor. After the explanation, staff nurse will proceed with the admission consent form in the system; and to be signed by the patient or family member prior to admission.

7. Admission process should be well communicated through proper channels between all multidisciplinary personnel including admitting doctor, specialized psychiatrist, hospital bed manager, nursing supervisor, ward in-charge nurse and the assigned ward nurse.

8. Admission of Non-Omani psychiatric patients must include sponsor consent or any concerned agency before the admission and PRO must be notified to do the needed interventions.

Procedure

1. The assigned staff receives the patient from: car, ambulance, and wheelchair or by walking, then welcomes the patient; provide privacy and comfortable place for both the patient and relatives.

- Assess the patient for mental states examination. If in emergency department (ED), fill ED Triage registration form in Al Shifa System and categorize the case (i.e.: routine, urgent and emergency).
- Check the vital signs of the patient, weight and height and RBS as per doctor's order.
- Check doctor order for admission in the system.
- Identify the patient accurately by confirming key identifiers, e.g., patient's full name, medical record number and date of birth.
- Ensure purpose of admission and management plan are explained by the doctor to both the patient and his family.
- Explain hospital policy and regulation.
- Ensure the agreement of admission from patient's family and in case of self-admission; PRO must be involved to inform the concerned close relative about the admission

2. Proceed with the admission consent form in the system; which should include:

- Document ID number of patient and the responsible admitting relative.
- Document three relative names with their contact numbers.
- Obtain signature of admission from patient or responsible admitting relative.
- The admitting nurse finalizes the admission consent by signing for verification.

3. Perform nursing assessment and needed interventions including:

- Mini mental status examination (MSE) (*Refer to appendix 2).*
- Checking of vital signs and recording it in the system.
- Check doctor order for any laboratory tests required or ECG.

- Assess the need for medical clearance and physical examination.
- Assess the need for any physical or chemical restrain.
- Check patient's visional parts of body for any marks like; abrasions, trauma, injury, hematoma. And notify the doctor for the need of Medico- legal form. If the patient is uncooperative for body check, to document the reason of refusal in nursing Kardex.
- Assess the need for risk assessment score tools such as the Brocet Violence Score (BVC), Alcohol withdrawal scale (AWS), Clinical Opiate Withdrawal Scale (COWS), Sad Person Scale (SPS), Risk For Fall (*Refer to Appendices Section).*
- Assess the need for isolation room and refer to infection control protocol.

4. Inform PRO regarding the admission payment if needed for expatriates' patients.

5. Secure ID band with proper type of color, e.g., green, white or red; according to patient condition *(Refer to Policy and Procedure of Patient identification, AMRH/ADMIN/P&P/013/Vers.01).*

6. Patient's belonging should be returned back to relatives if they are available. If self-admission and has valuable things (e.g. money or gold) or the patient refused to give it to his relative; to inform PRO to collect it during the working hour, during the non- working hours, the valuable things to be kept in patient belonging locker inside the ward and to notify the PRO on duty. Patient belonging form to be filled with specific details and signature from duty PRO (*Refer to Appendices Section).*

7. Notify bed manger and shift ward in-charge about the admission before escorting.

8. Escort the patient safely to the ward accompanying by relative.

9. Endorse to the received staff, including:

- Patient name
- Diagnosis, chief complaints,
- Any given medications or pending procedures or investigations.
- Any devices or contraptions connected to the client (example: cannula, NGT, catheter etc.); including the type, location, date and time of insertion.

- Psychiatric history for the client including (multiple admission or new case) and family history of mental or physical illness.
- Patient's physical assessments including presence of any injuries, hematoma or lesion are described in details; e.g. size, type of injury and location.
- Presence or absence of: Allergies, Any physical disabilities or impairment, withdrawal symptoms and delirium symptoms (for patients with substance abuse or alcoholic problems.)
- Special observation or precautions like suicidal precautions, homicidal precautions, fall risks or escape risks.
- Any chemical or physical restraint given to the patient.
- Patient's belonging.
- If the patient needs isolation room as per infection control protocol.

