Ministry of Health Malaysia

MOH/P/PAK/274.14(GU)

GUIDELINE ON SUICIDE RISK MANAGEMENT IN HOSPITALS

Suicide Risk Management Committee

2014

Medical Services Development Section

Ministry of Health Malaysia

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Medical Services Development Section of the Medical Development Division,
Ministry of Health Malaysia and the Drafting Committee for the
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MESSAGE FROM THE DIRECTOR GENERAL OF HEALTH MALAYSIA

Salam Sejahtera dan Salam 1Malaysia

I would like to congratulate the Psychiatric Services of the Ministry of Health Malaysia for preparing the groundwork of this guideline; and to everyone involved in the writing and reviewing process for their commitment, technical inputs and shared experiences which had resulted in the production of this important guideline.

With the advent of medical technologies, it is important for health professionals to maintain their mindfulness and empathy towards patients. Patients who self-harm are a challenge to our values as healers. It is also a challenge to the system, because we are their custodians. We are bound by our duty to care and duty to protect, so that patients who receive care in our facilities can move on with their lives, despite the impairments caused by their ailments.

This guideline is one of the outputs from our Incident Reporting and Learning System, and illustrates how we can create service improvements at systemic level, with strong clinical governance and willingness to work together as a team. I am optimistic that with the launching of this guideline, there will be increased awareness and competency levels in handling people at risk of suicide in our hospitals. This improvement in the quality of care will be in tandem with the corporate culture movement propagated by the Ministry of Health Malaysia, i.e. Caring, Teamwork and Professionalism. It is also in line with our Government Transformation Plan which is deeply rooted in the motto of 1Malaysia i.e. **"People First, Performance Now".**

It is my greatest wish that each and every one of the staff in Ministry of Health will continue to serve with efficiency, genuineness and non-judgmentally, especially when facing patient who are giving up hope due their chronic health conditions. Let us all give our commitment and work as a team to implement the recommendations in Suicide Risk Management Guidelines for the betterment of our services.

Thank you

Datuk Dr. Noor Hisham Bin Abdullah
Director General of Health, Malaysia

MESSAGE FROM THE TECHNICAL ADVISOR TO THE MINISTRY OF HEALTH FOR PSYCHIATRY AND MENTAL HEALTH

Assessment of suicide risk and management of suicidal patients in hospital wards are highly important aspects of clinical practice that have to be prioritized in all hospitals. Potentially suicidal patients are managed not only in psychiatric wards but in medical, surgical and all other wards. It is essential that all hospital staff, and not only the staff of the Department of Psychiatry and Mental Health, is trained in the requisite skills and knowledge of suicide risk management.

These guidelines are a very important step in the improvement of management of patients with suicidal risk in the hospital. Even more crucial will be the operationalization of these guidelines i.e. translating words into daily clinical and nursing practice. For this to be successful, it is important to have the support of the hospital management, particularly the hospital director, deputy directors as well as all heads of departments and all levels of staff.

In this regard, on behalf of Psychiatric and Mental Health Services of Ministry of Health Malaysia (MOH), I would like to thank the Medical Development Division for their collaboration that has made these guidelines a reality. My appreciation is also extended to the writing team members who have worked tirelessly to produce a comprehensive guideline. This initiative was started in Hospital Selayang: the challenge now is in the implementation and also the dissemination to other hospitals in the MOH.

Thank you.

Dr Toh Chin Lee
Senior Consultant Child and Adolescent Psychiatrist and
Technical Advisor to Ministry of Health for Psychiatry and Mental Health Services

1. INTRODUCTION

Suicide of a patient while in a staffed, round-the-clock care setting is a rare but devastating incident. This has been recognised by the Ministry of Health Malaysia (MOH); which has included inpatient suicide attempts as one of the incidents which requires a mandatory reporting (1).

Ministry of Health (MOH) staff needs to be aware that their patients have an increased risk of suicide. Research on these patients' profiles had identified those who have received a life-threatening diagnosis and who appear particularly agitated, despondent, or withdrawn; or patients who have severe, intractable pain (2). Other factors associated with chronic ill-health e.g. increasing debts, disrupted family ties and loneliness may also put patients at risk.

The challenge is that, suicide in general medical settings has different characteristics from suicides in psychiatric inpatients: past history of psychiatric illness, substance abuse or suicidality is typically absent. Inpatient suicides also tend to be impulsive (3-6). In view of that, hospitals need to improve the competency of non-psychiatric staff in recognizing mental health symptomatology and suicidality. This can be facilitated by having adequate training and screening tools; followed by a referral system for psychiatric consultation services for follow-up of positive responses. The hospital also needs a system that could balance between the seriousness of medical condition vs. the suicide risk posed by the patient.

This document is in line with the quality assurance practices outlined by the Incident Reporting and Learning System Manual (IR Manual)[1] and the Joint Commission on Accreditation of Healthcare Organizations(7) (JCAHO). These guidelines are not to be construed or to serve as a standard of care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve.

2. DEFINITIONS

Defining self-harm is not straightforward due to the varying types of self-harm, the different contexts in which it occurs, and the different motives and meaning for the individual concerned. The NICE guidelines (National Collaborating Centre for Mental Health, 2004)

[1] The IR manual can be accessed online at http://patientsafety.moh.gov.my/uploads/incident_reporting2013.pdf

use the short and broad definition: 'Self-poisoning or self-injury, irrespective of the apparent purpose of the act' (8). Meanwhile, the American Psychiatric Association in its practice guideline for the assessment and treatment of patients with suicidal behaviours gave several definitions for suicidal behaviours, as listed below(9):

2.1. Suicide:Self-inflicted death with evidence(explicit or implicit) that the person intended to die

2.2. Suicide Attempt: Self-injurious behaviour with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die

2.3. Near-miss Suicide Attempt: Potentially self-injurious behaviour with evidence (either explicit or implicit) that the person intended to die but stopped the attempt before physical damage occurred

2.4. Suicidal Ideation: Thoughts or serving as the agent of one's own death. It may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent

2.5. Suicidal Intent: Subjective expectation and desire for a self-destructive act to end in death

2.6. Lethality of suicidal behaviour: Objective danger to life associated with a suicide method or action. Note that lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous

2.7. Non-suicidal self-injury: Direct, deliberate destruction of one's own body tissue without any intent to die, such as cutting or burning one's own skin

2.8. *Intentional self-harm or poisoning:* this is the term used to describe suicidal behaviour in the The International Statistical Classification of Diseases and Related Health Problems version 10 (ICD-10). The various categories are listed in Chapter XX i.e. External Causes of Mortality and Morbidity (codes X 60-X 84) (10).

2.9. *Inpatient suicide:* suicide committed by a medically ill patient who is hospitalized; within the hospital premises.

3. STRATEGIES

The commitment of an organisation in preventing inpatient suicides can be gauged by strategies that they use to fulfil certain indicators and steps as outlined in Table 1.

Table 1: Indicators and steps involved for prevention of inpatient suicides

INDICATOR	STEPS INVOLVED
INDICATOR 1. The risk assessment includes identification of specific factors and features that may increase or decrease the risk for suicide	Step 1. Identify risk factors, noting those that can be notified in the short term to reduce risk; AND protective factors, noting those that can be enhanced.
	Step 2. Ask specifically about suicide, suicidal ideation and history of suicidal behaviour

INDICATOR 2. The client's immediate safety needs and most appropriate setting for treatment are addressed	Step 3. Determine level of risk/ develop appropriate treatment setting/ plan to address risk
INDICATOR 3. Providing information to the relevant parties	Step 4. Document the assessment, treatment plan and instructions and adequate management of a post-suicide event

4. OBJECTIVES

This guideline responds to the general objective of the Incident Reporting and Learning system, which is "to facilitate a learning organisation through the reporting of and learning from adverse incidents, "near misses" and hazards so that a just and safe culture will be nurtured amongst health care providers, in our efforts to enhance the safety of the Malaysian health care system" (1). The scope of this guideline is for risk management of inpatient suicide/ suicide attempts; thus specific objectives would be:

GENERAL OBJECTIVES	DESCRIPTION
4.1 To adopt a collaborative approach in the prevention of inpatient suicide	*4.1.1 Membership of the suicide risk management committee may include:* i. Hospital Director and other administrative officers ii. Psychiatrist/Psychologist/Counsellor iii. Specialists from other relevant units e.g. Medicine, Surgery, Emergency etc. iv. Matrons and sisters from relevant units v. Head of Assistant Medical Officer vi. Hospital security Officer vii. Telephone operator viii. Assistant Environment Health Officer ix. Public Relations Officer x. Information technology officer xi. Medical Record Officer – secretariat for documentations xii. Quality Unit – secretariat for the Incident Reporting Committee, including inpatient suicides

	4.1.2 The role of the suicide risk management committee: i. To assist the hospital management in the implementation of Suicide Risk Management policies/ program ii. To develop hospital-wide strategies and standardised methods in the prevention of suicide and manage post-suicide incidents iii. To assist in the investigation of suicide intent and follow up on the implementation of corrective measures to be undertaken iv. To monitor the incidence of suicide and provide feedback to the Hospital Incident Report Committee v. To review and continuously improve suicide risk management vi. Frequency of meetings of at least 4 times a year
4.2 To educate staff and clients (patients and their relatives) about suicide awareness	*4.2.1 Training objectives for staff:* i. To improve the knowledge-base of doctors with respect to suicide screening and assessment[2] i.e. a. conduct take a thorough history b. recognize relevant risk factors c. design and implement a treatment plan that provides precautions against completed suicide ii. To increase the comfort level of staff by familiarizing them with mental health symptomatology iii. To recommend adequate screening tools for use by staff *4.2.2 Training objectives for patients and relatives* i. Patients and accompanying relatives with moderate to high risks will be given pamphlets about early detection of depression and suicidal ideations ii. Relatives of patients who have high risk or had attempted suicide are highly encouraged to accompany patients in the ward

[2] Simon RI. Psychiatry and law for clinicians. Washington, D.C.: American Psychiatric Press, 1992

