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Nurses' attitudes and understanding of the suicidal patient

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NURSES' ATTITUDES AND UNDERSTANDING OF THE SUICIDAL PATIENT

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Dedication

To those who have lost their lives by suicide,

To those who struggle with thoughts of suicide,

To those who have made an attempt on their lives,

To those caring for someone who struggles,

To those left behind after a death by suicide,

To those in recovery, and

To all those who work tirelessly

to prevent suicide and suicide attempts in our nation.

We believe that we can, and we will make a difference.

(U. S. Surgeon General, 2012)

NURSES' ATTITUDES AND UNDERSTANDING
OF THE SUICIDAL PATIENT

An Abstract of the Scholarly Project by
Cheryl A. Lemmon

Motivation / Problem statement: While not all suicides are predictable, there are reasonable guidelines for identifying those individuals at risk and reducing risk for high-risk individuals. There is, however, an apparent gap in best practice as there is a continual climb in suicide statistics. The aim of this project is to survey emergency department nurses to discover their attitudes and understanding of suicide. The purpose is to better understand the phenomenon, and guide education initiatives, as nurse professionals are in a key position of prevention when working with these patients.

Methods / Procedure / Approach: A non-probability, purposive and voluntary sample (n=23) of all registered nurses in one emergency department were requested to participate in a survey. The response rate was 52%. A mixed approach was used to assess nurses' attitudes and understanding of the patient with suicidal behavior. The quantitative section evaluated attitudes and understanding using five-point Likert scales. Attitude concepts measured included self-perceived competence, commitment, empathy and irritation. The qualitative section evaluated attitudes and understanding based on published statistics, risk factors and warning signs. Questions concerning honesty in the survey and interest in education concerning the suicidal patient were included.

Results / Findings / Product: The understanding of the suicidal patient proved significantly less than positive. Although the reported attitudes toward the patient with suicidal behavior were midway between negative and positive, emergency department

nurses were less committed, less empathetic and more irritated with patients who carried risk factors for suicide. The nurses had a more negative attitude toward patients with mental health diagnoses and an even more negative attitude toward patients with substance misuse diagnoses. Of the 12 who replied to this survey, eight designated that their responses should be "accepted as fully honest." Two indicated that their responses should be "accepted but with some reservation." Two did not select a response. Though the simple majority had some degree of interest in education in suicidology, half of the respondents identified as having no interest to little degree of interest.

Conclusion / Implications: While the survey tool is not factorially pure, the results are consistent with other research. Nurse education and discussion of current challenges may be discerning as attitudes and understanding affect safety and quality of care.

Keywords: Attitude, Nurse, Suicide, Understanding

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Introduction/Purpose

Suicide is of epidemic proportions. The global incidence of suicide is as many as one million deaths annually (World Health Organization, 2018). In the U.S., there are over 40,000 suicides per year (Substance Abuse and Mental Health Services Administration, 2017). Kansas has its own sobering statistics with 512 deaths by suicide in 2016 (Kansas Suicide Prevention Resource Center, 2018).

With the benefit of hindsight, many suicides are cases of lives lost to missed opportunities of professionals who missed the red flags of suicide. Data from 2011 show that 45 percent of individuals committing suicide had been seen by their primary health care provider within the previous month, and 77 percent had visited their primary provider within the preceding year (Substance Abuse and Mental Health Services Administration, 2011). The proactive opportunity to ask about suicide was seldom raised (Substance Abuse and Mental Health Services Administration, 2011). Hospital emergency department (ED) personnel have an especially important role to play in identifying those at risk of suicide. Emergency department staff see a wide range of patients and deliver almost half of all hospital-associated medical care (Wallace, 2017). One in eight visits to emergency departments (EDs) in the U.S. is related to a mental or substance use disorder (Weiss, Barrett, Heslin, & Stocks, 2016). Both disorders are

common and critical risk factors for suicide; however, many of those treated in EDs, including those experiencing mental health or substance use crises, simply do not receive the recommended follow-up treatment (Asarnow et al., 2011). Others are not identified as being at risk for suicide. Statistics from 2014 show that 40 percent of those who had died by suicide had an ED visit within the last year, many of them for non-psychiatric complaints (Commonwealth of Massachusetts Board of Registration in Medicine, 2014). In another study of 1,599 suicides over a three-year period, more than ten percent of those who committed suicide had been discharged from an ED within the previous six weeks (Cereal et al., 2015). Even more immediate is a study by Drake, Garza, Cron, and Wolf, (2016) of 3,944 suicides committed in Harris County, Texas, during the period from 2006 to 2014. Of those suicides, 30 occurred within 72 hours of the individuals' discharge from medical care. In their 2016 sentinel event alert, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) published their own data. Among patients receiving treatment in a staffed, 24-hour-care setting, or within 72 hours of discharge including from a hospital's ED, from 2010 to 2014, there were 1,089 suicides (Joint Commission, 2016). The most frequent root cause documented was failures in assessment, most commonly psychiatric assessment (Joint Commission, 2016).

Clinicians have a crucial role in detecting risk for suicide. The Joint Commission concluded with the recommendation of universal screening of all patients (behavioral, emergency and primary) for the risk of suicide, using a brief, evidence-based, standardized screening tool. In their 2017 Hospital National Patient Safety Goals, the Joint Commission published their safety goals. The goal then was the identification of patients at risk for suicide. This Joint Commission's standard focused on an assessment

that applied to those patients being treated for behavioral or emotional disorders in general hospitals, and all patients in psychiatric hospitals. Clinicians are to identify characteristics and environmental factors specific for risk of suicide. When a patient is found at risk, they are to receive the appropriate treatment. Of priority is the stability and safety of the patient. When discharged from the inpatient setting, a close working relationship between the patient and the provider will serve as a framework for appropriate and safe outpatient treatment to provide for prevention of suicide.

Concerning the problem of suicide, the focus is how to prevent them. Specific to this project, the Joint Commission, in their mission to continuously improve the quality and safety of care, published the expectation and set the standard. All patients presenting to EDs will be screened for behavioral and emotional disorders, and possible prevention needs. Those who screen positive will be further screened for risk of suicide and any intervention necessary (Joint Commission, 2017). Despite the evidence, the recommendations, and the mandates, the statistics show little sign of improved screening. In the second quarter of 2017, suicide was the second most frequently reported sentinel event (Fenner, 2017). By the year's end suicide numbers had dropped from 90 in 2016, to 89 in 2017. This placed suicide as the third most frequently reported sentinel event (Joint Commission, 2018).

Description of the Clinical Problem/Issue

While not all suicides are predictable, there are reasonable guidelines for identifying those individuals at risk and reducing risk for high-risk individuals. There is, however, an apparent gap in best practice as there is a continual climb in suicide statistics. Prior to The Joint Commission's 2016 recommendations, it would be rational

to assume that this gap was due to healthcare workers not screening patients. After the Joint Commission's 2017 requirements, all patients are being screened for suicide risk. The universal screening is accomplished and verified by way of a stopgap in the electronic medical record. This has become the long-term fix of circumventing the problem of healthcare workers not inquiring about risk factors.

The clinical problem then is that nurses are failing to recognize the suicidal patient. Nurses should be knowledgeable of risks for suicide and be expert in how to identify these patients. Nurses should be skilled in the assessment via a brief but deliberate screening. The questions asked are systematic and standard yet individualized according to and as the patient may answer in the algorithm. This method is accurate and is the foundation of all prevention programs.

Some studies show that clinicians and nurses specifically, although in a unique position to recognize those at risk for suicide and initiate an intervention, may have negative attitudes toward and poor understanding of those at risk for suicide. A negative attitude is one that is judgmental, lacks sympathy, and is unwilling to help. This would render the healthcare provider ineffective in applying the screening tool. Instead of feeling helped and hopeful, the patient is left feeling helpless and hopeless. Perhaps this is the gap that, if addressed, could decrease the numbers of suicide. Literature suggests that a nurse's lack of understanding and poor attitude toward the suicidal patient can unfavorably impact nursing care and patient outcome (Osafa et al., 2012; Valente, 2011). Attitudes related to a lack of knowledge and skills can be corrected by education. Attitudes secondary to personal values are not so easily corrected and confound the clinical problem.

Project Questions

The project questions are:

■ How do emergency department nurses working at Ascension Via Christi Hospital, Pittsburg, Kansas, caring for patients with circumstances of suicidality, perceive their understanding of and attitude toward patients who have attempted suicide?

■ What level of understanding do emergency department nurses have toward patients who have attempted suicide?

■ What attitudes do emergency department nurses have toward patients who have attempted suicide?

It is understood that nurses play a central role in the outcome of the suicidal patient. The objective of this project is to understand the perspectives of nurses. The results of the present study may provide support for the planning of educational strategies and psychosocial support for nurses. Progress forward will translate into recommendations for best practices.

Specific Aims/Purpose

The aim of this project is to survey ED nurses to discover their attitudes and understanding of suicide. The purpose is to better understand the phenomenon, and guide education initiatives, as nurse professionals are in a key position of prevention when working with these patients. Assessment of ED patients may be completed using the Columbia Protocol. Combined with individual core competencies and skills, nurses can identify those at risk and ultimately prevent suicides. The Columbia Protocol was developed in 2007, adopted and recommended by the Centers for Disease Control and

Prevention in 2011, and declared the standard by the Food and Drug Administration in 2012 (Columbia Lighthouse Project, 2016). The tool is reliable and valid in identifying who is at risk, as well as the level of the risk (Columbia Lighthouse Project, 2016). When using the Columbia Protocol, some nurses may approach the concept of suicide as a mental health issue. The attitude will be one of helpfulness. With this mindset, education can more easily help improve the understanding and attitudes of these nurses. Despite using the reliable and valid tool, other nurses may approach the subject of suicide as a moral issue. This attitude will reinforce the patient's feelings of hopelessness. These attitudes are fed by experiences and morals and are not so easily changed (Osafo, Knizek, Akotia, & Jhelmeland, 2012).