10. Maintain the admission register book including patient sticker, ward name, unit and signature of both endorsed and received staff.

11. Document the admission procedure in nursing Kardex.as per the Guideline and/or Policy of Nursing Documentation. (*Refer to Nursing Documentation Policy, AMRH/ADMIN/P&P/013/Vers.01)*

12. Document all nursing procedures in nursing procedures record.

CHAPTER THREE:

Responsibilities (and/or Requirements)

1. Quality Management and Patient Safety Department (QMPSD) Shall:

- Review the developed document for validation.
- Ensure that all documents are developed, reviewed and approved based on these documents.

2. Doctors Shall:

- Ensure complete and clear assessment of patient condition upon assessing the patient in both ED and OPD.
- Ensure that there is no contradiction for admission in the psychiatric ward.
- Ensure proper explanation including purpose of admission and management plan is well explained to the patient or family members.
- Document the treatment plan clearly and completely including the management plan and level of observation required.

3. Public Relation Officer (PRO) Shall:

- Collaborate with other multidisciplinary team members with regard to any administrative issues.
- Ensure appropriate involvement of family members/ concerned agency if needed during the admission procedure.

CHAPTER FOUR:

Document History and Version Control Table

Version	Description	Review Date
1	Initial Release	September 2023
2	Version Two	September 2026
3		

References:

- Frauenfelder, F., Müller-Staub, M., Needham, I., & van Achterberg, T.(2013) Nursing interventions in inpatient psychiatry. Journal of psychiatric and mental health nursing, 20(10), 921-931.
- Balan, Y., Murrell, K., & Lentz, C. B. (2017) Big Book of Emergency Department Psychiatry: A Guide to Patient Centered Operational Improvement. Taylor & Francis.
- Sjöstrand, M., Karlsson, P., Sandman, L., Helgesson, G., Eriksson, S., &Juth, (2015) Conceptions of decision-making capacity in psychiatry: interviews with Swedish psychiatrists
- Crowe, M.(2006) Psychiatric diagnosis: some implications for mental health nursing care. Journal of Advanced Nursing, 53(1), 125-131.

Annexes

Appendix 1.Flow Chart of Procedure for Adult Psychiatric Admission

Appendix 2.Clinical Opiate Withdrawal Scale Form (COWS)

MINISTRY OF HEALTH SULTANATE OF OMAN DOCUMENTCODE: AMRH/ADMIN/GUD/05/FRM1/Vers01 REVIEW DATE: OCTOBER 2023	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** piloerection of skin can be felt or hairs standing up on arms **5** prominent piloerection
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 3.Alcohol Withdrawal Scale Form (AWS)

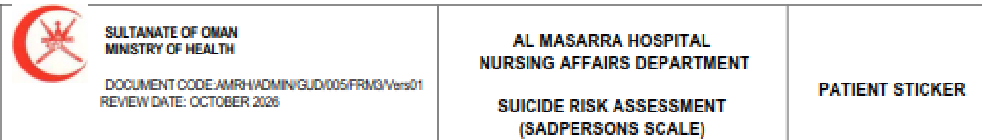
SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: AMRH/ADMIN/GUD/005/FRM2/Vers01 REVIEW DATE: OCTOBER 2026	AL- MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT ALCOHOL WITHDRAWAL SCALE	PATIENT'S STICKER

SYMPTOMS/SCALE	0	1	2	3	4
Perspiration	No 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	Slightly apprehensive	Apprehensive and easily gets distressed	Anxious and fearful and difficult to control/calm down	Uncontrolled anxiety including panic attacks
Agitation	Normal activity	Slight restlessness, unable to remain in one place & unable to sleep.	Tense, moves constantly, but obeys requests/instruction.	Constantly restless, un able 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 the 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 4.Suicide Risk Assessment (Triage & Inpatient)