4.3 To provide and maintain a safe environment to prevent in-patient suicides	*4.3.1 Role of respective clinical and facility managers* • To conduct the screening for risk factors and to assess the physical environment to control patient access to methods of self-injury (refer Section 5.0) *4.3.2 Role of the psychiatric team* • To assist other departments in conducting more detailed suicide risk assessment for patients who have current risks of suicide, and determine the level of intervention; and whether patients need to be transferred to the psychiatric ward. Re-assessments will also be conducted depending on clinical needs *4.3.3 Role of nursing staff* • To conduct monitoring of moderate to high risk patients in their respective wards *4.3.4 Role of administrative and record officers* • To facilitate regular training sessions and ensure environmental safety; and to facilitate the implementation of recommendations for suicide risk management
4.4 To establish Service-preparedness for inpatient suicides	*4.4.1 To ensure that staffs in various locations are able to provide the following services:* i. Appropriate emergency care is instituted ii. Management of the dead body iii. Appropriate debriefing for relatives and attending staff iv. Carry out a full assessment of the patient profile and suicidal act; and make recommendations

5. ENVIRONMENTAL SAFETY

All clinical and facility managers should conduct screening for risk factors and assess the physical environment to control patient access to methods of self-injury. The most common methods of suicide in hospitals are hanging, suffocation and jumping from height. Suicidal patients in medical units are in less controlled, therefore, higher-risk physical environments; safety is increased by providing closer observations, often one-to-one with an accompanying person (5). Areas to focus on:

5.1 Access to means of hanging, suffocation, and strangulation

5.1.1 The fixtures (shower heads, light fixtures, curtain rods, closet doors, door knobs) from which something heavy could be suspended
5.1.2 The closets and showers – should have break-away rods
5.1.3 Adequate observation for patients who require medical equipment (e.g. intravenous lines, pulse oximetry)
5.1.4 Shoelaces and belts - may need to be taken from patient
5.1.5 Linen closets are locked
5.1.6 Usage of guitars and other string instruments
5.1.7 Trash can liners in the unit

5.2 Access to jumping from height as a method of suicide

5.2.1 The unit located higher than ground level
5.2.2 Access to windows, balconies, fire escapes, any place from which they could jump
5.2.3 The windows can be opened or are broken

5.3 Access to other potentially harmful items for patients who are at risk of suicide

5.3.1 A body and belongings search done on admission.
5.3.2 A security officer is stationed at the ward entrances
5.3.3 The items brought in by visitors should be monitored
5.3.4 Monitoring of patients who have got items such as belts/ glass bottles/ cigarette lighters
5.3.5 Monitoring of cleaning supplies
5.3.6 Electrical outlets in the bathrooms.
5.3.7 Availability of blow-dyers or other electrical appliances.
5.3.8 Monitoring of razor for shaving

5.4 Challenges to transporting patients

5.4.1 Whether the reason for taking the patient off the unit is urgently needed or required. The increased risk associated with the transport should be balanced by the benefit of the procedure.

5.4.2 Consideration of the place of destination regarding its safety whether there is access to places for jumping or hanging

5.4.3 Consider a higher level of observation for the duration of the time the patient is away from the more secure unit.

5.4.4 Staff responsible for the observations must be informed of the status of the patient and aware of their options and level of responsibility for intervening in a crisis.

5.4.5 Consider adequate sedation before transporting patients.

6. SUICIDE ASSESSMENT AND TRIAGE

6.1 IDENTIFY RISK FACTORS: SCREENING

This is the responsibility of all doctors, especially when receiving patient into their units. Table 2 lists the stratification of risk factors(11). For a simpler method, doctors can use the "SAD PERSONS" scale (refer Appendix 1).

Table 2: Screening for patients at risk of suicide[3]

SYMPTOMS	HIGH RISK	MODERATE RISK	LOW RISK
'At risk' Mental State Depressed Psychotic Hopelessness, despair Guilt, shame, anger, Agitation Impulsivity	Severe depression Command hallucinations or delusions about dying Preoccupied with hopelessness, despair, feelings of worthlessness Severe anger, hostility.	Moderate depression Some sadness Some symptoms of psychosis Some feelings of hopelessness Moderate anger, hostility	Nil or mild depression, sadness No psychotic symptoms Feels hopeful about the future None/mild anger, hostility.

[3] To be used as a guide only and not to replace clinical decision-making and practice

Suicide attempt/ thoughts Intentionality Lethality Access to means previous suicide attempt/s	Continual / specific thoughts Evidence of clear intention An attempt with high lethality (ever).	Frequent thoughts Multiple attempts of low lethality Repeated threats.	Nil or vague thoughts No recent attempt or 1 recent attempt of low lethality and low intentionality
Substance disorder Current misuse of alcohol and other drugs	Current substance intoxication, abuse or dependence	Risk of substance intoxication, abuse or dependence	Nil or infrequent use of substances
Corroborative History Family, carers Medical records Other service provider/ sources	Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk	access to some information Some doubts to plausibility of person's account of events.	able to access information/ verify information and account of events of person at risk (logic, plausibility)
Strengths & Support Expressed communication	Patient is refusing help	Patient is ambivalent	Patient accepts help; therapeutic alliance formed
Availability of supports Willingness/ capacity of support person/s Safety of person/ others	Lack of supportive relationships / hostile relationships Not available/ unwilling / unable to help	Moderate connectedness; few relationships Available but unwilling/ unable to help consistently	Highly connected / good relationships and supports Willing and able to help consistently
Reflective practice Level & quality of engagement Changeability of risk level Assessment confidence in risk level	Low assessment confidence; or high changeability; or no rapport, poor engagement.		High assessment confidence / low changeability Good rapport, engagement.
Reviews by Psychiatry team	At least twice daily	At least daily	At least weekly
No (foreseeable) risk	Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network		

6.2 IDENTIFY PROTECTIVE FACTORS

Internal protective factors	External protective factors
Good coping and problem-solving skills	Strong perceived social supports/ connection
Positive values and beliefs	Family cohesion
Ability to seek and access help.	Peer group affiliation
Spirituality	Children or pets at home
Capacity for reality testing	Religious prohibition
Reasonable frustration tolerance	Positive therapeutic relationships
Hopefulness/ optimism	Sense of responsibility
Fear of suicide	Receiving mental health care
	Fear social disapproval

6.3 IDENTIFY PROTECTIVE FACTORS

6.3.1 General Considerations

i. ASKING ABOUT SUICIDE WILL NOT MAKE THE PATIENT BECOME SUICIDAL
ii. The key is to set the stage for the questions and to signal to the patient that the questions are naturally part of the overall assessment of the current problem
iii. All these questions must be asked with **care, concern and compassion**
iv. Establish rapport so that patients are more open to talk to us; tips as listed in Table 3

Table 3: Tips for Establishing Rapport

Do's	Don'ts
Engage with the person	Don't be judgmental
Be respectful	Don't be shocked or embarrassed and panic
Be professional	Don't try to cheer the patient by making jokes about his/ her suicidal thoughts
Be emphatic	Don't make the problem appear trivial

6.3.2 Factors that need to be assessed

i. Current mental state and thoughts about death and suicide
ii. Current suicide plan – seriousness of intent, methods etc.
iii. The person's support system (family, friends)

6.3.3 General Questions before Asking About Suicide

Questions to build rapport and serve as an opening for the patient to talk about their problems and for health care staff to gradually ask about suicide;

i. How do you feel at the moment? (Apa perasaan encik/ puan sekarang?)
ii. Is there anything troubling you lately? (Adakah apa-apa merisaukan anda akhir-akhir ini?)
iii. Do you feel that no one cares for you? (Pernahkah terasa bahawa tiada sesiapa pedulikan awak?)

Responses that indicates suicidal thoughts and a cry for help
" I just can't take it anymore" *('Saya sudah tak larat lagi')*
"I can't do anything right" *('Saya tidak mampu membuat sebarang perkara dengan betul')*
"I wish I was dead" *('Saya rasa lebih baik saya mati')*
"All my problems will end soon" *('Semua masalah saya akan berakhir tidak lama lagi)*
"There is no way out" *(Tiada jalan keluar lagi)*

6.3.4 Questions to Assess Suicide Intent

i. I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/ symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts.
(Saya maklum kesusahan yang awak tanggung disebabkan masalah ini. Kadang-kadang ada pesakit lain dengan masalah yang sama berkata yang mereka pernah terfikir untuk menamatkan hidup. Pernahkah kamu terfikir perkara yang sama?)
ii. When did you have these thoughts? *(Bila yang awak terfikir begitu?)*
iii. How often do you have these thoughts? *(Berapa kerap awak terfikir sebegitu?)*
iv. Do you think that that your situation is hopeless? *(Adakah awak rasa keadaan awak sudah tiada harapan?)*
v. Do you have a plan to take your life? *(Adakah awak merancang untuk menamatkan hidup?)*
vi. Have you had similar thoughts before? *(Pernahkah awak terfikir perkara yang sama sebelum ini?)*
vii. Have you ever attempted to harm yourself before? *(Pernahkah awak cuba untuk mencederakan diri sebelum ini?)*

6.3.5 Questions to Assess for Suicide Plan

i. Have you thought of harming yourself? *(Pernahkah awak terfikir untuk mencederakan diri?)*

ii. What have you thought of doing? *(Apa yang awak nak lakukan?)*
iii. Have you come close to acting on this? *(Pernahkah awak hampir-hampir melakukannya?)*
iv. Have you made any plan to carry this out? *(Pernahkah kamu membuat perancangan untuk melaksanakannya?)*
v. What has stopped you up until now? *(Apa yang menghalang awak setakat ini?)*

6.4 MANAGEMENT OF PATIENTS WITH SUICIDAL RISK

6.4.1 Triaging for Patients with Suicide Risk

The following is a triaging tool developed by the Victorian Government Department of Human Services(12).