Significance

Although suicide is of epidemic proportions, it can be prevented. As the act of suicide is multifactorial, the approaches to the prevention of suicide must be multimodal. Assessment of and intervention for these individuals must consist of a strategy that includes the assessment of access to lethal means, media coverage in a responsible way, and education of the public, as well as identification methods through screenings, and healthcare personnel training and education (Schwartz-Lifshitz, Zalsman, Giner, & Oquendo, 2012). A nurse's primary responsibility is patient care, and they spend most of their time with patients. They spend more time with patients than any other provider (University of New Mexico, 2016). It is this pivotal position that gives the nurse the greatest opportunity to recognize and intercede with the patient at risk of suicide (Bolster, Holliday, Oneal, & Shaw, 2015). To be successful, nurses on the front line must look for clues and listen to the patient, as well as the patient's family and friends. Nurses must

survey the patient in a direct and straightforward manner. Weinstock, (2018b) says that the interview doesn't have to be perfect but must be done with respect and in attempt to understand the patient's situation. Nursing education can result in competent and confident knowledge and skills that results in the therapeutic care and connection required for prevention of life.

Theoretical Framework

More commonly known as the Change Theory, Kurt Lewin's Field Theory will be used as a framework for this scholarly project, to explore the nature of nurses' attitudes and understanding of patients with suicidality. A conceptual model might include certain factors that influence a person's understanding and attitude. Such concepts might include nurses' education and skills, the reputation of the patient, stigma of suicidal patients, needs of the nurse, previous personal experiences, personal characteristics of the nurse, and social norms. These factors are what Lewin calls life forces in the field of the individual. These forces impact the nurses' approach to all patients. Further, the nurses' approach will influence the patient's outcomes. Should the study reveal a lack of understanding or poor attitudes, the study could still be used. Lewin made the acute observation that "So far as interdependence of events is concerned, we live in one world" (Burnes & Bargal, 2017, p. 97). Considering the total social force field, Lewin recognized that "Changing people's attitudes or behaviors is tantamount to trying to break a well-established custom or social habit" (Burnes & Bargal, 2017, p. 94). Lewin observed the unique role of management and the power of leadership in assessing the forces to resolve any social conflicts and see the change through to a planned, new equilibrium.

Composed of and secondary to the life forces, a phenomenon called change occurs. In Lewin's theory, the basis for any change model consists of three steps. These three steps are 1. unfreeze; 2. move (or change); and 3. freeze. Virtually all literature refers to the third stage as "refreeze;" however, Lewin uses the term "freeze" (1951, p. 228). The unfreeze stage entails driving forces and restraining forces. With the facilitators and push, the opportunity of a more desirable state is realized. With the barriers and pull, the threat of a less desirable state is a threat. The change stage is dependent on only the current fields and is independent of the past or future fields. The present field will move or change depending on the sum strength of the coexisting and opposing forces. The freeze stage occurs when the proposed change has been adapted. This translates to a change that is a part of the organization's culture. At this point there is an equilibrium or a new norm in the status quo.

In the context of suicide, the statistics indicate an area in need of quality improvement. Key stakeholders must identify the barriers to change. For this study, the negative forces considered relate to the function of the nurses. Do they have the knowledge and skills to identify and manage the acute phase of a suicidal patient? Are they competent? Confident? Does their attitude and understanding contribute as a positive outcome, or is this a barrier? Kurt Lewin's adage is still applicable: "There is nothing so practical as a good theory" (1951, p. 169).

Definition of Key Terms/Variables

The guidelines (Departments of Veterans Affairs and of Defense, 2013), list terms and define them as listed in Table 1. While a person's history of self-harming behaviors or non-fatal attempts is important, their current ideation or thoughts, (aggressive,

Table 1
Terms and Definitions

Interrupted By Self or Other	A person takes steps to injure self but is stopped by self or another person prior to fatal injury. The interruption may occur at any point.
* Non-Suicidal Self-Directed Violence Behavior	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of intent to die.
* Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.
Physical Injury	A bodily injury resulting from the physical or toxic effects of a self-directed violent act interacting with the body.
Preparatory Behavior	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Suicidal Ideation	Thoughts of engaging in suicide-related behavior. (Various degrees of frequency, intensity, and duration.)
Suicidal Intent	There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and inferred in the absence of suicidal behavior.

* Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.
Suicide	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.
Suicide Attempt	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior.
* Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence.

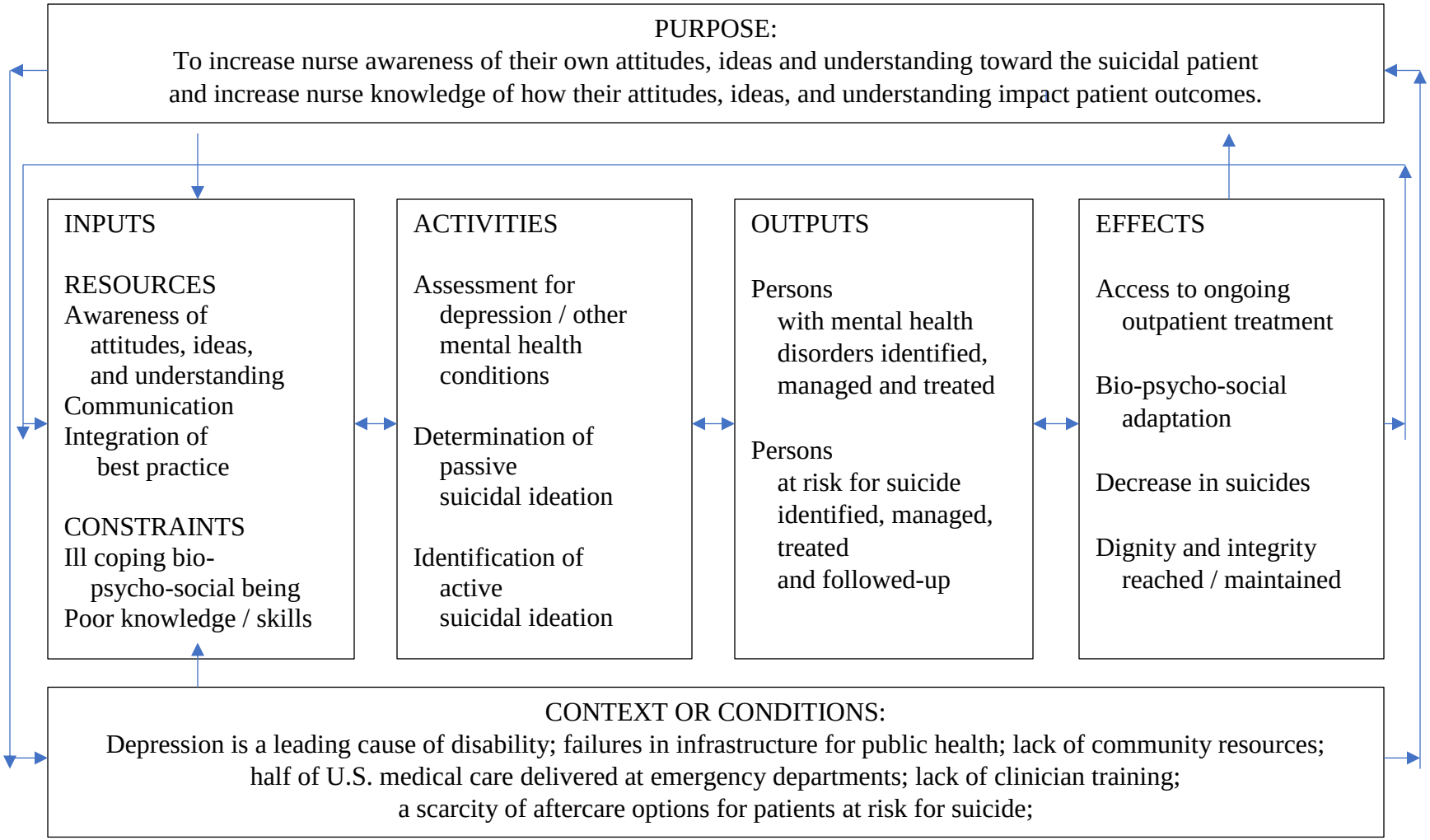
* The guidelines advise that those marked with an "*" are different and each has their important recommended treatment; however, the distinction may at times be unclear. (Department of Veterans Affairs, & Department of Defense, 2013, page 13).

homicidal and / or suicidal), present plan and intent, behavior, in addition to the contextual trigger, and the current mental state all figure into determination of risk (Department of Veterans Affairs, & Department of Defense, 2013).

Logic Model of the Proposed DNP Project

A correlating logic model has been created and is found in Figure 1. It depicts how change will occur. Input to nurses will include both resources and constraints. The balance of the psychological and social forces in the field will determine which direction the change heads. The greater the constraints, the more difficult the change. Constructs include "position, locomotion, cognitive structure, force, goal, conflict, fear, power, and values" (Lewin, 1951, pp. 39–41). As the resources grow, change occurs toward a more desirable state. Nurses will increasingly, competently and confidently assess for risk

Figure 1
Kurt Lewin's Field Theory: A logic model for change and assessment for risk for suicide



factors of suicide, determine if there is any concern of risk and, if there is, assess for significance of that risk, or refer the individual for further assessment. Patients will be appropriately assessed and treated. Overall, there will be an increase in referrals for treatment and a decrease in suicide rates.

Summary of Chapter

Suicide statistics are significant. If a nurse's understanding and attitude is contrary to the assessment and management of the patient, the clinical problem will render opportunities lost. Lives will continue to vanish in growing numbers. The aim of this project is to evaluate nurses' attitudes and understanding of suicide. With better understanding of the nurse perspective, appropriate education initiatives will increase competence and confidence, and change attitude, which will be reflected in the care and outcome of the patient.