4.1. Triage



SULTANATE OF OMAN
MINISTRY OF HEALTH

DOCUMENT CODE:AMRH/ADMIN/GUD/005/FRM3/Vers01
REVIEW DATE: OCTOBER 2026

AL MASARRA HOSPITAL
NURSING AFFAIRS DEPARTMENT

SUICIDE RISK ASSESSMENT
(SADPERSONS SCALE)

PATIENT STICKER

PATIENT'S DIAGNOSIS: DATE: TIME:

Risk Factors	Number of Points Assigned	Assessment Score
1. Sex: Male	1	
2. Age: < 20 years; > 45 years	1	
3. Depression: Major Depression	1	
4. Previous suicidal attempt	1	
5. Excessive Alcohol or drug abuse	1	
6. Rational Thinking loss, Psychosis, Organic Brain Disorder	1	
7. Separated/Divorced/widowed	1	
8. Organized Plan or serious attempt	1	
9. No Social Support	1	
10. Sickness: especially if chronic, 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 Hospitalisation 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 PERSON Scale. Psychosomatics 1983*

4.2 Inpatient

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: AMRH/ADMIN/GUD/05/FRM4/Vers01 REVIEW DATE: OCTOBER 2026	AL MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT IN-PATIENT SUICIDE ASSESSMENT CHECKLIST	PATIENT'S STICKER

PATIENT'S DIAGNOSIS: WARD: DATE:

ASSESSMENT DATA	MORNING SHIFT	AFTERNOON SHIFT	NIGHT SHIFT
1. **Feeling of Hopelessness**-Client is unable to see self in the future.			
2. **Suicidal ideas**-Client speaks and preoccupied with suicidal thoughts.			
3. **Suicidal plan**- Client is able to give an exact method/means on how to end his/her life.			
4. **Unexpected change in behaviour**- Client is making a will, giving away important possessions, intense or serious talk with friend.			
5. **Auditory hallucinations**- Client is hearing voices commanding him/her to end his/her life.			
6. **Depressed or Anxious mood**- Client is in depressed or anxious mood due to an underlying depression.			
7. **Unexpected change in mood**- Client suddenly becomes cheerful, angry or withdrawn.			
8. **Recent loss of loved ones or important relationships**- Client is having a disrupted family life, undergoing bereavement/grief, poor support system and social isolation.			
9. **Presence of terminal illness or chronic pain**- Patient is recently diagnosed with terminal illness such as AIDS or Cancer.			
10. **Depressed client who begin with antidepressant treatment**- Client may have an increased risk for suicide for the first few weeks of therapy.			
11. **History of previous suicidal attempt and presence of suicidal risk**- Client is having history of attempted suicide, history of alcohol and drug substance abuse and positive result in emergency screening on suicide risk assessment.			
12. **Specific hidden or obvious verbal/non-verbal response** pls. specify:_______________			

NURSING INTERVENTION		
Morning Shift	Afternoon Shift	Night Shift

SIGNATURE OF ASSIGNED STAFF			
SIGNATURE OF SHIFT IN CHARGE			

***Note:** Verify to client if the assessment data is positive then client is having suicidal risk and needs prompt intervention.*
***Disclaimer:** The determination of the presence of suicidal ideation/behaviour depends on the professional judgement of the individual utilizing this assessment checklist form. This serves as a nursing clinical guide and teaching reference for staffs.*

Appendix 5.MSE Form

SULTANATE OF OMAN MINISTRY OF HEALTH Guideline for Psychiatric Nursing Assessment (MSE) AMRH/NSG/GUD/01/FRM01/Vers01 August, 2023	AL- MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT MENTAL STATUS EXAMINATION	Patient Sticker

Ward:	Date of Admission:
Date:	Time:

I. Presentation	II. Stream of Talk
A. General Appearance ○ Well Groomed ○ Unkempt ○ Peculiarities in Appearance Describe:_________________________________ _____	*A. Organization Of Talk* ○ Looseness of Association ○ Neologism ○ Flight of Ideas ○ Circumstantiality ○Echolalia ○ Tangentiality ○ Echopraxia ○Perseveration ○ Clang Association ○ Word Salad Others: ______________________________
B. General Motility Posture and Gait ○ Erect ○ Slouched ○ Walk in Stiff ○ Shuffling ○Mannerisms ○ Tremors ○ Tics ○ Unusual Gestures ○ Posturing ○ Waxy Flexibility Others: _____________ Activity ○ Over Activity ○Under Activity ○ Stereotyped Behaviour ○ Agitation Others:________________________________ Facial Expression ○ Smiling ○ Tense ○Alert ○ Sad Angry ○ Worried ○earful ○Happy ○ Suspicious ○ Distant ○ Ecstatic ○Frightened Others: __________________________________	**III. Emotional State And Reactions** *A. Mood* ○Euthymic ○Depressed ○ Euphoric Others: ____________________________ *B. Affect* ○ Appropriate ○Inappropriate ○Flat ○Blunted ○ Elated ○ Angry ○Labile ○Histrionic ○ Anxious Others: ______________________________ *C. Depersonalization and Derealization* Depersonalization:○ Present ○ Not Present Derealization: ○ Present ○Not Present Remarks: ____________________________

C. Behaviour	*D. Suicidal – Homicidal Potential*
○ Friendly ○ Dramatic ○ Negativistic ○ Seductive ○Hyperactive ○ Withdrawn ○ Angry Others:___________________ *D. Nurse- Patient Interaction* ○Cooperative ○ Uncooperative ○Initially ○ All throughout Others: ____________________________________	○ Present ○ Past history○ Not Present If Present and/or Past History: ○Attempt ○Plan : How ________________ When ________________ Where ________________ ○ Thoughts Remarks : ______________________________________ ______________________________________

IV. Thought Control and Perceptual Disturbance	V. Neuro-vegetative Dysfunction
A. Perception ○Illusion ○Hallucinations○ Visual○ Tactile○ Olfactory ○ Gustatory○ Auditory (○ Commanding) Remarks: ________________________________	*A. Sleep* ○Normal ○ Hypersomnia ○Insomnia : Types: ○ Early ○ Late ○ Mixed Remarks: ________________________________
B. Delusions ○ Thought Control ○ Thought Broadcasting ○ Thought Insertion○ Influence ○ Somatic ○ Persecutory ○ Grandiose Remarks: ________________________________	*B. Appetite* ○Normal ○Increased ○ Decreased Remarks: ________________________________
C. Ideas Of Reference ○ Present ○ Not Present Remarks: ________________________________	*C. Weight* ○Normal ○ Weight Loss ○ Weight Gain Remarks:________________________________
D. Preoccupation and Rumination ○ Preoccupation○ Rumination ○ Rituals ○ Intrusive Thoughts ○ Phobia Remarks: ________________________________	**VI. General Sensorium and Intellectual Status** *A. Orientation* ○Time ○ Place ○ Person ○ Situation Remarks: ________________________________
E. Déjà vu and Jamais Vu Déjà vu : ○ Present ○ Not Present Jamais Vu: ○ Present ○ Not Present Remarks: ________________________________	*B. Memory* ○Remote ○ Recent ○ Immediate Remarks: ________________________________

Appendix 6.Code White Form with BVC

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENTCODE: AMRH/ADMIN/GUD/05/FRM5/Vers01 REVIEW DATE: OCTOBER 2026	AL MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT CODE WHITE RESPONSE FORM WITH 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)

Date										Score Interpretation with Suggested Management
Time										
Confused										0 = THE RISK FOR VIOLENCE IS LOW
Irritable										
Boisterous										1-2 =THE RISK OF VIOLENCE IS MODERATE Preventative Measures should be taken (e.g. Verbal De-escalation, Diversion technique, Quiet Room)
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 7.Patient Belonging's Form