	REPORTED BY PATIENTS	OBSERVATION BY STAFF	RECOMMENDED INTERVENTIONS
Low Risk Patients **BLUE**	Some mild or passive suicide ideation, with no intent or plan No history of suicide attempt Available social support	Cooperative; communicative; compliant with instructions No agitation/ restlessness Irritable without aggression Gives coherent history	Suicide caution* Allow accompanying family/ friend to monitor while waiting for psy intervention. Refer to psychiatry from ED or as in -patient referral if in ward. Reassessment of suicidal behaviour as required.
Moderate Risk Patients **YELLOW**	Suicide ideation with some level of suicide intent, but who have taken no action on the plan No other acute risk factors History of psychiatric illness & receiving treatment	Agitated/restless Intrusive behaviour; bizarre/ disordered behaviour Confused; withdrawn/ uncommunicative Ambivalence about treatment	Body & belonging search to remove items that could be used for self- harm. Suicide caution* & if indicated absconding precaution. Refer to psychiatry from ED or as in -patient referral if in ward. If in medical/surgical ward, encourage family to accompany. Reassessment of suicidal behaviour as required.
High Risk Patients **RED**	Made a serious or nearly lethal suicide attempt Persistent suicide ideation or intermittent ideation with intent and/or planning	Extreme agitation/ restlessness Physically/ verbally aggressive	Body & belonging search to remove items that could be used for self- harm

High Risk Patients **RED**	Psychosis, including command hallucinations Other signs of acute risk Recent onset of major psychiatric syndromes, especially depression Been recently discharged from a psychiatric inpatient unit History of acts/threats of aggression or impulsivity	Confused/ unable to cooperate Requires restraint Violent behaviour Possession of a weapon Self-harm in ward	Urgent referral to & rapid evaluation by psychiatry. Constant staff observation and/or security in ED and in the wards. Psychiatry inpatient admission (if medically stable). If not medically stable, to manage in the ward of origin and emphasise on multidiscipline team actions & ensure effective communication. Administer psychotropic medications and/or apply physical restraints as clinically indicated suicide caution*

*** Suicide Caution Procedure is available in appendix 2**

6.4.2 Referral for Psychiatry Assessment and Management

i. As part of good clinical practice, patient should be informed prior to the referral.

ii. However, if the patient is at risk, the patient should be referred to psychiatry team despite his/ her objection.

iii. Notwithstanding, where there are situations when patients has to remain in a general ward, the Suicide Caution Procedure can be used to monitor their progress. Appendix 2 describes the general considerations and implementation methods for this chart.

6.4.3 Indication for Psychiatry Inpatient Management

PSYCHIATRIC IN-PATIENT MANAGEMENT IS INDICATED FOR PATIENTS IN THE YELLOW AND RED CATEGORIES:

i. After a suicide attempt or aborted suicide attempt if:
   a. Patient is psychotic.
   b. Attempt was violent, near-lethal, or premeditated.
   c. Precautions were taken to avoid rescue or discovery.
   d. Persistent plan and/or intent is present.
   e. Distress is increased or patients regret surviving.
   f. Has limited family and/or social support.

g. Current impulsive behaviour, severe agitation, poor judgement, or refusal of help is evident.
h. Change in mental status secondary to changes in medical condition.

ii. Presence of suicidal ideation with
a. Specific plan with high lethality
b. High suicidal intention
c. Severe anxiety and agitation

iii. Admission to inpatient psychiatry ward must be according to Mental Health Act 2001.

CAUTION:

Transfer to psychiatric ward is indicated only after the patient is medically stable.

6.4.4 CHECKLIST BEFORE TRANSFERRING PATIENT

- Is the reason for taking the patient off the unit urgently needed or required? The increased risk associated with the transport should be balanced by the benefit of the procedure
- Consider where the patient is going. Is that facility safe? Does the patient have access to places from which to jump or hang?
- Consider a higher level of observation for the duration of the time the patient is away from the more secure unit
- Staff responsible for the observations must be informed of the status of the patient and aware of their options and level of responsibility for intervening in a crisis.

6.4.5 BEFORE DISCHARGING FROM GENERAL WARD

- The psychiatric team has been consulted
- Comprehensive suicide risk management has been conducted
- Harmful items and lethal medications have been removed.
- A supportive person is available and instructed in follow up observation and communication regarding signs of escalating problems or acute risk.
- A follow-up appointment with a psychiatrist and/or psychologist scheduled.
- Patient understands the conditions that warrant a return to the emergency department.

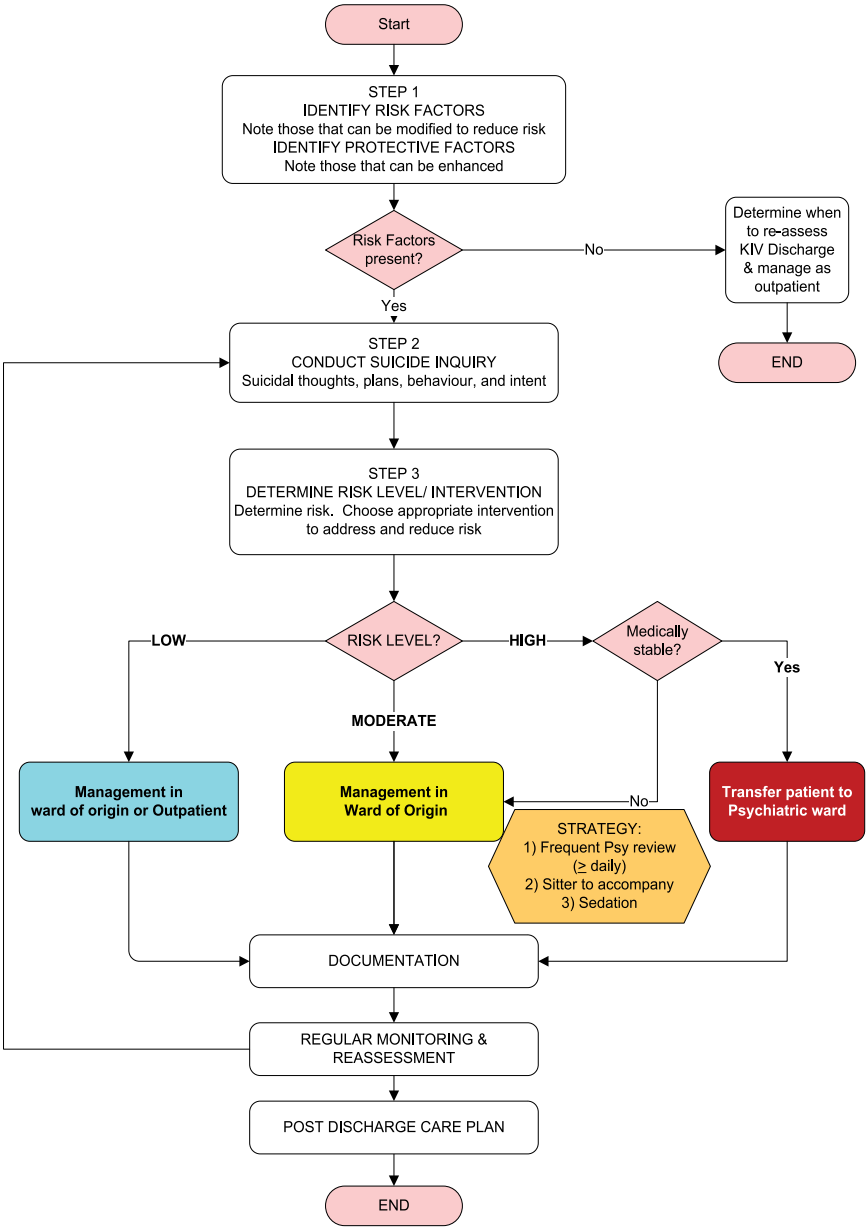


Figure 1: Risk assessment and triaging of inpatient suicides

6.5 PROVIDING INFORMATION AND DOCUMENTATION

6.5.1 Documentation for Suicide Prevention

Document the assessment, treatment plan and instructions to include crisis resources for individuals and their family members

i.	Discharge From the Emergency department	a. Identify and, if appropriate, contact outpatient support system; family/ friends b. Develop appropriate plan; referral to current treatment providers/ outpatient clinic c. Inform patient and/or family/friends (if indicated) about the signs of increased suicide risk; especially sleep disturbance, anxiety, agitation, and suicidal expressions and behaviours d. There must be a plan to contact significant support people about the potential suicide risk and follow-up arrangements. All attempts at contacting should be documented. e. If the patient does not wish to permit contact with family, this should be documented
ii.	Transfer from an inpatient unit to psychiatry	a. Patient with high risk shall be transferred to a psychiatric ward when their medical status allows. b. Those with moderate and low risk, with good social support – should be given the option of an outpatient treatment.
iii.	Discharge from wards	a. Provide the patient and the family/carer with discharge instructions b. Explain the uneven recovery path from their illness, especially depression. e.g., “There are likely to be times when you feel worse— that doesn’t mean that the medications have stopped working. Contact your healthcare clinician if this happens” c. Inform the family/friends (if indicated) about the signs of increased suicide risk; especially sleep disturbance, anxiety, agitation and suicidal expressions and behaviours d. If the patient does not wish to permit contact with family, this should be documented e. Provide information for follow-up appointment, which may include contacting and/or scheduling an appointment f. Provide prescriptions that allows for a reasonable supply of medication to last until the first follow-up appointment (when indicated) g. Provide information about local resources available, such as emergency contact numbers and instructions
iv.	Suicide risk following discharge	a. Suicide risk increases following discharge across diagnostic categories b. Suicide attempts are also more frequent in the time period following discharge

6.5.2 Other Documentation Guidelines

i.	When to Document Suicide Risk Assessments	a. At the time of hospital admission b. With occurrence of any suicidal behaviour or ideation c. Whenever there is any noteworthy clinical change d. Before transferring from high dependency setting to a general ward e. Before discharge
ii.	What to Document in a Suicide Assessment	a. Basis for the risk level (including presence and characteristics of any suicidal or non-suicidal self-injury thoughts or behaviours) Treatment plan for reducing the risk, including observations and b. other restrictions Ward round discussions and communications can facilitate c. communication as well as risk management
iii.	Examples	a. Example of a Physician's Note: This 62 year-old, recently separated man is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide, because of his serious suicide attempt and his continued anxiety and hopelessness. The plan is to hospitalize with suicide precautions and medications, consider ECT. Reassess tomorrow. b. Example of a Nursing Note: Mr X consistently denied suicidal ideation this evening when asked. However, he continued to pace and ruminate about how he had ruined his life and shamed his family by making a suicide attempt and being hospitalized. PRN Lorazepam was given. Patient was restricted to public area and monitored on 15 minute checks. The Lorazepam was somewhat effective, after one hour he was sitting still in the TV room and not pacing.