Chapter II

Evidence/Integrated Review of the Literature

Although this review of the literature is not exhaustive, this summary of the review focuses on prevalence, Kansas statistics, circumstances of suicide, and research examining attitudes and understanding of healthcare workers and suicide. The summary will give the reader a glimpse of the complexity of the phenomenon of suicide, to include the role of the healthcare worker. We know that a nurse's negative attitude toward a patient who is suicidal can be apparent, and signs of a negative attitude can include anxiety, avoidance, hostility, and rejection (Bolster, Holliday, Oneal, & Shaw, 2015). It is also known that a clinician may lack education related to suicidality and consequently might be fearful (Bolster, Holliday, Oneal, & Shaw, 2015). Fear can result in the nurse ignoring the patient or limiting interactions with the patient (Bolster, Holliday, Oneal, & Shaw, 2015). Education can help change attitudes and improve risk assessment skills, thereby likely influencing patient care and outcome. The level of learning about suicide directly influences understanding of suicide and has been identified as an influence on attitudes toward the suicidal patient (Bolster, Holliday, Oneal, & Shaw, 2015). Lewin (1951, p. 65) captures this concept and defines learning as "doing something better than before." With increased knowledge, attitudes can change, and nurses will recognize the suicidal patient and be better equipped to intervene in the prevention of suicide.

Prevalence

In 2015, 2,712,630 deaths were recorded in the U.S., of which 44,965 (1.66%) were due to suicide, making suicide the tenth leading cause of death (National Center for Health Statistics, 2017). Findings from a cross-national study of seventeen countries including the United States found the adult lifetime prevalence of suicidal ideation, plans, and attempts at a corresponding 9.2%, 3.1% and 2.7% (Nock et al., 2008). A later study of twenty-one countries together with the United States shows that of persons with a history of lifetime suicidal ideation, the likelihood of movement from the "ideation" stage to the "planning" stage is about 33 percent, and the probability of continued forward movement to the imminent "autopilot" stage is approximately 30 percent (Cummings Institute, 2016; Schreiber, & Culpepper, 2018). In a survey completed solely in the continental United States, adolescents had a lifetime prevalence of suicidal ideation, plans and attempts of 12.1%, 4.0% and 4.1%, respectively (Nock et al., 2013).

Kansas Statistics

Each year from 2004 to 2013, the Kansas suicide rate was higher when compared to the national suicide rate (Kansas Department of Health and Environment, 2013). In 2013, the Kansas rate was 16.7 percent higher than the national rate (Kansas Department of Health and Environment, 2013). In 2016, suicide was one of the five leading causes of death for Kansans age 5 to 44 (see Table 2).

Table 2
2016 Kansas Suicide Rates

	Age Groups and Suicide		
Age	5-14	15-24	25-44
Rank	4th	2nd	3rd

(Kansas Department of Health and Environment, 2017).

A factor that could significantly limit the validity of these numbers is the under-reporting of suicides. According to Gray et al., (2014) because there is no standard method of determining suicide, in the absence of clear evidence of suicide, a death can be classified as "accident," (the third leading cause of death in 2015) even if suicide is suspected (National Center for Health Statistics, 2017). Examples of deaths for which clear evidence might be absent include auto accidents (Henderson, & Joseph, 2012), overdoses (Weinstock, 2018a), and even gunshot wounds (Gray et al., 2014). Further, when there are no conclusive signs of the manner of death, the cause could be listed as "undetermined" rather than as suicide (Bournemouth University,2015; Centers for Disease Control, 2003; Snohomish County Government, n. d.).

To further explain the confounds within the suicide and death classification scheme, it is necessary to remember that the precursors to suicide are typically suicidal ideations, plans, and then self-directed violence. That said, not all self-directed violence that results in death is a suicide. Non-suicidal self-directed violent behavior may indeed result in death by "accident." In other situations, the intent of self-directed violence is undetermined. Both non-suicidal self-directed violence and undetermined self-directed violent behavior can skew the statistics, possibly resulting in over- and underreporting.

The National statistics for the United States show that in 2016, of those age eighteen or older, 9.8 million had ideations of committing suicide, 2.8 million made plans for suicide, and 1 million acted with self-directed violence (National Institute of Mental Health, 2018). Suicidal ideations, plans, and behaviors are all damaging and dangerous, and all could be considered an emergency (National Alliance on Mental Illness, 2018). Historical factors including a previous suicide attempt or prior suicidal self-directed

violence are most important and would place this person on the "high acute risk" level of suicide (Department of Veterans Affairs, & Department of Defense, 2013; World Health Organization, 2017).

Circumstances of Suicide

Major risk factors include mood disorders, substance use, prior suicide attempts, and access to lethal means (Substance Abuse and Mental Health Services Administration, 2017). That said, more than 60 percent of people who need treatment for mental health problems do not perceive the need for care, and more than 90 percent of people who need treatment for substance use problems do not perceive the need for care (Substance Abuse and Mental Health Services Administration, 2011). Villa (2018) reports that of the 8.2 million adults who had a co-occurring mental illness and substance use disorder in the previous year, only about 6.9% of adults received the mental health and substance abuse care they needed. Besides the individual risk factors including chronic pain, clinical depression, coping difficulties, life-altering injury, mental illness, substance use, terminal disease and previous attempts, socioeconomic status can also translate into risk factors. Societal risk factors could include lack of access to mental health care. Community risk factors might include too few safe and supportive relationships. Relationship influences would include a family history of suicide, and violent relationships. Availability of a lethal means to suicide is also a social risk factor (U. S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012). In Barr's book (2014), he elaborates on the toll of toxic stress related to childhood adversity. There is overwhelming evidence that abuse, loss, neglect, psychiatric disorder, poverty, or trauma "has protean effects on children's physical and mental health" (Barr, 2014, p. 149). This adversity has been

linked to several chronic conditions including cardiovascular disease, depression, obesity, smoking, substance abuse and attempted suicide (Barr, 2014).

While certain factors increase an individual's risk of suicide, there is no single reason for the phenomenon (Kahn, 2018). For example, while debilitating disease is often associated with suicide, Kashdan (2014) argues that people do not commit suicide due to pain but because they believe they are a burden, and they believe that others would be better off without them (Kashdan, 2014). Olson (2014), disagrees, arguing that pain that is intolerable past endurance leads to suicide. Tracy explains that this extreme pain can be due to physical disease, mental illness, social circumstance, or a combination of the three (2018).

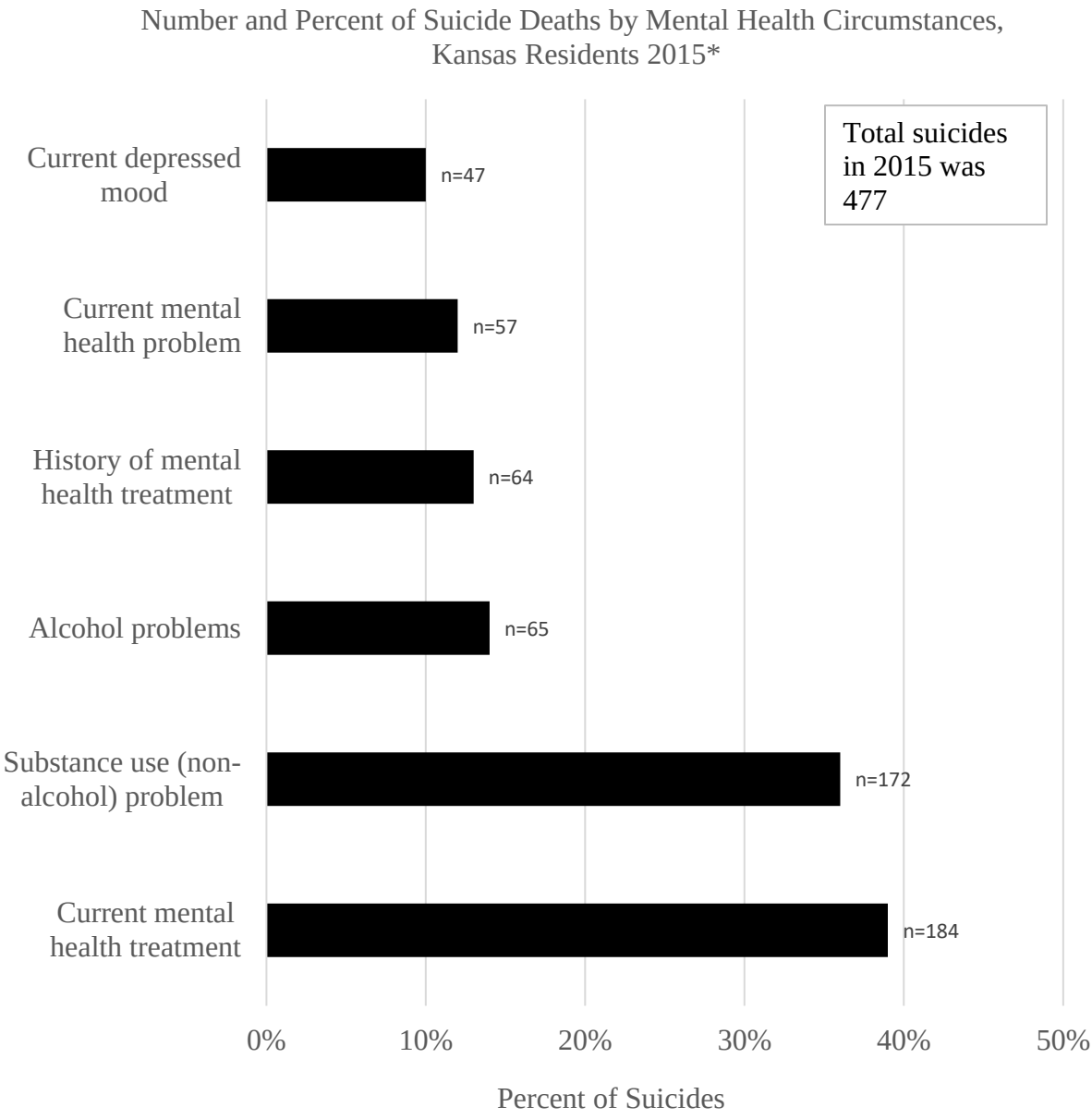
In considering an individual's motivations for suicide, it is vital to know that "Most suicides are driven by a flash flood of strong emotions, not rational, philosophical thoughts in which the pros and cons are evaluated critically" (Baer, 2014, para. 6). The ruminative flooding of negative thoughts suggests a "thwarted sense of belongingness" and a "perceived sense of burdensomeness" (Hutton, 2015, Thoughts associated with, para. 1). This flash flood theme is supported by research that reveals that the ratio of planned attempts to suicide impulsivity is 13:87 (Suicide Prevention Resource Center, 2016). The same study found the planners to be older and leave less opportunity for rescue (Suicide Prevention Resource Center, 2016).