SULTANATE OF OMAN MINISTRY OF HEALTH AMRH/NSG/FRM/03/Vers02 Review Date:	AL- MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT PATIENT BELONGINGS FORM

DEPARTMENT:

CLIENTS STICKER		BED NO: LOCKER NO: DATE OF ADMISSION:
SNO	**ITEMS**	**REMARKS**

Staff Name: Name of Relative:

Signature: Signature:

Date: ID & Tel No:

All the items mentioned above handed over to Client /Relative on:

Staff Name: Name of Relative:

Signature: Signature:

Date: ID & Tel No

Appendix 8.Competency Checklist

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: AMRH/ADMIN/GUD/005/CHL1/Vers.01 Review Date: October 2026	**AL- MASARRA HOSPITAL** **NURSING AFFAIRS DEPARTMENT** **Nursing Procedure Competency Checklist**

Adult Psychiatry Admission Procedure Competency		Revised on: 20/04/2022		
Name:	Area:	Rating	Passed	
Staff No.:	Date:		Failed	

No.	Procedure	S (3)	NI (2)	U (1)	Comments
1.	Assigned staff receives the patient from: car, ambulance, wheel chair or by walking.				
2.	Provides privacy and comfortable place for both the patient and relatives.				
3.	Assess the patient for mental states examination.				
4.	If in emergency department (ED) fill: • ED Triage registration form in Al Shifa System 3+ • Categorize the case (i.e.: routine, urgent and emergency).				
5.	Check patient's initial vital signs, SPO2, weight and height and RBS as per doctor's order.				
6.	Check doctor order for admission in Al Shifa System 3+				
7.	**Identify the patient accurately by confirming key identifiers,** e.g., • Patient's full Name • Medical record number (IP. No.) • Date of birth.				
8.	Ensures patient and family received proper explanation about the admission procedure from the admitting psychiatrist.				
9.	Explains hospital policy and regulation (visiting time, ward set-up etc.)				
10.	Ensure the patient' agreement of admission from patient's family as and in case of self-admission; PRO must be involved as a witness for admission.				
11.	**Proceed with the admission consent form in the system; which should include:** • Full information about patient and relative. • Document ID number of patient and the responsible admitting relative. • Document three relative names with their contact numbers. • Obtain signature of admission from patient or responsible				

	admitting relative. • The admitting nurse finalizes the admission consent by signing for verification.				
12.	Perform nursing assessment and needed Interventions including: • Mini Mental status examination (MSE) • Checking of vital signs and records it in the system. • Check doctor order for any laboratory tests required or ECG. • Assess the need for medical clearance and physical examination. • Assess the need for any physical or chemical restrain. • Check patient's body for any marks like; abrasions, trauma, injury, hematoma. And notify the doctor for the need of Medico- legal form. • Assess the need for using assessment tool, e.g. Brøset Violence Score (BVC), Alcohol withdrawal scale (AWS), Clinical Opiate Withdrawal Scale (COWS), SADPERSONS Scale. • Assess the need for isolation room and refer to infection control protocol.				
13.	Inform PRO regarding the admission payment if needed for expatriates' patients.				
14.	Secure ID band with proper type of color, e.g., green, white or red; according to patient care.				
15.	Patient's belonging should be returned back with relatives if they are available and if self-admission and has valuable things (e.g. Money or gold) or the patient refused to give it to his relative to inform PRO to collect.				
16.	Notify ward shift in-charge about the admission before escorting.				
17.	Escort the patient safely to the ward accompanying by his/her relative.				
18.	Endorse to the receiving staff, including: • Patient Name • Diagnosis • Chief complaints • Any given medications or pending procedures/Investigations. • Any devices/contraptions connected to the client (example: cannula, NGT, catheter etc.); including the type, location, date and time of insertion. • Psychiatric history for the client including (multiple admissions/new case) and family history of mental/physical illness. • Patient's physical assessment including; injuries, hematoma or lesion are described in details which includes; size, type of injury and location.				