7. POST INCIDENT MANAGEMENT: SUICIDE POST-VENTION

Despite our best efforts, there may be time when a patient will successfully carry out an attempt. The main thrust of action at this time is to work together seamlessly to resuscitate, protect patient's dignity and breaking the bad news to the family. Appendix 3 gives an overview of the actions to be taken.

7.1 IMMEDIATE ACTIONS

Scope: within 24 hours of the event

7.1.1 Aim:

i. Provide resuscitation if patient is still alive, and ensure patient's dignity if he/ she had died
ii. To ensure immediate activation of emergency response team
iii. Efficient scene management and transfer of victim

7.1.2 Implementation

Table 4 and Figure 2 show the various actions and persons involved in this process. Inpatient suicide is considered a major event and the reporting process is summarized in a flow chart in Appendix 6. For details, please refer to the Incident Reporting Manual 2013(1).

Table 4: Immediate actions following an inpatient suicide attempt

No.	Action	Responsibility
1.	**Detection of Event** Upon witnessing or discovering the body of a suicide victim, staff shall remain calm. If patient still alive, to administer Basic Life Support: i. Inform operator/ coordinator via the designated emergency line ii. Staff to introduce self to operator: Name, place of work, contact number iii. Information to be relayed: a. Location of incident/ body found b. Time of incident c. Patient's condition (dead or alive) d. Patient's gender e. Patient is adult or child f. Patient's ethnic group	Staff whom first arrived at scene or informed by public
2.	**Activation of the Suicide Emergency Response Team** Operator shall activate the emergency response team i. Emergency Department via MECC (Medical Emergency Call Centre) or its equivalent ii. Sister on-call iii. Assistant Medical Officer Supervisor (Penyelia) on-call iv. Security Officer v. Others e.g. Matron on call, Environment Health Officer, Public Relations Officer, Deputy Director (Management) to be on the standby if any needs arise. This is based on local resources and applicability	Operator/ Coordinator

3.	**Immediate medical management** i. If patient still alive, to initiate emergency clinical management. ii. If patient has died, please refer to the steps for management of dead body and management of death site	Emergency Department for item (i) Penyelia on-call to supervise transfers (item ii)
4.	**Immediate Communication** i. Sister on-call to activate network for identification of patient and his/ her ward of origin via victim's wrist tag or other communication means. Once ascertained, information should be relayed to the Security Officer and the superiors ii. Sister-on-call to notify Matron-on-call iii. Security Officer to notify Hospital Director or Deputy Director iv. Hospital Director / authorised personnel will lodge a police report about incident	Sister on call Security Officer
5.	**Management of dead body** i. Maintain patient's dignity while waiting for police i.e. by shielding view from passers-by ii. Provide cooperation for police to conduct investigations iii. Coordinate transfer of patient from scene to the mortuary	Security Officer (item I & ii) Forensic team and Penyelia on-call (item iii)
6.	**Management of the physical environment** i. Seal / cordon the area where the suicide victim carried out the act e.g. in cases of jumping from height, this should be the window where the victim made his/ her final exit ii. Seal and cordon the incident site while awaiting for the police iii. Provide assistance to the police during investigation iv. Notify the Assistant Environmental Health Officer when police had finished their investigations, so that cleansing process can begin	Security Officer
7.	**Management at ward of origin** i. Sister/ staff nurse to notify medical officer in-charge or on-call ii. Nurses and doctors need to confirm identity of the victim via facial identification at site iii. Sister or team leader to obtain contacts for patient's next-of-kin and compile patient's clinical notes and investigations iv. In cases of jumping from height, staff to identify the exit point and to secure the area until Security Officer and police arrives v. Medical officer to inform the specialist in-charge or on-call vi. Specialist to notify the head of department vii. Medical officer and/ or specialist to assess staff, patients, and witnesses at risk for trauma reaction: to pacify them and to refer accordingly viii. All staff need to make necessary documentation in patient records and for incident reporting	Ward staff/s Ward sister Medical Officer / Specialist in-charge

8.	**Management of next-of-kin** i. The medical officer or specialist in-charge or on-call shall inform the deceased's or attempter's next of kin (refer Appendix 4. ii. The specialist shall ensure that there is a staff to escort the next-of-kin to either the emergency department or the mortuary iii. Next of kin may be referred to psychiatry if necessary	In hospitals with specialists, this task need to be carried out by specialist
9.	**Management at Forensic Unit/Department** i. Ensure availability of a bereavement room where next-of-kin can wait for the release of the deceased's remains ii. Procedure of the release of remains, to adhere to available policy	Multidisciplinary
10.	**Management of death site after removal of body** i. Handling/ collection of remains/ body parts to refer protocol for management of patients with HIV ii. To ensure the cleaning process done by the cleansing team follows the standard operating procedure	Assistant Environmental Health Officer
11.	**Health and Safety Management** i. To investigate ward of origin and death site to identify any environmental or infective disease risk factors. ii. To instruct the cleansing team to clean the death site according to the Infection Control Policy, once they receive the go-ahead from the Security Officer iii. To ensure that the WEHU A1 and A2 forms are completed iv. To notify the incident to the Department of Safety and Health (DOSH) for the respective state via phone v. Prepare investigative report for the State Health Department and DOSH	Assistant Environmental Health Officer
12.	**Universal precaution must be observed at all times by all staff who has direct contact with the victim**	All staff
13.	**Other relevant officers:** i. Psychiatry department : to provide support for next-of-kin or staff who has acute crisis reaction or other significant symptoms ii. Public relations officer: to coordinate media communications and coordinate preparations for press statement if necessary iii. Hospital administration: Assembles reports from all relevant officers and to coordinate post-event meeting, which is chaired by the Hospital Director or Deputy Director	

7.2 SHORT TERM TASKS

Scope: within 1 week of the suicide

No.	Action	Responsibility
1.	**Continued Communication, Clinical Assessment and Management** Continue conversations with family; offer referral to psychiatry if they develop serious grief reaction symptoms/ signs Encourage open communications between patients and staff	Ward sister/ Staff nurse in charge at ward of origin
2.	**Debriefing** Provide counselling to patients and staffs for emotional reactions – these may include those who had to do the body identification and cleansing (in cases of jumping from height) Continue monitoring other patients for suicide risk	Doctor-in-charge/ on-call Location: ward If necessary, to involve the psychiatry team
3.	**Environment of care** Identify and reduce access to lethal means (e.g. windows)	OSHA Committee Hospital Management
4.	**Mortality Review** Conduct Root Cause Analysis and create action plan	Ward of origin Hospital Incident Committee
5.	**Other services available** Involvement of other services such as Religious unit at hospital level eg. BAHEIS (Bahagian Hal Ehwal Islam) To help next-of-kin and staffs to deal with their emotional reactions from spiritual perspective when available	

7.3 LONG TERM GOALS

Scope: within 1 week of the suicide

No.	Action	Responsibility
1.	**Communication and Administration** Complete changes in Action plan Avoid excessive clinical and administrative reactions Create multidisciplinary team to review incident	Suicide Risk Management Committee
2.	**Clinical Assessment and Management** Assure adequacy of staff training in depression and suicide. Avoid undue assessments of patients	Multidisciplinary
3.	**Environmental aspects** Institute environmental modifications as outlined in Action Plan Incorporate design modifications and changes for new construction	OSHA Hospital management
4	**Policy and procedures** Identify legal concerns Address systemic changes.	Hospital Management