Additional aid in the identification and understanding of the suicidal person comes with the development of the National Violent Death Reporting System (NVDRS). Kansas began participating in the system in 2015 (Kansas Department of Health and Environment, 2018). This is a methodical system that surveils and compiles data on

violent deaths. Information comes from multiple sources. The four major ones are coroner / medical examiner reports, death certificates, law enforcement reports and toxicology reports (Centers for Disease Control, 2017). The purpose is to help provide for a better understanding of suicide. The purpose is also to guide decision-making and to identify appropriate suicide prevention strategies (Kansas Department of Health and Environment, 2018). Better understanding of the suicidal individual will result in a more rapid recognition of the person in need of help and will result in an attitude that contributes to helpfulness to the patient. With the benefit of the data published by Kansas' Violent Death Reporting System, the following are tables illustrating circumstances surrounding suicide deaths in Kansas in 2015. Table 3 shows data on suicide deaths by mental health circumstances. Table 4 shows data on suicide deaths by non-mental health circumstances.

There is evidence that a public health approach would be considered effective in reducing suicides. Released by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention, the 2012 approach for suicide prevention was proposed to guide the suicide prevention movement in the United States (U. S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012). The strategy provides guidance for clinicians and health systems. Addressed specifically is the adoption and promotion of education and training guidelines on the prevention of suicides.

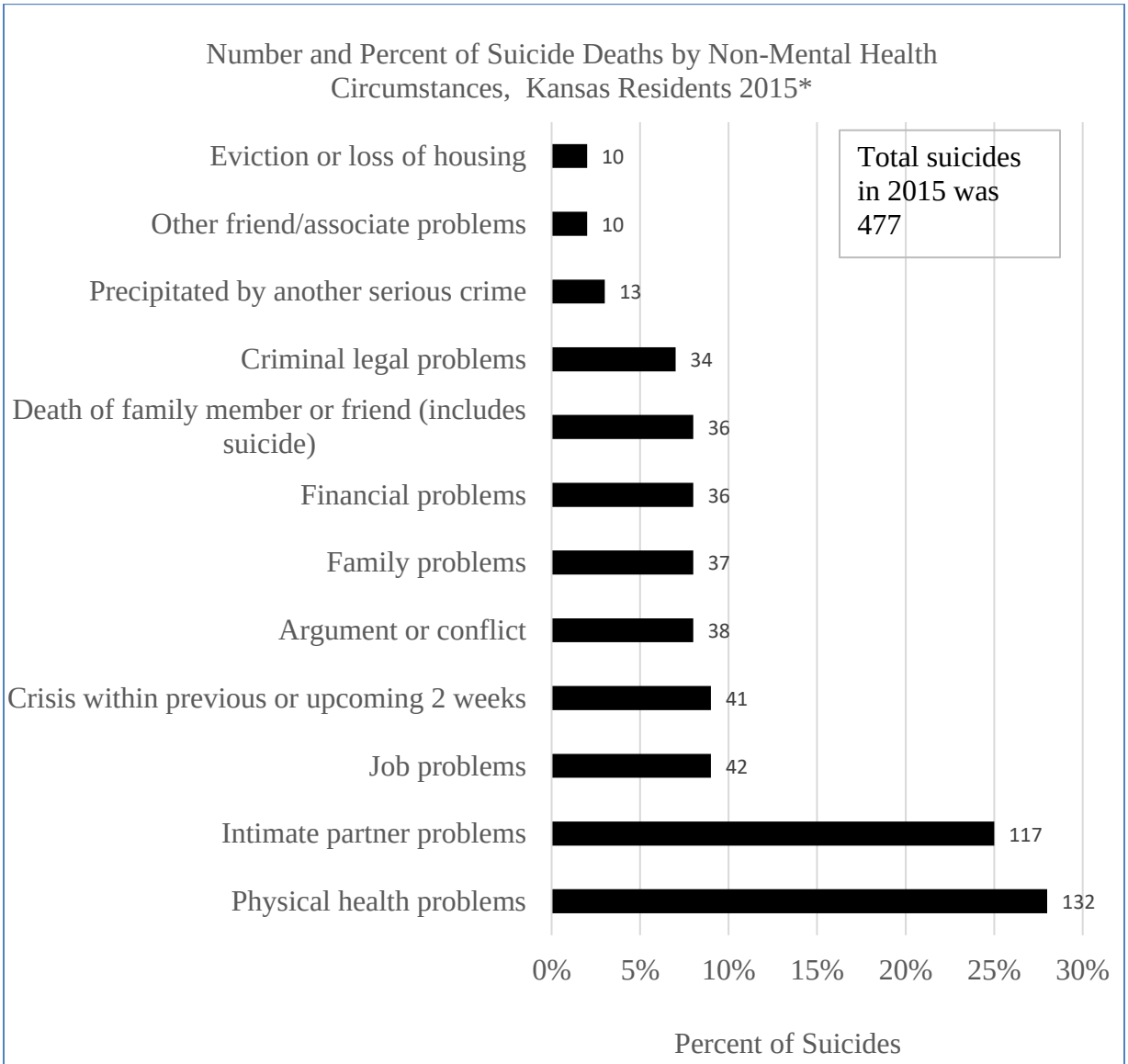
Table 3
Number and Percent of Suicide Deaths by Mental Health Circumstances, Kansas Residents 2015



*Data is presented for suicide deaths with available circumstance information. In 2015, 90% of suicide deaths among Kansas residents had circumstances identified. Circumstances with counts less than 10 are not shown. (2015 KS-VDRS, Bureau of Health Promotion, KDHE)

From "Suicide in Kansas: Gathering the data," by Zolck, D. 2018. Copyright 2018 by The University of Kansas Medical Center. Reprinted with permission.

Table 4
Number and Percent of Suicide Deaths by Non-Mental Health Circumstances, Kansas Residents 2015



*Data is presented for suicide deaths with available circumstance information. In 2015, 90% of suicide deaths among Kansas residents had circumstances identified. Circumstances with counts less than 10 are not shown. (2015 KS-VDRS, Bureau of Health Promotion, KDHE)

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Research of Attitudes and Understanding of Healthcare Workers

Research related to attitudes and understanding of the suicidal patient is scarce, particularly for nurses. The following is a brief overview of ten studies relevant to suicide and healthcare providers' attitudes and / or understanding. Subjects surveyed include doctors, medical students, mental health clinic professionals, nurses, nursing students and health care providers in general. Of the ten studies, three were specific to nursing, two being licensed nurses and one being nursing students. All studies surrounded the concept of attitudes, ideas and / or understanding of health care professionals regarding suicide. Six of the studies primarily explored the attitudes of healthcare workers toward the suicidal patient. Four of the studies explored both the attitudes and understanding of the suicidal patient. No research exploring only the understanding of the suicidal patient was located. Studies were completed in seven different countries including Australia, Greece, India, Japan, Malasia, Norway and Sweden. None of the studies were completed in the United States. Studies were conducted from the years 2003 to 2014. Research instruments used were wide-ranging. Two studies used the Attitudes Towards Attempted Suicide Questionnaire (ATAS-Q). One investigation used the Attitudes to Suicide Prevention (ATSP) scale.
One inquiry used the Sympathy Acceptance Understanding Competence (SAUC) model. Two studies used the Suicide Opinion Questionnaire (SOQ).
Three of these six were adapted to the study. The other three mentioned no modification. Another two studies combined the Attitudes Towards Suicide (ATTS) and Understanding of Suicidal Patients (USP) tools. Authors and researchers designed their own tools in two

of the reviewed studies. One of these studies focused on attitudes toward and the other focused on attitude and understanding of the suicidal patient.

The chief findings in the literature referenced are next identified and discussed. Researchers designed their own survey in Sweden in 1998 to assess medical students' individual suicidal thoughts and ideas on suicide. About 39 percent of those surveyed had had their own suicidal thoughts. Though there was a strong belief held that the suicidal patient could be helped, those with a history of their own suicidal thoughts tended to have a less optimistic attitude about the possibility to help. Knowledge difference between first- and fourth-year students revealed the positive influence that education can bear on attitudes (Wallin, & Runeson, 2003). An inquiry of general health professionals in Australia, 2006, used the Attitudes to Suicide Prevention (ATSP) Scale and found that those that attended educational initiatives showed significantly more positive attitudes towards suicide prevention (Brunero, Smith, Bates, & Fairbrother, 2008).

In Greece, doctors' attitudes were assessed using the Attitudes Towards Attempted Suicide-Questionnaire (ATAS-Q). Overall, doctors displayed relatively unfavorable attitudes toward the suicidal patient (Ouzouni, & Nakakis, 2012).
In Greece, nurses' attitudes were assessed using the same questionnaire (ATAS-Q). Nurses also held relatively unfavorable attitudes toward the suicidal patient (Ouzouni, & Nakakis, 2013).

Indian nursing students, in 2012, completed the Suicide Opinion Questionnaire (SOQ). Results showed that early and enhanced education can mold a favorable attitude in nursing students who are uncertain in their abilities to work with the suicidal patient

(Nebhinani, M., Nebhinani, N., Tamphasana, & Gaikwad, 2013). Malasian psychiatric and non-psychiatric healthcare workers completed the same questionnaire (SOQ). A majority demonstrated a lack of knowledge of risk factors of suicide. Some expressed judgment of patients as being manipulative or less religious. Some were irritated and were convinced that suicide was a selfish act. Psychiatric workers were found to have more positive attitudes (Siau, Wee, Yacob, Yeoh, Adnan, Haniff., . . . Wahab, 2017).