	• Presence or absence of: • Allergies • Any physical disabilities and impairment. • Withdrawal symptoms and delirium symptoms for patients with substance abuse or alcoholic problems. • Special observation/precautions like suicidal precautions, homicidal precautions, fall risk and close observations and at risk for escape, etc.Any chemical or physical restraint given to the patient • Patient's belonging. • If the patient needs isolation room as per infection control protocol.				
19.	Maintain the admission register book including patient sticker, ward name, unit and signature of both endorsed and received staff.				
20.	Document the admission procedure in nursing Kardex.				
21.	Document all nursing procedures in nursing procedures record.				
	Total				

Appendix 9.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 aware of the content of the document?				
2	Is/are the staff aware of the risks assessment tools during and prior to admission procedure?				
	Training or (Document Review & Interview)				
3	Is there a training conducted?				
4	Admission procedure explained by the doctor to patient and his/her relative accurately.				
5	Admission consent form filled by admitted nurse in the Shifa system.				
6	Admitted nurse notified bed manger and ward staff about the admission before escorting the patient.				
7	All necessary forms are handed over to the ward staff and documented: Broset Violence Score (BVC) Alcohol withdrawal scale (AWS) Clinical Opiate Withdrawal Scale (COWS) Sad Persons Scale (SPS) Patient belonging				
8	OPD/ED staff document the complete admission procedure in nursing Kardex and recorded in the Nursing Procedure				
	Observation				
9	Mental states examination and vital signs including weight and height of the patient (RBS if require) are done by assigned staff.				
10	Assigned staff approaches the client and welcome him/her and ensure the staff provide privacy and comfortable place for				

	both the patient and relatives				
11	The patient was identified accurately by confirming key identifiers, e.g., patient's full name, medical record number and date of birth				
12	Patient ID band secure with appropriate color coding				
13	OPD/ED staff escort the patient safely to the ward accompanying his/her relative				

Appendix 10: Document Request Form

<table>
<tr><td colspan="4">Document Request Form
MoH/DGQAC/GUD/001/FRM001/Vers.2</td></tr>
<tr><td colspan="4">Section A: To be completed by Document Writer</td></tr>
<tr><td colspan="4">Writer Details</td></tr>
<tr><td>Name</td><td>Khalsa Al-Naabi</td><td>Date of Request</td><td>October 2023</td></tr>
<tr><td>Institution</td><td>Al Masarra Hospital</td><td>Contact information</td><td>-------------</td></tr>
<tr><td>Department</td><td colspan="3">Nursing Affairs</td></tr>
<tr><td colspan="4">Purpose of Request:
☑ Develop new document ☐ Modify existing document ☐ Cancel existing document</td></tr>
<tr><td colspan="4">Document Information</td></tr>
<tr><td>Document title (for new & existing documents)</td><td colspan="3">Guideline of Adult Psychiatry Admission</td></tr>
<tr><td>Document code (for existing documents)</td><td colspan="3">AMRH/ADMIN/GUD/005/Vers.01</td></tr>
<tr><td>Required Amendments</td><td colspan="3">nil</td></tr>
<tr><td>Reasons</td><td colspan="3">nil</td></tr>
<tr><td colspan="4">Section B: To be completed by
Document Section of Quality Management and Patient Safety</td></tr>
<tr><td colspan="4">☑ Approved ☐ Rejected ☐ Cancelled</td></tr>
<tr><td colspan="4">Comment and Recommendation: to proceed with the document</td></tr>
<tr><td>Name and Title</td><td>Kunooz Balushi
(Document Manager, QMPSD)</td><td>Date</td><td>October 2022</td></tr>
</table>

Appendix 11: Document Validation Checklist

Document Validation Checklist					
Document Title: Guideline of Adult Psychiatry Admission		**Document Code:** AMRH/ADMIN/GUD/005/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 Balushi (Document Manager, QMPSD)** [signature]					