FLOWCHART FOR POST-INCIDENT MANAGEMENT: RESPONDING TO SUICIDES IN THE HOSPITAL

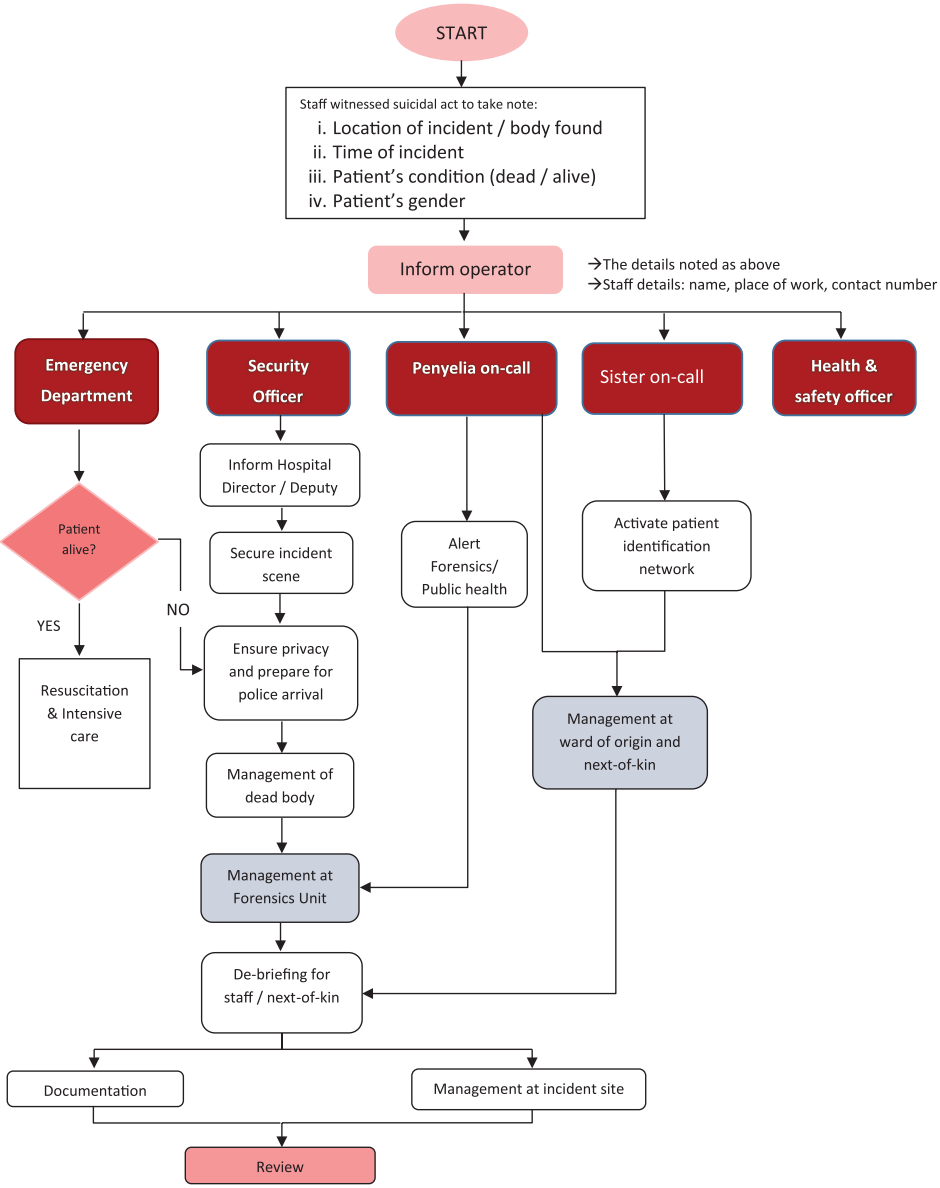


Figure 2: FLOWCHART FOR POST-INCIDENT MANAGEMENT: RESPONDING TO SUICIDES IN HOSPITALS

8. TRAINING

A template for training is available in Appendix 5. The Suicide Risk Management Guideline Committee recommends that Hospitals Directors in all MOH hospitals to take the lead in suicide risk management for the staff in their respective hospitals. Training should include inputs on knowledge, attitude and skills; thus there shall be components of information-sharing, role-play and attitude questionnaires. It should be carried out regularly, e.g. during the World Suicide Prevention Day which is celebrated globally on 10 September annually.

9. CONCLUSION

The Suicide Risk Management Committee strongly supports the efforts of the Incident Reporting and Learning System committee. This reporting system can lead to learning and improved safety through generation of 'alerts'; dissemination of "lessons learnt" by health-care organizations from investigating a serious event; and preparation of reports to identify unrecognized trends and hazards requiring attention, insights into underlying systems failures and generate recommendations for "best practices" for all to follow. Inpatient suicide is one of the incidents graded as RED, and need to be reported to the relevant State Health Departments within five working days of the date of occurrence. For all CATEGORY RED incidents and sentinel events, a full root cause analysis shall be undertaken by the local organisation and reported to the relevant State Health Departments within 60 working days of occurrence of the incident.

As outlined by the IR Manual, this guideline has maintained that recommendations shall be focused on changes in systems, processes or products, rather than being targeted at individual performance. This is a cardinal principle of safety that must be reinforced by the nature of recommendations that come from any reporting system; which is based on the concept that individual error results from systems defects, and will recur with another person at another time if those systems defects are not remedied.

We certainly hope that this national guideline will facilitate the learning process in the risk management of inpatient suicides.

END

APPENDIX 1 : SAD PERSONS

The SAD PERSONS scale is an acronym based on 10 suicide risk factors. The scale has found widespread acceptance in assessing the likelihood of a suicide attempt. However, clinicians are reminded that suicide risk factors are qualitative (not quantitative) measures that need to be viewed within the overall clinical presentation.

Factor	Points
S = Sex (male)	1
A= Age (<19 or >45 years)	1
D = Depression	1
P = Previous suicide attempt	1
E = Ethanol abuse	1
R = Rational thinking loss	1
S = Social supports lacking	1
O = Organized plan	1
N = No spouse / significant other	1
S = Sickness (chronic debilitating illness)	1

Score less than 2 : Discharge with outpatient psychiatric evaluation
Score of 3 – 6 : Consider hospitalization or at least very close follow-up
Score of at least 7 : Hospitalise

Source : Patterson WM, Dohn HH, Bird J et al. Evaluation of Suicidal Patients : the SAD PERSONS scale. Psychosomatics .1993;24(4): 343-345, 348-349.

APPENDIX 2 : SUICIDE CAUTION PROCEDURE

This procedure encompasses several steps which include environmental manipulation and regular review of the patient. Considerations that should be made:

1. The procedure is carried out by paramedic staff in the ward
2. Documentation will be made using a Close Observation Form, as below (Source: Appendix IV, CD Charts H:Psychiatry from the Hospital Information System

Close Observation Chart (Carta Pemerhatian Rapi)				
Patients Demographic				
Time interval from initiation	**Date**	**Time**	**Patient's condition**	**Observation by**
0 min				
30 min				
60 min				
90 min				
120 min				
150 min				

*add row for every 30 minutes until 1440 minutes (24 hours)

3. Intervention/ Management plan:
   a. Placement of patient should be centrally located, preferably near nurses' station and within view of staff
   b. Avoid placing patient at the end of cubicle, near exit, or the window
   c. Patient is restricted to his/ her area and not permitted to use any thing that may cause harm
   d. Preferably to have one-to-one supervision with staff/ family member at all times, even when going to bathroom. The latter should know the whereabouts of these patients
   e. Be especially alert to potentially dangerous items e.g. anything sharp, anything that can be used for strangulation, anything that can be a danger to self (e.g. glass containers, scissor, fork, knife, shaver, nail clipper etc.) Also be alert on the possibility of patients at risk saving up their own medication to harm themselves.
   f. Check at frequent and regular interval to ensure safety. This may range between 15 minutes to one hour
   g. Ask patient for any plans for suicide, and attempt to ascertain how detailed and feasible the plans are.
   h. Observe and document the patients' behaviour pattern, sleep and interaction.

APPENDIX 3 : BREAKING OF BAD NEWS

Vandekieft (13) had adapted the practical and comprehensive model formulated by Rabow and McPhee, that uses the simple mnemonic ABCDE

The ABCDE Mnemonic for Breaking Bad News

BREAKING BAD NEWS
Advance preparation Arrange for adequate time, privacy and no interruptions (turn pager off or to silent mode). Review relevant clinical information. Mentally rehearse, identify words or phrases to use and avoid. Prepare yourself emotionally.
Build a therapeutic environment/ relationship Determine what and how much the family wants to know. Have family or support persons present, if available Introduce yourself to everyone. Warn the patient that bad news is coming. Use touch when appropriate. Schedule follow-up appointments.
Communicate well Ask what the family already knows. Be frank but compassionate; avoid euphemisms and medical jargon. Allow for silence and tears; proceed at the family member's pace. Have the family member describe his or her understanding of the news Allow time to answer questions; write things down and provide written information. Conclude the interview with a summary and follow-up plan (e.g. referral to other relevant agencies)
Deal with patient and family reactions Assess and respond to the family's emotional reaction Be empathetic. Do not argue with or criticize colleagues.
Encourage and validate emotions Explore what the news means to the family Offer realistic hope according to the patient's goals. Use interdisciplinary resources. Take care of your own needs; be attuned to the needs of involved house staff and office or hospital personnel.

APPENDIX 4 : CHECKLIST FOR MANAGEMENT OF INPATIENT SUICIDES

Sources: Ballard ED, Pao M, Horowitz L, Lee IM, Henderson DK, Rosenstein DN. Aftermath of suicide in the hospitals: institutional response. Psychomatics. 2008 Nov-dec; 49(6): 461-9

	Communication and Administration	Clinical Assessment and Management	Environment of Care	Policy and Procedures
Immediate Actions	• Designate team leader • Create working group to respond to event • Notify family, staff, patients, administrators, legal, and regulatory bodies • Decide on possible media notification	• Identify individuals at risk for suicide. • Assess staff, patients, and witnesses at risk for trauma reaction • Decide on possible debriefing of staff	• Identify changes to the ward (e.g. lock unit, check for windows and cords) • Interact with police and medical examiner (if necessary)	• Create emergency Response checklist with items such as inpatient safety, staff response, communication, and environment • Assess existing policies and procedures for immediate safety • Consider implementing short-term unit restrictions
Short-Term Tasks	• Encourage open communication between patients and staff • Continue conversations with family	• Provide counselling to patients and staff for emotional reactions • Maintain mental health presence on all hospital units • Continue monitoring patients for suicide risk	• Identify and reduce access to lethal means (e.g. temporary netting in atrium, barred windows).	• Conduct Root Cause Analysis and create Action plan • Evaluate patient passes and assessment policies • Decide on policy for travel costs for family members
Long-Term Goals	• Complete changes to policies in Action Plan • Avoid excessive clinical and administrative reactions • Create multidisciplinary team to review adverse events	• Assure adequacy of staff training in depression and suicide • Avoid undue assessment of patients	• Institute environmental modifications as outlined in Action Plan. • Incorporate design modifications and changes for new construction.	• Continue interactions with regulatory agencies. • Identify legal concerns. • Institute Failure Modes and Effects Analysis.

APPENDIX 5 : EXAMPLE OF SUICIDE POST-VENTION ACTION CARDS

Pre-requisite: each hospital should designate a specific EMERGENCY NUMBER to enable their staff to trigger the response in the fastest manner.

Preamble: these actions cards are in Bahasa Malaysia, which is the usual medium of instruction in Ministry of Health Hospitals. The aims at the top of each card are only to serve the purpose of this guideline. This set of action cards are developed in a high-rise hospital where most of the suicides were by **jumping from height**. The word 'mangsa' (victim) will be used to refer to the person who carried out the suicidal attempt; while 'pesakit' (patient) refers to other patients who are present in that hospital.

ACTION CARD FIRST (1ST) RESPONDER

AIM: TO TRIGGER THE RESPONSE

First (1st) Responder adalah kakitangan yang menyaksikan/ mendapat makluman daripada orang awam tentang kejadian.