These six studies highlight the history of and persistence of attitudes that are not conducive to the patient and positive outcomes. Four of the six studies found that education can positively impact attitude. Two of the four studies showed that attitude can change the approach to the patient.

Four studies explored both the attitudes and understanding of the suicidal patient. Research was conducted to understand professionals attitudes and understanding in mental health clinics in Norway, in 2010 and 2011. The Understanding of Suicidal Patients (USP) Scale and Attitudes Towards Suicide (ATTS) Questionnaire were adopted for the study. The most common cause of suicidal behavior was indicated as psychiatric disorders. Findings revealed that there was an overall belief that suicide could be prevented; however, there was a shared understanding that those with other conditions of comparable severity, such as heart disease, were more systematically followed (Norheim, Grimholt, & Ekeberg, 2013). Norwegian physicians in 2010 completed the same scale (USP) and questionnaire (ATTS). Overall, there were findings of a positive attitude toward the suicidal patient, although physicians were most irritated by patients who misused substances. It was found that increased competence with suicide and attitudes of

providers can translate to high-quality care (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

Swedish nurses completed the questionnaire from the Sympathy-Acceptance-Understanding-Competence (SAUC) model. Results showed that although nurses understand the significance of encounters with suicidal patients, the actions and goals of the nurse didn't strengthen the patients' self-perspective (Larsson, Nilsson, Runeson, & Gustafsson, 2007). Researchers designed their own survey in Japan, in 2004, to assess medical students' knowledge of suicide. Students had a lack of competence about the characteristics and frequency of suicide, with attainment of only half the maximum score related to knowledge. Less than 50% of those surveyed showed sympathy toward the suicidal patient (Sato, Kawanishi, Yamada, Hasegawa, Ikeda, Kato., . . . Hirayasu, 2006).

These four studies bring to light the persistence of attitudes with only a basic or minimal knowledge of the suicidal patient. Congruence is lacking in lieu of the self-report of good attitude, as demonstrated by more systematically following those with somatic complaints and as evidenced by being more irritated by those with risk factors for suicide. Encounters with the patient absent engagement of the patient translates to a lost opportunity that could be fatal.

Reviewed research studies show that key to suicide prevention is education and understanding of the phenomenon (Brunero, Smith, Bates, & Fairbrother, 2008). Competence has been shown to lead to higher quality of care (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014). Other studies show that, despite education and understanding, some nursing encounters with suicidal patients are not supportive of the patient (Larsson, Nilsson, Runeson, & Gustafsson, 2007). Further research reveals that

"enhanced education" can favorably affect the attitudes of nurses and their ability to impact patient outcomes in a more supportive manner (Nebhinani, M., Nebhinani, N., Tamphasana, & Gaikwad, 2013). Even with belief in the preventability of and severity of suicide, some clinicians do not as closely and systematically follow these patients as compared to other conditions such as heart disease (Norheim, Grimholt, & Ekeberg, 2013).

There is an unfavorable attitude toward these patients by doctors and nurses alike (Ouzouni, & Nakakis, 20132; Ouzouni, & Nakakis, 2013). Some studies show an outright lack of sympathy for the patients (Sato, Kawanishi, Yamada, Hasegawa, Ikeda, Kato., . . . Hirayasu, 2006). Other healthcare workers become irritated and are quite judgmental (Siau, Wee, Yacob, Yeoh, Adnan, Haniff., . . . Wahab, 2017). The most promising results came from a group of surveyed medical students who felt that the suicidal patient could be helped; however, of the same respondents, more than one-third had experienced their own suicidal thoughts (Wallin, & Runeson, 2003).

Further search was completed to find more recent studies conducted in the United States and specific to nurses. PubMed was searched with the medical subject heading (MeSH) of "survey." The first search result subheading, "Surveys and Questionnaires" was used. The words "suicide" and "nurse" were added to the search, for a total of 362 results. "No assist" was added and narrowed the search to twenty. Of these 20 search results, only one matched the research topic of attitudes and understanding of nurses and the suicidal patient. A study by Wheatley and Austin-Payne (2009) of both licensed and unlicensed nursing staff suggested that emotions can be a mediating factor in one's opinion of deliberate self-harm and are linked to an inclination to assist. The indication

was that education would help nurses feel less anxious about working with the patient who self-harms and more confident about working with suicidal patients (Wheatley, & Austin-Payne, 2009). Still, the research was not specific to nurses, was not conducted in the United States, and is dated.

Practice Change Guideline and Appraisal

The gap in lack of identification of individuals at risk for suicide is crossed with consideration of a practice change guideline. The Department of Veterans Affairs and Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013) is considered for adoption and use in this scholarly project. The Appraisal of Guidelines for Research & Evaluation (AGREE II) Instrument serves as a framework to "Assess the quality and reporting of the practice guideline" (Brouwers et al., 2010, para. 1).

Domain one, scope and purpose, is met with objectives and questions described. The guideline does not address risk in children.

Domain two, stakeholder involvement, is met with a relevant and expert guideline group. The target population is "adults who are managed in the VA and DoD healthcare clinical settings. The population at risk includes patients who have suicidal ideation with or without an established diagnosis of a Mental or Substance Use Disorder and patients with any level of risk for suicide, ranging from thoughts of about death or suicide to SDV behavior or suicide attempt" (Department of Veterans Affairs, & Department of Defense, 2013, p. 4). The target user is "all clinicians caring for patients at risk for suicide" (Department of Veterans Affairs, & Department of Defense, 2013, p. 4).

Domain three, rigour of development, is met with multiple study designs and the conduction of thirty-eight systematic reviews. Criteria selection is described. Limitations are clear in that VA researchers concluded, "There is a lack of strong evidence for any interventions in preventing suicide and suicide attempts" (Department of Veterans Affairs, & Department of Defense, 2013, p. 5). "Two core challenges markedly diminish quality of evidence in suicide prevention research: difficulty conducting randomized controlled trials, and low base rates of suicide and suicide attempts, even in groups at higher risk for suicide" (Department of Veterans Affairs, & Department of Defense, 2013, p. 5). Formulation of recommendations methods are described. Benefits, side effects and risks are considered. Evidence is linked to recommendations. The guideline was externally reviewed. There is a procedure for updating the practice guideline.

Domain four, clarity of presentation, is met as recommendations are specific. Options for management are clearly presented. Key recommendations are identifiable.

Domain five, applicability, is met with the description of barriers and facilitators. Tools are recommended with how to apply to practice. Resource implications are considered. Criteria for monitoring are presented.

Domain six, editorial independence, is met with an approach that ensured that work outside of the work group meetings focused on evidence that supported the guideline. Competing interests were recorded and addressed.

Overall Assessment

The applied rating scheme data was less than desired related to domain three, lacking scientific data secondary to the subject of suicide. It is a limitation of the body of

evidence, Domain 3 / Item 9, that comes with the topic of suicide. The inherent and changing risk of the subject creates difficulty with reliable and valid research. Recommendations are thus based on the clinical experience and expert consensus of the working group, experts in their field (Department of Veterans Affairs, & Department of Defense, 2013, p. 7). With consideration of the risk of this population and their diagnosis related to suicide, this guideline is recommended for use.

Summary of Chapter

The lifetime prevalence of suicide is alarming. The decision to end one's own life is a phenomenon that professionals can only attempt to comprehend and explain. Circumstances that increase the risk of suicide are both acute and chronic. Both mental health and non-mental health circumstances can intensify the risk of suicidal situations. Kansas statistics differentiating mental health and non-mental health circumstances of suicide are listed. The clinical practice guideline is relevant to all providers in any setting. One of the goals is "to motivate administrators at each of the… patient care access sites to develop innovative plans to break down barriers that may prevent patients from having prompt access to appropriate assessment and care" (Department of Veterans Affairs, & Department of Defense, 2013, p.4). Some studies have been completed to explain barriers to prevention. Although understanding and attitudes have been shown to influence quality of care, research is wanting.

Chapter III

Methods/Plan

The research shows and experts publish that suicide is preventable (Each Mind Matters, 2018; Harborview Injury Prevention and Research Center, 2018). Although prevention is the responsibility of all healthcare providers, including nurses who most times are on the front lines, preventive steps should start prior to the first suicide attempt as "Prevention efforts beginning after index attempt would be too late for the nearly two-thirds dying on first attempt" (Bostwick, 2018, Practice implications, para 2). Yet, the numbers are wide-ranging and climbing to include patients who have most recently sought medical care. The purpose of this study is to assess the understanding of nurses and their attitudes toward the suicidal patient. The guideline states that understanding the patient's history and the origins of risk and warning signs can help target interventions that will prevent the suicide (Department of Veterans Affairs, & Department of Defense, 2013). The practice guideline recommends this understanding be translated into "effective evidence-based screening and assessment," though the whitepaper acknowledges that absolute certainty of risk cannot be predicted (Department of Veterans Affairs, & Department of Defense, 2013, p. 49, 53). Bolster, Holliday, Oneal and Shaw (2015) tell us that most registered nurses (RNs) have minimal or no education in the assessment, evaluation, treatment, or referral of suicidal patients. Because of this lack of

education, nurses feel ill-prepared and are not confident to talk to patients about suicide. It stands that the more knowledgeable a nurse on the phenomenon of suicide, the better prepared he / she is to intervene and to prevent suicide (Hutton, 2015). In addition to knowledge specific to suicide prevention, age, clinical experience, education level, and religion influence attitudes toward the suicide (Osafo, Knizek, Akotia, & Jhelmeland, 2012). A negative attitude is reflected in the health and safety of the patient (Neville & Roan, 2013). The aim of this project was to evaluate nurses' understanding and attitudes of suicide.