1. Hubungi:
   TALIAN KECEMASAN HOSPITAL YANG DIPERUNTUKKAN
2. Maklum operator telefon identiti anda – nama/ tempat kerja/ no telefon
3. Maklumkan butir-butir kejadian
   3.1. Lokasi kejadian
   3.2. Keadaan mangsa
   3.3. Bangsa/ jantina mangsa

ACTION CARD OPERATOR TELEFON (TELEFONIS)

AIM: TO DEPLOY THE RESPONSE TEAM

1. Terima panggilan daripada First (1st) Responder
2. Dapatkan dan lengkapkan maklumat mangsa pada borang:
   2.1. Nama pelapor/ lokasi/ no telefon
   2.2. Lokasi kejadian
   2.3. Masa kejadian
   2.4. Keadaan mangsa (hidup/ mati)
   2.5. Jantina
   2.6. Dewasa/ kanak-kanak
   2.7. Bangsa
3. Membuat panggilan kepada:
   3.1. Call centre Jabatan Kecemasan (MECC)
   3.2. Penyelia Jururawat Atas Panggilan
   3.3. Penyelia PPP Atas Panggilan
   3.4. Pegawai Keselamatan
   3.5. Pegawai Unit Kesihatan Persekitaran
   3.6. Pegawai Unit Perhubungan Awam
   3.7. Penolong Pengarah Pengurusan

ACTION CARD 'CALL CENTRE' JABATAN KECEMASAN

AIM: IMMEDIATE CLINICAL MANAGEMENT

1. Terima laporan tentang insiden daripada telefonis
2. Arahkan pasukan kecemasan ke lokasi kejadian dengan segera
3. Pastikan keadaan mangsa
4. Jika mangsa masih bernyawa, jalankan perawatan klinikal kecemasan
5. JIka mangsa telah meninggal dunia, maklumkan Ketua Penyelia Atas Panggilan untuk pengendalian mayat dan tempat kematian
6. Sediakan dokumentasi insiden

ACTION CARD PEGAWAI KESELAMATAN

AIM: SECURITY & NETWORK WITH POLICE

1. Terima laporan daripada telefonis
2. Maklumkan Pengarah Hospital
3. Hubungi ibu pejabat polis terdekat
4. Seal/ Cordon lokasi kejadian
5. Pastikan 'dignity' mangsa dengan menghadang mangsa dari pandangan umum
6. Cegah orang awam daripada berkumpul/ mengambil gambar
7. Tunggu pihak polis datang serta iringi mereka untuk bantu urusan siasatan
8. Beri 'clearance' kepada Penolong Pegawai Kesihatan Persekitaran apabila polis telah selesai siasatan tempat kejadian
9. Sediakan dokumentasi insiden

ACTION CARD
KETUA JURURAWAT ATAS PANGGILAN

AIM: PATIENT IDENTIFICATION & NURSING SUPERVISION

1. Terima laporan tentang insiden daripada telefonis
2. Pergi ke tempat kejadian untuk pengesahan kes
3. Telefon semua wad yang berkenaan untuk pengenalpastian identiti mangsa dan 'ward-of-origin'
4. Apabila telah kenalpasti 'ward-of-origin', maklumkan kepada Penolong Pegawai Kesihatan Persekitaran tentang 'exit point'
5. Laporkan insiden kepada Penyelia Ketua Jururawat (Matron) Atas Panggilan
6. Pantau respons daripada jururawat di 'ward-of-origin'
7. Sediakan dokumentasi kejadian

ACTION CARD
KETUA JURURAWAT/ 'TEAM LEADER' 'WARD OF ORIGIN'

AIM: PATIENT AND EXIT POINT IDENTIFICATION, NURSING MANAGEMENT, PREVENT FURTHER RISK

1. Terima laporan daripada Ketua Jururawat Atas Panggilan
2. Arahkan anggota wad untuk buat 'head count' untuk kenalpasti pesakit yang 'missing'. Jika ada, beri maklumat identiti mangsa kepada Ketua Jururawat Atas Panggilan
3. Pergi ke lokasi kejadian/ Jabatan Kecemasan untuk buat pengecaman mangsa
4. Skrin/ kunci lokasi 'exit point'
5. Sediakan maklumat perawatan mangsa serta nombor telefon waris beliau
6. Laporkan kejadian kepada Pegawai Perubatan Yang Menjaga (YM) / Atas Panggilan
7. Buat pemerhatian untuck kenalpasti sama ada terdapat pesakit dan keluarga di dalam wad yang 'agitated' akibat kejadian: cuba tenangkan dan maklumkan pegawai perubatan
8. Sediakan dokumentasi kejadian dalam nota kejururawatan serta borang insiden

ACTION CARD PEGAWAI PERUBATAN Y/M/ ATAS PANGGILAN 'WARD-OF-ORIGIN'

AIM: CLINICAL INVESTIGATION AND MANAGEMENT, PREVENT FURTHER RISK

1. Terima laporan tentang insiden daripada Ketua Jururawat / team leader dari 'ward-of-origin'
2. Pastikan informasi seperti berikut:
   - 2.1. Lokasi kejadian dan wad asal
   - 2.2. Demografi
   - 2.3. Keadaan mangsa
3. Pergi ke tempat kejadian dan buat pengesahan
4. Semak rekod pesakit untuk kenalpasti masalah kesihatan/ risiko pesakit berkenaan dan buat ringkasan kes
5. Laporkan kejadian kepada:
   - 5.1. Pakar Y/M/ Atas Panggilan
   - 5.2. Ketua Jabatan
6. Hubungi waris mangsa & minta waris datang ke hospital
7. Memeriksa pesakit atau ahli keluarga di wad yang 'agitated' akibat kejadian dan rujuk ke Jabatan Psikiatri jika perlu
8. Sediakan dokumentasi insiden dalam rekod perawatan mangsa serta borang insiden

ACTION CARD PAKAR PERUBATAN Y/M/ ATAS PANGGILAN 'WARD-OF-ORIGIN

AIM: CLINICAL FORMULATION, NEXT-OF-KIN MANAGEMENT, DEPARTMENTAL RESPONSE

1. Terima laporan tentang insiden daripada Pegawai Perubatan Y/M atau Atas Panggilan
2. Pergi ke tempat kejadian dan buat pengesahan
3. Dapatkan ringkasan kes daripada Pegawai Perubatan Y/M atau Atas Panggilan
4. Jumpa keluarga kesakit dan jalankan prosedur 'breaking of bad news' di wad. Pastikan suasana yang kondusif
5. Arahkan Jururawat untuk iringi keluarga Jabatan Kecemasan atau Jabatan Forensik (berdasarkan input daripada Penyelia Atas Panggilan) jika perlu
6. Maklumkan kepada Ketua Jabatan
7. Selia dokumentasi kes.

ACTION CARD
PENYELIA PPP ATAS PANGGILAN

AIM: SUPERVISE LOGISTICS AND MOVEMENT

1. Terima laporan tentang insiden daripada telefonis
2. Pergi ke tempat kejadian untuk pengesahan kes
3. Selia perpindahan mangsa daripada tempat kejadian ke Jabatan Kecemasan atau Jabatan Forensik
4. Teruskan komunikasi dengan Penyelia di Jabatan Kecemasan atau Jabatan Forensik untuk pemantauan keadaan/ pergerakan mangsa
5. Bertindak sebagai 'contact person' bagi maklumat pergerakan mangsa
6. Sediakan dokumentasi kejadian

ACTION CARD
PEGAWAI KESIHATAN AWAM

AIM: MANAGE WORK & ENVIRONMENTAL RISK

1. Terima laporan tentang insiden daripada telefonis
2. Terima laporan daripada Ketua Jururawat Atas Panggilan tentang 'ward-of-origin'
3. Lakukan siasatan di 'ward-of-origin' dan lokasi pendaratan untuk kenalpasti risiko persekitaran atau jangkitan
4. Beri arahan dan selia petugas pembersihan untuk membersihkan lokasi kejadian mengikut tatacara Infection Control Policy (setelah dapat 'clearance' Pegawai Keselamatan)
5. Laporkan kejadian kepada pihak DOSH negeri dengan segera melalui telefon
6. Isikan borang WEHU A1 dan A2 (penyelia lokasi / Jabatan Kecemasan)
7. Sediakan laporan siasatan untuk Jabatan Kesihatan Negeri dan DOSH

* DOSH : Department of Occupational Safety and Health

ACTION CARD
PENGURUSAN

AIM: COORDINATED REPORTING & RESPONSE

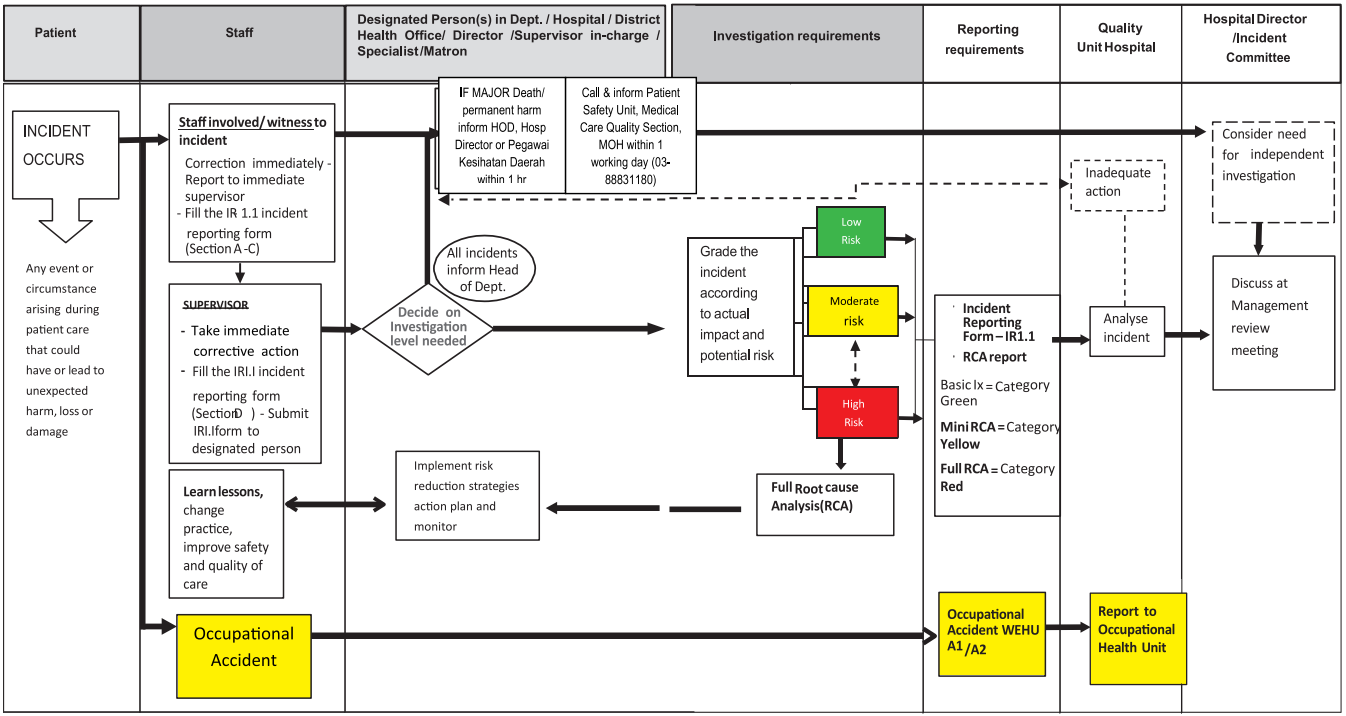
1. Terima laporan tentang kejadian daripada telefonis
2. Kumpul semua laporan dari semua pegawai yang terlibat
3. Koordinasi mesyuarat dalam selepas stand down yang dipengerusikan oleh Pengarah Hospital / Timbalan Pengarah Perubatan

ACTION CARD
PERHUBUNGAN AWAM

AIM: MEDIA MANAGEMENT

1. Terima laporan tentang insiden daripada telefonis.
2. Dapatkan pengesahan maklumat daripada:
   - 2.1. Ketua Jururawat Atas Panggilan
   - 2.2. Penyelia PPP Atas Panggilan
   - 2.3. Unit Keselamatan.
3. Kawalan Media / siaran media.
4. Persiapan Sidang Media dan Jurucakap

APPENDIX 6 : FLOW CHART FOR THE MANAGEMENT & REPORTING OF INCIDENTS



Excerpt from the Incident Reporting and Learning System Manual 2013;

APPENDIX 7 : TEMPLATE FOR TRAINING

SUICIDE IN HOSPITALS AWARENESS & RESPONSE (SHARE) WORKSHOP

MASA	AGENDA	TASKS
8:00 – 8:30	Registration	Interactive
8.30 – 8:45	Pre-test: Healthcarer's attitude (Modified 22-Item Suicide Opinion Questionnaire)	
8:45 – 9:00	Officiating ceremony	
9.00 – 9.30	Morning break	
9.30 - 10.30	***Introduction*** - Epidemiology and myths - Importance and objectives of guideline - Impact of health carers attitude - Diagnosis coding	Slides and interactive discussion
1030 – 11.15	***Primary Prevention*** Infrastructure: access and safety - Identify risk factors - Identify protective factors	Slides and interactive discussion
11.15 – 12.00	***Assessment and triaging*** - General questions - Focused questions: ideas, plans, attempts - Triaging & recommended interventions	Slides and interactive discussion
12.00 – 12:45	***Post-Incident Management*** - Immediate: Collaborative & multi-level approach - Short-term and Long-term - Documentation	Slides and KIV video presentation
12:45 – 1300	Post-test: Healthcarer's attitude	Interactive
13:00 – 14.00	Lunch	
14.00 – 15.30	Practical session – identifying risk factors & how to ask about suicide	Case vignettes and role play
15:30 – 16:30	Post-incident management - Service preparedness & forming prevention team - Action card - Debriefing	Case vignettes and role play
16.30 – 16:45	Closing ceremony	

MODIFIED 22-ITEM SUICIDE OPINION QUESTIONNAIRE (English Version)

This questionnaire contains 22 items of questions that assess your opinion regarding suicide. There are no right or wrong answer. Please tick (√) column the best describe your opinion.

No	Item	Strongly Disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly Agree
1	Suicide is an acceptable way to end an incurable illness						
2	If someone wants to commit suicide, it is their right and we should not interfere						
3	Suicidal behaviour in younger people is unacceptable						
4	Potentially, every one of us can be a suicide victim						
5	Suicide is a selfish behaviour						
6	It is the professional duty of the health care provider to prevent any suicidal client from dying						
7	Those people who attempt suicide are usually trying to get sympathy from others						
8	People who attempt suicide are usually mentally ill						
9	People should not have the right to take their own lives						
10	Suicidal behaviour among younger people is particularly puzzling as they have everything to live for						
11	People who attempt suicide and live should be required to undertake therapy to understand their inner motivation						
12	Suicidal behaviour can be irritating						
13	Suicidal behaviour is particularly difficult to deal with and requires specialist care						
14	Further training in the development of interpersonal skills would be of benefit when caring for the suicidal patient						

15	50% of suicidal persons sought medical help within the six months preceding the suicide						
16	Suicidal behaviour is essentially a way of crying out for help						
17	Suicide attempters who use public places (buildings or bridges) are more interested in getting attention than committing suicide						
18	Often, it feels as though suicide attempters are trying to make someone else sorry						
19	People who talk about suicide often commit suicide						
20	Suicide attempter are less religious than others						
21	People who lack family relationships are more likely to attempt suicide						
22	Once a person survives a suicide attempt, the probability of his/her trying again is minimal						

SOALSELIDIK PENDAPAT BERKAITAN BUNUH DIRI (BM Version)

Hospital: _____
No rujukan peserta: ___

Soal selidik ini mengandungi 22 pernyataan yang mencerminkan pendapat anda tentang tindakan membunuh diri. Tiada jawapan yang betul atau salah. Sila jawab semua soalan. Sila tandakan (√) dalam ruang kosong yang paling tepat menggambarkan pendapat anda.

Bil	Pernyataan	Sgt Tidak Setuju	Tidak Setuju	Agak Tidak Setuju	Agak Setuju	Setuju	Sangat setuju
1	Membunuh diri boleh diterima sebagai cara untuk menamatkan penyakit yang tidak dapat diubati.						
2	Jika seseorang mahu membunuh diri, tindakan itu adalah hak mereka dan kita tidak sepatutnya campur tangan.						
3	Tingkah laku bunuh diri di kalangan golongan muda tidak boleh diterima.						
4	Semua orang berkemungkinan menjadi mangsa bunuh diri.						
5	Bunuh diri merupakan tingkah laku yang mementingkan diri sendiri.						
6	Memang menjadi tanggungjawab anggota kesihatan untuk mencegah pesakit yang cuba membunuh diri daripada meneruskan niatnya.						
7	Mereka yang cuba membunuh diri biasanya ingin mendapatkan simpati orang lain.						
8	Biasanya, mereka yang cuba membunuh diri mempunyai penyakit mental.						
9	Sesiapa pun tidak berhak mengambil nyawa mereka sendiri						
10	Tingkah laku membunuh diri dalam kalangan golongan muda sukar difahami kerana mereka mempunyai masa depan yang cerah.						
11	Mereka yang cuba membunuh diri perlu menjalani terapi (rawatan) bagi memahami apa yang mendorong tindakan mereka.						
12	Tingkah laku bunuh diri merupakan sesuatu yang menjengkelkan (irritating)						
13	Tingkah laku bunuh diri sukar ditangani dan memerlukan rawatan pakar						

14	Latihan lanjutan dalam kemahiran interpersonal adalah berguna untuk menjaga pesakit yang mahu membunuh diri						
15	Separuh daripada orang yang cuba membunuh diri pernah mendapatkan rawatan perubatan dalam tempoh enam bulan yang lepas.						
16	Tingkah laku bunuh diri merupakan cara untuk meminta pertolongan						
17	Mereka yang cuba membunuh diri di tempat awam (bangunan atau jambatan) sebenarnya lebih berminat untuk menarik perhatian						
18	Sering kali saya berasa mereka yang cuba Membunuh diri ingin membuatkan orang lain berasa kesal						
19	Mereka yang menyuarakan hasrat untuk membunuh diri selalunya akan melakukannya						
20	Mereka yang cuba membunuh diri tidak mempunyai pegangan agama yang kuat						
21	Mereka yang tidak mempunyai hubungan kekeluargaan yang baik lebih cenderung untuk cuba membunuh diri						
22	Apabila seseorang terselamat daripada cubaan membunuh diri, kemungkinan untuknya mencuba lagi adalah rendah						

ROLE PLAY USING CASE VIGNETTE

Case Vignette 1

Madam A, 60 year old widow has been in the palliative ward for 1 month due to recurrent infected stoma. She was diagnosed to have carcinoma of colon 3 years ago with liver metastasis which gradually deteriorated with substantial blood loss. She underwent a corrective surgery to secure the bleeding in which a stoma was performed subsequently. She required several admissions due to infected wounds and resulted with intensive care in the hospitals.

She was always accompanied by the daughter and occasionally by the grandchildren during school holidays. They were afraid to leave her unattended in the ward, thinking the condition may turn critical suddenly. She required multiple analgesics including opioids to address the pain in which she became drowsy most of the time. She had to be assisted in almost all aspects of her personal needs including hygiene and meals. She hardly moved around and only confined to her bed.

For the past 2 weeks, she was noted to be more withdrawn, less talking to the staff during bed making, no interest to talk about her daily activity. She seldom talked with the family during visiting hours and was noted by the staff to be quiet and not interested to engage in conversations. She preferred to be alone and at times cried for attention when in pain. She used to mention about feeling no hope to recover this time.

This morning, Mdm A whispered to the nurse the wish to end her life. She was not able to bear the pain and felt helpless. She wished she could ask the doctors to stop the treatment and to allow her to go home. She did not want to burden her children and would want to join her deceased husband very soon. She wanted to end her suffering and said that she had the right to make such decision. Since that afternoon, she refused to take any medication and remained quiet during the session with the doctors. The family started to worry with the change and informed the doctor.