Project Design

Methodology for this project integrated quantitative and qualitative data. Mixing within this project allowed a more complete and synergistic use of the data as compared to either the closed-ended or open-ended method alone. Lewin (1951, p. 31) supports the combination stating, "Quantitative and qualitative approaches are not opposites but necessary complements of each other." The project questions benefited from this process, as the results more clearly and sufficiently measured and described the nurses' attitudes and understanding of the phenomenon of suicide.

Sample Access/Target Population

Ascension Via Christi Hospital in Pittsburg, Kansas is the target hospital for implementation of this nursing leadership best practice guideline and scholarly project. The 130-bed hospital offers an ED, a 10-bed, Level II trauma center with four fast track beds. During the fiscal year that began on 1 July 2017 and ended on 30 June 2018, the following data was available for the local hospital. Of the 15,216 patients who presented to the ED for care, 19 presented for detoxification, 60 presented for overdose, 79

presented for substance use, and 292 presented for psychological/social disorder (J. Cobb, personal communication, November 1, 2018). The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations. In 2017, The Chartis Center for Rural Health and iVantage Health Analytics named this hospital one of the "top 100 rural and community hospitals in the United States" (Hoener, 2017).

Many organizational changes have occurred at Ascension Via Christi since 2009. It was that year that Mount Carmel Regional Medical Center became affiliated with and rebranded as Via Christi Hospital, with the parent company in Wichita, Kansas. Then, in 2013, Ascension Healthcare bought-out Via Christi. It is primarily at the corporate organizational levels that communication, key knowledge, and implementation processes are originated. Such implementation strategies can change the climate and culture of the workforce.

The hospital has adopted the change management model, Diffusion of Innovations by Everett Rogers, to implement or incorporate evidence-based practice in patient care. Adopters of change are categorized as defined by the individual's degree and rate of acceptance of change. All adopters are included within the arranged six levels of the organizational structure. Levels include those of the board of directors, hospital president, chief nursing officer, directors, managers, and nurses.

Located in Crawford County, Ascension Via Christi Health (2017) posted its community benefit in fiscal year 2016, as $77.8 million. The county has been identified as the poorest in the state. Between 2009 and 2013, the rural county in southeast Kansas showed a poverty rate of over 20%, compared to the national poverty rate of 15.4% (Frohlich, 2015, Kansas). The hospital is located within five miles of a regional four-

year state university enrolling approximately 7,000 students (Pittsburg State University, 2019), yet Crawford County remains the poorest county in the state (Comen, Stebbins, & Sauter, 2018). The area and county population of 39,034 (United States Census Bureau, 2018) served clearly has additional needs related to mental health and substance use disorders as compared to Ascension's 141 hospitals covering 22 states (Ascension, 2016). This author is personally aware of two of the hospital's own employees that committed suicide within the past year.

The author of this scholarly project has been affiliated with the institution for twenty-seven years. The first seven years were worked as an RN in capacities including staff nurse in the ED, house supervisor and medical-surgical manager. The last twenty years were served as an advanced practice registered nurse (APRN) in an Employee Health / Occupational Health clinic. The multiple work situations have afforded an opportunity to appreciate the overall complexity and ever-changing inner workings of healthcare, particularly within this organization. The years of experience have allowed the building of connections with various and multiple employees.

With permission from the hospital president and chief nursing officer, further communication about the project involved the ED department manager. The goal was to avoid probability sampling and approach purposive sampling, to include all available ED registered nurses (RNs). The target population was all 23 RNs employed in the ED. There was an additional one position that remained vacant. The composition of the population included two part-time RN's, six "as needed" (PRN's who came from a float pool), six PRN's who were dedicated specifically to the ED, and 9 full-time RN's.

Sample/Target Population Recruitment

The manager of the target population expressed confidence that "all" RN's would help by participating provided the self-administered survey was sent by email. The department manager advised the employees during the January monthly meeting of the coming survey, of the expectation to complete the survey and to watch their emails. The meeting took place on Thursday, 31 January 2019. The email with the electronic survey was sent on Tuesday, 5 February 2019. The survey was launched via Google Forms, an online survey tool. Notices were posted in the employees' break room and in the medication room on that same day. These reminders were changed daily in effort to draw attention to the survey and to prompt participation. The survey was prefaced by a letter that clarified the purpose of the study, declared anonymity, explained why they were asked to participate, described what was expected of them, and advised them that they could, if they chose, receive a report of the research findings. Thursday, 14 February 2019, a mass email, again containing the survey, was sent with a reminder for those who had not completed the survey to do so. The first email was sent by this researcher while the second emails was sent by the ED director. The survey was closed at the end of the day on Monday, 18 February 2019.

Inclusion and Exclusion Criteria

Criteria for inclusion were that the participant must be actively employed as a Kansas licensed RN at the target institution and work in the ED. Demographic information was collected solely to describe the population sample. It was not collected for exclusion or inclusion purposes, or as a predictor of variable. Exclusion criteria were any Via Christ RN that did not work in the ED and ED staff who were not RN's. This criteria source serves as a foundation for validity of the results.

Protection of Human Subjects

As this research involved human subjects, per federal regulations, authorization to proceed with the study was secured through the Institutional Review Board at Pittsburg State University. The purpose of the group is to review the material and process, for the protection of the research human subjects. Appropriate steps were taken, and no modifications were required to accomplish meeting the requirement of the Review Board.

Instrument

A systematic review of measurement scales of suicidal attitudes was completed in 2015 by Ghasemi, Shaghaghi, and Allahverdipour. Fourteen measurement scales of suicidal attitudes were identified. Years of publication ranged from 1982 to 2011. Item numbers ranged from 4 to 100. Only one was specific to attitudes of nurses and that was The Suicide Behavior Attitude Questionnaire. It was published in 2005 and contained 21 items (Ghasemi, Shaghaghi, & Allahverdipour, 2015). Three themes were extracted from this quantitative tool: feelings toward the patient, professional capacity, and right to suicide (Botega et al., 2005). Of the "feelings toward the patient" section, there were seven items, four addressing attitudes and three addressing understanding. The "professional capacity" section contained four items. All items were self-report. The third section, "right to suicide," did not apply to this study. This questionnaire does not specifically and adequately address the areas of interest of this study. Constructing a questionnaire specific to the project questions, although not proven reliable or valid, seemed more useful to this research. Ghasemi, Shaghaghi, and Allahverdipour, 2015, (p. 165) state "There is no gold standard approach to study suicide-related attitudes and ideations."

The created survey was divided in five parts. The first part included 10 demographic items. Data collected included age, gender, religion, education level of nursing, years of practice as a nurse, years worked in the ED, current scheduled hours in the ED, courses and training in assessment and treatment of the suicidal patient, hours participated in courses and training in assessment and treatment of the suicidal patient, and degree of interest in courses and training.

The second part of the survey was formed by modifying an existing and published survey: Understanding of Suicide Attempt Patient Scale, by Samuelsson, Asberg and Gustavsson, 1997 (Kodaka, M., Postuvan, V., Inagaki, M., & Yamada, M., 2010). A very similar approach was taken by Grimholt, Haavet, Jacobsen, Sandvik and Ekeberg, 2014. In a quantitative, 5-point Likert format, four items inquire of the nurse's self-report of competence, commitment, empathy and irritation towards those with somatic, psychiatric, suicidal, and substance use diagnoses. Using a continued quantitative, 5-point Likert scale, eight items further inquired of the nurse's self-report on ideas concerning suicide specifically.

The third portion of the survey was formed with consideration of assessment of understanding of suicide. In qualitative format, and of this researcher's design, four items inquire about nursing understanding of the suicidal patient. Responses were assessed as compared to published statistics, risk factors and warning signs of suicide.

The fourth part entails three items. First, the nurse was asked about experience with suicide. Next, the RN was asked how her / his experiences affect her / his work with suicidal patients. Last, the nurse was asked what is required for the prevention of suicide.

The survey is closed with a sort of summary within three items. The respondent was asked about their honesty in the survey. This item will serve as a footing for reliability of the results. The individual was asked if they have any comment, concern, or question about the survey. This item leaves the respondent free to write what they want and define central issues. Last, the respondent was asked if they would like a copy of the survey findings. Copies will be available to the respondents, who will be able to pick up copies from the ED manager.

The questionnaire was reviewed by multiple entities and multiple times, as described in the "Procedure" section, in the following section of this chapter. Changes were made as suggested and discussed and agreed upon. The survey was piloted by the ED manager prior to electronic distribution.

Procedure

The cooperating agency was kept appraised over nine months' time of the generalized intent of the study. The proposed questionnaire was first reviewed by the hospital pastoral care and psychiatric / mental health management. Changes were made as recommended, discussed and agreed upon. The questionnaire was then reviewed by the hospital Chief Nursing Officer. Aware that the created questionnaire would first be approved by the Institutional Review Board (IRB), permission to proceed with the plan of surveying all ED nurses was granted by the hospital president and chief nursing officer (CNO). The CNO then suggested further communication and orchestration go through the manager of the ED department. The manager was provided a copy of the questionnaire to pilot, and she was asked for input. Changes were made as suggested and discussed and agreed upon. The Associate Professor of Pittsburg State University's Writing Center was also consulted, and more amendments were made prior to sending the

survey and IRB paperwork for approval. This is a three-step process that began with approval by the researcher's Scholarly Project Committee. Next it went to the Pittsburg State University School of Nursing IRB committee and then to the Pittsburg State University IRB. This process assured that all federal and institutional policies were followed for research subjects and data collected. Once the survey was cleared through the IRBs, the need for a Statement of Mutual Understanding (SMO) was discussed with administration at Ascension Via Christi, Pittsburg, Kansas. No SMO was required for proceeding. At this point, there were limited necessary resources to complete the project. The fiscal requirement was nominal. The hospital authorized the questionnaire to be sent to associates via emails through the hospital web site. Technology support required for Google Forms access was not necessary.