Questions

1. Describe how you feel about this patient
2. List down the following
    a. Risk factors
    b. Protective factors
3. How do you determine the level of risk?
4. How do you approach this patient
    a. General questions
    b. Focused questions
5. How do you manage this patient
    a. Psychiatric diagnosis
    b. Biopsychosocial intervention

Answer guide for trainer (Case 1)

1. Participants shall describe their own feeling and explain underlying reasons for such feeling.

2. a. Risk factors : Age,(elderly), Widow; prolonged illness (Ca Colon); complicated course of illness (multiple operations, admissions, pain); evolving depressive symptoms
   b. Protective factor: Strong family support (always being accompanied); tolerance to pain (only revealed pain during high intensity); no active suicidal behaviour (most of the time confined to bed)

3. The patient level of risk will be YELLOW - moderate risk; due to the following features:
   a. Reported:
   Suicide ideation with some level of suicide intent, but without proper plan/ action

   b. Observed
   - Withdrawn
   - Less talking to the staff during bed making
   - No interest to talk about her daily activity
   - Seldom talked with the family during visiting hours
   - Quiet and not interested to engage in conversations

4. Approaching patient
   First build rapport with patients-introduce yourself. Be respectful, professional and empathetic during assessment.
   a. General questions:
   How do you feel at the moment?
   Is there any different the way you feel about your current emotion?
   What do you think about things which make you feeling like this?

   b. Focused questions

   Questions to assess suicide intent
   Some people would think that they could stop the suffering by wishing that they were better not to live anymore, does this also run into your mind currently?
   We have noticed that you seemed to be less interactive with us or your children, what has bothered your mind?
   I guess you have taken such a considerable moment to inform our staff about your wish to die, please tell us why do you have such thought this time?

Questions to assess for suicide plans

You are not eating adequately ever since you mentioned this, do you think this is your plan how you can carry out your wish?
How do you think that you would want this to happen/take place?
How long that you have been thinking like this?

5. Management
   a. Diagnosis: Major Depressive Disorder
   b. Biopsychosocial approach

Biological

- General well-being: (electrolytes, liver function test, Full Blood Count)
- Delirium: (orientation, organization of thought, fluctuation of behavior)
- Role of antidepressant: (SNRI, TCA)
- Role of adequate analgesics :(breakthrough opioids, fentanyl patch)

Psychological

- Pain assessment – Visual Analogue Scale (VAS)
- Distress Thermometer (DT)
- Hamilton Rating Scale for Depression (HAMD)

Social

- Family support to provide reassurance to patient
- Family grief information – KIV non aggressive CPR
- Collaboration with religious experts
- Ward Clinical/Nursing process
- To relocate patient to the cubicle near the nurses' counter
- To put behaviour chart for close monitoring
- To assist patient's personal needs (hygiene, meals, positioning)
- Doctors to review at least daily

Case Vignette 2

Miss MA, 18 years old girl, a college student, single, come from a broken family, was admitted to surgical ward for stabbing her abdomen with a knife. This is her third attempt. The first two episode of self-harm was overdosing herself with paracetamol and sleeping tablets.

She has been having on-going conflict with her mother. The father had left the family when she was only 2 years old and never met him since. She is very close with her maternal grandmother who was taking care of the patient when the mother goes to work. She also has a 15-year-old younger sister.

The patient had a quarrel with her mother a day before the incident over her relationship with her boyfriend. The mother did not approve the relationship because she believed that he has bad influence on her. This was shown by her deterioration in her academic performance and her increasing hostility towards the mother. In the morning of the incident, she posted on Facebook on her intention to die. She was alone during the attempt. She had locked the door. Her mother who was alerted by the patient's friend went home and found that her door was locked. Mother had to find a key to open the door. Patient was brought to the hospital immediately. In casualty, the patient was not cooperative, refused to talk and was avoiding eye contact. The grandmother reported that the patient was noted to be withdrawn, reduced oral intake and poor sleep at night for the past two months. She also conveyed to her grandmother on few occasions that her life is not worth living.

Questions

1. Describe how do you feel about this patient?
2. List down the following
   a. Risk factors
   b. Protective factors
3. How do you determine the level of risk?
4. How do you approach this patient
   a. General questions
   b. Focused questions
5. How do you manage this patient
   a. External coding
   b. Biopsychosocial intervention

Answer guide for trainer (Case 1)

1. Participants described their feelings towards the patient. Ask them to explain why they think the particular feeling developed

2. a. Risk factors : Age,(<19),broken family, poor social support, previous attempt, attempt of severe lethality(using knife), has symptoms of depression, conveyed feeling of hopelessness, organized plan (posting on FB and locking her door), took precaution from being rescue and refusing help during assessment
   b. Protective factor: Has a grandmother whom she is close to

3. The patient level of risk will be RED -high risk as patient has the following features:
   a. Reported:
   Made a serious/near lethal suicide attempt
   Has suicidal ideation with intent and planning
   History of recent onset of depression
   History of impulsive act

   b. Observed
   Refused to cooperate

4. Approaching patient
   First build rapport with patients-introduce yourself. Be respectful, professional and empathetic during assessment. Do not be judgemental and joke about the attempt of suicide
   a. General questions:
   How do you feel at the moment?
   Is there anything troubling you lately?
   Do you feel that no one cares for you?

   b. Focused questions
   Questions to assess suicide intent
   I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts.
   When did you have these thoughts?
   How often do you have these thoughts?
   Do you think that that your situation is hopeless?
   Do you have a plan to take your life?
   Have you had similar thoughts before?
   Have you ever attempted to harm yourself before?

Questions to assess for suicide plans
Have you thought of harming yourself?
What have you thought of doing?
Have you come close to acting on this?
Have you made any plan to carry this out?
What has stopped you up until now?

5. Approaching patient

a. Diagnosis: External code X 78 –Intentional self-harm by sharp objects

b. Biopsychosocial approach

Biological
Blood investigation (FBC,RP,LFT, Thyroid function)-Routine and TRO organic cause of depression,
Start patient on antidepressant in view of prominent depressive symptoms for the past 2 months

Psychological
Educate patient on problem solving skills
Educate on coping skills and strategies
Supportive psychotherapy
Family therapy

Social
Improve patient social network- link with NGO such as befrienders

APPENDIX 8 : EXTERNAL CAUSES FOR INJURY MORTALITY MATRIX (ICD-10)

	INTENT				
MECHANISM	**Unintentional**	**Suicide**	**Homicide**	**Undetermined**	**Legal intervention/war**
All injury	V01-X59 , Y85-Y86	X60-X84,Y87.0,*U03	X85-Y09,Y87.1,*U01-*U02	Y10-Y34,Y87.2, Y89.9	Y35-Y36, Y89(.0, .1)
Cut/pierce	W25-W29, W45	X78	X99	Y28	Y35.4
Drowning	W65-W74	X71	X92	Y21	
Fall	W00-W19	X80	Y01	Y30	
Fire/ hot object or substance	X00-X19	X76-X77	X97-X98,*U01.3	Y26-Y27	Y36.3
Fire/flame	X00-X09	X76	X97	Y26	
Hot object/substance	X10-X19	X77	X98	Y27	
Firearm	W32-W34	X72-X74	X93-X95,*U01.4	Y22-Y24	Y35.0
Poisoning	X40-X49	X60-X69	X85-X90,*U01.6-.7	Y10-Y19	Y35.2
Struck by or against	W20-W22, W50-W52	X79	Y00, Y04	Y29	Y35.3
Suffocation	W75-W84	X70	X91	Y20	
Other specified, classifiable	W23, W35-W41, W44	X75, X81,*U03.0	X96, Y02, Y05-Y07,	Y25, Y31	Y35(.1, .5) Y36(.0, .2,.4-.8)
	W49 W85-W91, Y85		*U01.0, .2, .5		
Other specified	X58, Y86	X83, Y87.0	Y08, Y87.1,*U01.8, *U02	Y33, Y87.2	Y35.6, Y89 (.0, .1)
Unspecified	X59	X84,*U03.9	Y09,*U01.9	Y34, Y89.9	Y35.7 Y36.9

REFERENCES

1. Medical Care Quality Section Medical Development Division. Incident Reporting and Learning System Manual. Putrajaya: Ministry of Health Malaysia; 2013. Available from: http://patientsafety.moh.gov.my/uploads/incident_reporting2013.pdf.
2. Bostwick JM, Rackley SJ. Completed suicide in medical/surgical patients: who is at risk? Curr Psychiatry Rep. 2007 Jun;9(3):242-6.
3. Farberow NL. Suicide Prevention in the Hospital. Hosp Community Psychiatry. 1981 February 1, 1981;32(2):99-104.
4. Ho T, Tay M. Suicides in general hospitals in Hong Kong: retrospective study. PMID: 15479960 [PubMed - indexed for MEDLINE]. 2004;10(5):319-24.
5. Morgan HG, Vassilas CA, Owen JH. Managing suicide risk in the general ward. British Journal of Hospital Medicine. 1990;44:56-9.
6. Suominen K, Isometsä E, Heilä H, Lönnqvist J, Henriksson M. General hospital suicides--a psychological autopsy study in finland. General Hospital Psychiatry. 2002 2002/12//;24(6):412.
7. Joint Commission on Accreditation of Healthcare Organizations. National Patient Safety Goal. Goal 15 - Suicide Risk Reduction [serial on the Internet]. 2010: Available from: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals.
8. National Institute for Clinical Excellence. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. London: National Institute for Clinical Excellence (NICE); 2004.
9. American Psychiatric Association. Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. Virginia: Americal Psychiatric Association; 2003.
10. Pelham B, Nyiri Z. In more religious countries, lower suicide rates. Gallup [serial on the Internet]. 2008: Available from: http://www.gallup.com/poll/108625/more-religious-countries-lower-suicide-rates.aspx.
11. NSW Department of Health. Determining suicide risk level. Framework for Suicide Risk Assessment and Management for NSW Health Staff. North Sydney: NSW Health; 2004. p. 18-20.
12. National Institute of Clinical Studies. Emergency department mental health triage tool and worksheet. Victorian Emergency Department Mental Health Triage Project 2005–06 training manual. Melbourne: Victorian Government Department of Human Services; 2007. p. 6-11.
13. Vandekieft GK. Breaking Bad News. American Family Physician. 2001;64(12):1975-8.

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