As discussed earlier in this chapter, under the subheading "Sample/Target Population Recruitment," a letter prefaced the survey. Anonymity was configured in the set-up of the survey. An electronic link to the survey was sent by email on Tuesday, 5 February 2019, and was available through Monday, 18 February 2019. Return of the survey served as implied consent. The results were to be collected electronically.

Of the 23 nurses to be surveyed, only 12 responded. Some nurses advised they had difficulty accessing the electronic form and some requested a hard copy for convenience. Of these 12, only six replied electronically. The other six each asked for a paper or hard copy of the survey for the following reasons. Two stated that they could not get on the hospital email system. After multiple attempts were made to access the survey, on request, both were given hard copies. Two stated that they did not receive the email. One stated she did not receive the email, but then stated she may have simply

deleted it. The other stated she did not receive the email, but then stated she only checks her home email. On invitation, the two were also given paper copies of the survey. One asked for a copy stating that she was not adept with technology. This individual was also given a copy. Apparently the survey was reproduced, as another completed questionnaire was left under the door of the office of the researcher.

Treatment of Data/Outcomes/Evaluation Plan

Both the quantitative and qualitative data were primarily analyzed in a descriptive fashion. The first four items, numbered 11 through 14, assess and compare the nurses' self-perceived competence, commitment, empathy and irritation toward patients with somatic, psychiatric and substance misuse diagnoses with that of the patient with suicidal behaviors. Data was not correlated with demographic information.

Somatic diagnoses comprised heart disease, cancer, infectious disease, and diabetes mellitus. Psychiatric diagnoses encompassed anxiety, depression, and psychosis. Substance misuse diagnoses included alcohol, minor tranquilizers, and major tranquilizers. The responses to each diagnosis was individually averaged by the specific diagnosis and then compared to other diagnoses within the same category.

Heart disease, cancer, infectious disease, and diabetes mellitus were then combined to represent the category of somatic diagnoses. Anxiety, depression, and psychosis were combined to represent the category of psychiatric diagnosis. Misuse of alcohol, minor tranquilizers, and major tranquilizers were combined to represent the category of substance misuse diagnosis. All items were scored from 1 (very low) to 5 (very high). Each of the three categories of diagnoses were averaged and compared to

the suicidal rating. Descriptive statistics describing the basic features of the results are presented in Chapter 4.

The next eight items, all within No. 15, looked at the individual's self-report of ideation about suicide: of their competence (two questions), so identified by concepts of training; commitment (three questions), which was so identified by concepts on sympathy, wanting to help and willingness to help; empathy (one question); and irritation (one question). Items were again scored on the 5-point Likert scale. The themes with more than one question were averaged to give a final rating.

Competence in the first section was compared to training (two questions) in this second set of items. Commitment scores from the first section was compared to commitment (three questions) in this second set of items. Empathy in the first section was compared to empathy (one question) in this second set of questions. Irritability in the first section was compared to irritability (one question) in this second set of questions. An average was taken of the two sections, giving an overall picture of the nurses' competence, commitment, empathy, and irritation toward the suicidal patient. The last question in this section was about knowledge of suicide risk. This is another quantitative and self-perceived question that was compared to actual knowledge in the next set of items.

This second set of quantitative items were also individually measured, and the sum was used to further measure attitudes and ideas about suicide and on suicide attempters. The eight items were taken, in part, from the Understanding of suicidal Patients Scale. The original scale consisted of 11 items. The tool was modified for this

study. Of the six modified and remaining questions, a five-point scale from 1 (I agree completely) to 5 (I disagree completely) was used. Five items were reversed.

Following the demographic and quantitative sections is the qualitative section. This portion of the questionnaire entailed four items, numbered 16 through 19, to assess the respondent's knowledge of suicide. Item one, No. 16, asked about the number of suicides in Kansas. Chapter 1 offered the most recent statistics, 2016, with 512 deaths by suicide (Kansas Suicide Prevention Resource Center, 2018). Should a nurse estimate the number and be within 20 percent of 512, or from 461 to 563, the nurse was considered knowledgeable on this item. The next item, No. 17, asked about critical risk factors. Chapter 2 presented that major risk factors include mood disorders, substance use, prior suicide attempts, and access to lethal means (Substance Abuse and Mental Health Services Administration, 2017). The individual could score up to four points for each of the four risk factors named. Between these two questions the total possible points were five. Demonstration of actual knowledge in this risk factor question was compared to the last question in the previous section which inquired about self-perceived competence of suicide risk.

The next two questions continue to build on the respondent's knowledge of suicide. First, the next item, No. 18, asked if people who are thinking about suicide express warning signs. Should a nurse answer "Yes," the nurse was considered knowledgeable on this item. The same item, under No. 18, asks about warning signs. Accepted warning signs have been developed by an expert review and consensus process and are listed here:

■ Acting anxious or agitated
■ Any talk about wanting to die or to kill oneself
■ Displaying extreme mood swings
■ Increasing the use of alcohol or drugs
■ Looking for a way to kill oneself
■ Reckless or impulsive behavior
■ Showing rage or talking about seeking revenge
■ Sleeping too little or too much
■ Talking about being a burden to others
■ Talking about feeling hopeless or having no purpose
■ Talking about feeling trapped or being in unbearable pain
■ Withdrawing from community and friends, or feeling isolated
(Cummings Institute, 2016; Suicide Awareness Voices of Education, 2017).

The respondent can score up to two points for any of the 12 risk factors named. Between these two questions the total possible points is another three. Demonstration of actual knowledge in this warning sign question is compared to the two questions in the previous section which inquired about training to care for the suicidal patient.

The last question to build on the data collection surrounding the concept of knowledge about suicide surrounded the phenomenon of cutting, and people who specifically cut their wrists. In Item 19, the respondent was asked what he / she thinks "about people who present with cutting or other self-harm." Data confirms that death by cutting the wrist is not common. The most common method of suicide for males is firearms (56.6%), and the most common mode of suicide for females is poisoning (33%) and firearms (32.1%) (National Institute of Mental Health, 2018). Although self-cutting results in few deaths, the behavior has special significance (Ersen, Kahveci, Saki, Tunali, & Aksu, 2017). While a common reason to cut includes getting a reaction from others, the physical pain from cutting apparently eases emotional pain for some (Yohe, 2018). These individuals are likely to repeat the behavior until they receive the intervention necessary. Unchecked mental health disorders and substance use disorders increase the

risk of more extensive lacerations and increased risk of death (Ersen, Kahveci, Saki, Tunali, & Aksu, 2017). Respondents who answered the item with a phrase similar to "To get attention," with no further explanation, lost the otherwise additional two points in this qualitative section. Respondents who answered the item with demonstration of the above cited information received two points, for a total of another five points in this qualitative section. This item was then be compared to the overall score of attitudes, in the quantitative section of the survey.

The next item, No. 20, inquired about experience with suicide. This information was added to the demographics to describe the population. It was not used as a predictor of variable. Item No. 21 then asked how the RN's experiences with suicide affect their work. Analysis of replies included a search for themes. No. 22 asked about what is required for the prevention of suicides. Responses are listed for review and to follow specific ideas or add extra information to this study. However, for purposes of scoring, the minimum reply for someone who is knowledgeable might include a generalizable comment on knowledge and skills on the part of the RN. Items Nos. 23 through 25 are discussed in the previous section, "Instrument." They closed the survey with a sort of summary.

Evaluation Measures Linked to Objectives

With the central role that nurses play in the outcome of the suicidal patient, the objective of this project was to understand the nurses' perspectives. The results of the present study provide evidence of nurses' understanding of the suicidal patients and also provide indication of nurses' attitudes. Understanding and attitudes reflect on the concept of best practice and can directly influence patient outcomes.

Outcomes/Evidence-Based Measures are Appropriate for Objectives

There are best practice guidelines for identifying those individuals at risk and reducing the risk for high-risk individuals. The Department of Veterans Affairs, & Department of Defense guidelines of 2013 instruct to "Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient's suicidality." The objectives of this project correlate with the best practice guideline.

Tools/Instruments Described and Linked to Measures and Objectives

The hybrid tool used in this study includes a portion of The Understanding of Suicidal Patients Scale. The original scale contained 11 items and was rated on a four-point Likert scale (Kodaka, M., Postuvan, V., Inagaki, M., & Yamada, M., 2010). Grimholt, Haavet, Jacobsen, Sandvik and Ekeberg (2014) state the scale was previously validated. Reliability of the original study was 0.74 (Samuelsson, Asberg, & Gustavsson, 1997). Just as Grimholt et al., 2014, found parts of the tool suitable for their research, they added and amended the survey to more clearly and specifically meet the needs of their study. Although a near identical selection of quantitative questions were borrowed from Grimholt et al., 2014, this researcher also took the liberty to add and amend for this project. Further, there is also an added qualitative portion of the instrument to objectively investigate understanding. The revised tool is believed to be a better fit in assessment of both the understanding and attitudes of nurses toward the suicidal patient.

Methods of Analysis for Each Measurement

As discussed above under the "Instrument" and "Treatment of Data/Outcomes/Evaluation Plan," descriptive analysis in Chapter 4 quantitatively describes the collected information of the quantitative section of the survey. The range and mean of the quantitative questions is explored. Numerical values are placed on responses of the quantitative section of the survey. The self-perceived knowledge is compared to the assessed knowledge of the nurses. Self-perceived attitude is also compared to the assessed knowledge of the nurses.

Evaluation Measures Linked to Objectives

Evaluation measures within the proposed tool are meant to identify and understand the nurses' perspectives of the suicidal patient. Specifically, this project assesses ED nurses' understanding and attitudes of the suicidal patient. The goal is to break down barriers that limit a suicidal patient access to quality care.

Project Sustainability

The challenge of sustainability of this project is first and fundamentally influenced by the presentation of outcomes of this scholarly project to the host organization that has authorized this study. The CNO will be provided a bound hard copy of the project. With outcomes that show a lack of knowledge and poor attitudes surrounding the phenomenon of suicide, the sustainability of the project is shifted to the host organization. Education of the ED nurses would translate to best practice and would be the only sustainable strategy. The increase in knowledge with a secondary benefit of change of attitude could ultimately and positively affect outcomes of the suicidal patient.

Dissemination of the results could reach beyond the target institution and outside of the supervising educational arena. With results that show lack of understanding and unfavorable attitudes, the challenge of closing the evidence-practice gap is highlighted for others. Replication of the study would not only assist with reliability and validity of the survey, but could help with application of process improvement to real world situations. When best practice guidelines correlate with nursing practice, best care indeed reaches the patient.

Summary of Chapter

With the objective of understanding nurses' perspectives of suicide, project questions were aimed at assessing nurses' understanding and attitudes toward the suicidal patient. The tool used aided in determining not only the nurses' perception of their own individual understanding and attitudes but compare the nurses' self-report data to data that attempts to measure actual understanding and attitude. A quantitative and qualitative mixed method approach was used in this project. Demographic statistics were not considered or compared in analysis of results. Qualitative date has been translated into numerical terms to ease comparison with that found in the quantitative data. Descriptive statistics including the range and mean of the questions are explored. Results serve as indicators for education, such that there would be improvement in access and quality and safety of care of the suicidal patient.

Chapter IV

Evaluation Results

To get a clearer picture of the community and timing of the survey, on the first day the survey was available online a nurse commented, “It is about time somebody does something. We had three of them last week.” Respondents didn’t seem to hesitate to share their experiences with suicide. Results of the survey were telling, considering there were only 12 respondents. Table 5 outlines experiences of nurses with suicide as found in the survey. Of concern is that while all 12 participants indicated that they had had some experience with suicide, when questioned about experience of suicide for self, only 11 of the 12 participants responded by checking “none.” On the hard copies, four respondents commented in the margin as to their experience in number of situations with suicides: “15+;” “greater than 10;” “many;” and “too many.”

Table 5
Experiences of Nurses with Suicide (N = 12)

	None	Thoughts	Attempt	Death by Suicide
Self	11	0	0	
Family	7	1	4	2
Friend	4	3	1	4
Work Associate	6	1	3	2
Patient	0	0	8	6
Other	2	0	0	2

Description of Sample Population

Most of the respondents in this non-random sample identified themselves as 30 years of age or less, female, and Christian. The majority were bachelor's degree prepared with five or less years of practice as a nurse. Additionally, the largest number had ED experience of five or less years and were working full-time in the ED. Table 6 reflects the specific composition of the participants by number and percentage.

Table 6
Demographics of Respondents (N = 12)

Age					
	30 or less	31 – 40	41 – 50	51 – 60	More than 60 years
	5 or 41%	2 or 17%	3 or 25%	2 or 17%	0
Gender					
	Male	Female			
	1 or 8%	11 or 92%			
Religion					
	Christian	Other religion	No religion		
	10 or 83%	0	2 or 17%		
Education Level of Nursing					
	Associate Degree	Bachelor Degree	Master Degree		
	3 or 25%	9 or 75%	0		
Years Practiced as a Nurse					
	5 or less	6 – 10	11 – 20	21 – 30	More than 30 years
	4 or 33%	3 or 25%	2 or 17%	2 or 17%	1 or 8%
Years Worked in the ED					
	5 or less	6 – 10	11 – 20	21 – 30	More than 30 years
	7 or 59%	1 or 8%	3 or 25%	0	1 or 8%
Current Scheduled Hours in the ED					
	Full-time	Part-time	Float pool	PRN	
	8 or 66%	2 or 17%	0	2 or 17%	

Although most had not participated in courses or other training in assessment and treatment of patients with suicidal behavior during the last five years, the simple majority had some degree of interest in courses and training in suicidology. Tables 7 through 9 reflect the dispersion of the participants' education for and interest in the care of suicidal

patients. Of notice is though the simple majority had some degree of interest in education in suicidology, one-fourth of the respondents identified as having a little degree of interest while another one-fourth had no interest at all.

Table 7
Previous Participation in Courses or Other Training (N = 12)

Yes	No
3 or 25%	9 or 75%

Table 8
Number of Hours Participation in Courses or Other Training (N = 12)

	0 hours	1–10 hours	11–20 hours	> 20 hours	> 30 hours
Courses	0	3	0	0	0

Table 9
Degree of Interest in Courses and Other Training (N = 12)

Not at all	To a little degree	To some degree	To a rather high degree	To a very high degree
3 or 25%	3 or 25%	5 or 42%	1 or 8%	0

Description of Key Terms / Variables

Key terms include attitude, nurse, suicide and understanding. With no doubt, professional education and experience, or lack thereof, translates to sum of understanding, which reflects on attitudes that in turn impacts clinical practice. Attitudes of a positive nature are necessary for high-quality and safe patient care and outcomes. While reflection on attitudes is important when caring for patients of any illness, for patients with suicidality the impact can be even greater. Unfortunately, as some studies show, attitudes toward patients who are suicidal are often negative (Saunders, Hawton, Fortune, & Farrell, 2012). This can be a serious barrier to the prevention of suicide.

Assessment of understanding in this study is first by self-report of nurses' competence, skills and training. Attitude is measured via self-report of competence,

commitment, empathy and irritation. Attitudes toward the suicidal patient are compared to attitudes toward other patients with others diagnoses, including somatic, mental health and substance misuse. The participants' subjective responses will be compared to the objective items in the survey. All responses are broken down into descriptive statistics including measures of central tendency (mean) and measures of variability (range).

Self-perceived competence.

Table 10 demonstrates the descriptive statistics as the nurses perceived their competence. It is as would be expected that these ED nurses feel an overall "high" amount of competence regarding patients with heart disease, with that average higher than any other listed condition. Some rated their competence as "very high." The nurses feel a general "intermediate" degree of competence toward patients with substance misuse, mental health diagnoses and suicidal behavior. Some rated their competence as "low."

Self-perceived commitment.

The average and range of the nurses' self-perceived commitment is displayed in Table 11. Although the range is rated as high as 5 in all the somatic conditions, conversely the range is rated as low as 1 in each of the substance misuse, mental health diagnoses and suicidal behavior conditions. This narrows the difference of the calculated mean of the commitment to 3.3 for the comparators to 3.1 for the suicidal patient.

Table 10
Self-Perceived Competence with Somatic Diagnoses, Substance Misuse Diagnoses, Mental Health Diagnoses and Suicidal Behavior (N = 12)

Attitude	Broad category	Specific condition	Mean	Range
Competence Scale range: 1 (very low) to 5 (very high)				
	Somatic diagnoses			
		Heart disease	4.0	3 - 5
		Cancer	3.3	2 - 5
		Infectious disease	3.5	3 - 5
		Diabetes mellitus	3.5	2 - 5
	Substance misuse			
		Alcohol	3.0	2 - 4
		Minor Tranquilizers (anxiolytics)	3.0	2 - 4
		Major tranquilizers (opiates)	3.0	2 - 4
	Mental health diagnoses			
		Anxiety	3.1	2 - 4
		Depression	3.1	2 - 4
		Psychosis	3.0	2 - 4
	Suicidal behavior		3.0	2 - 4
			Comparison mean	Comparison range
			3.3	2 - 5
			Suicide mean	Suicide range
			3.0	2 - 4

Table 11
Self-Perceived Commitment with Somatic Diagnoses, Substance Misuse Diagnoses, Mental Health Diagnoses and Suicidal Behavior (N = 12)

Attitude	Broad category	Specific condition	Mean	Range
Commitment Scale range: 1 (very low) to 5 (very high)				
	Somatic diagnoses			
		Heart disease	4.3	4 - 5
		Cancer	4.0	3 - 5
		Infectious disease	3.6	3 - 5
		Diabetes mellitus	4.0	3 - 5
	Substance misuse			
		Alcohol	2.8	1 - 4
		Minor Tranquilizers (anxiolytics)	2.8	1 - 4
		Major tranquilizers (opiates)	2.8	1 - 4
	Mental health diagnoses			
		Anxiety	3.0	1 - 5
		Depression	3.0	1 - 5
		Psychosis	3.0	1 - 5
	Suicidal behavior		3.1	1 - 5
			Comparison mean	Comparison range
			3.3	1 - 5
			Suicide mean	Suicide range
			3.1	1 - 5

Self-perceived empathy.

Table 12 demonstrates the descriptive statistics as the nurses perceived their empathy. Considering the broad categories separately, nurses rated their empathy as highest for the somatic diagnoses. In descending order, suicidal behavior, then mental health diagnoses, and those with substance misuse were given the least average empathy rating. Although empathy for the suicidal patient was overall rated higher at 3.5 compared to the average of the comparators at 3.3, this lowest rating for the substance misuse diagnosis and the low rating for the mental health diagnosis is not conducive to the care of the suicidal patient, given that they are two of the top four risk factors for suicide.

Self-perceived irritation.

The average and range of the nurses' self-perceived empathy is displayed in Table 13. Although the range is rated as "low" to "very low" in all the somatic conditions, conversely the range is rated as "low" to "very high" in substance misuse cases, as "very low" to "high" in mental health conditions, and from "very low" to "high" in suicidal behavior situation. This item augments the findings of the 3 previous questions. The somewhat marginalized poor attitudes as evidenced by the concepts of commitment, competence and empathy, in the previous 3 questions has magnified findings here. At this point in analysis, it is apparent that it is not helpful to combine and compare the average measurements of all categories to suicide, but rather consider each broad category individually.

Table 12
Self-Perceived Empathy with Somatic Diagnoses, Substance Misuse Diagnoses, Mental Health Diagnoses and Suicidal Behavior (N = 12)

Attitude	Broad category	Specific condition	Mean	Range
Empathy Scale range: 1 (very low) to 5 (very high)				
	Somatic diagnoses			
		Heart disease	3.8	3 - 5
		Cancer	4.1	3 - 5
		Infectious disease	3.7	3 - 5
		Diabetes mellitus	3.6	3 - 5
	Substance misuse			
		Alcohol	2.8	2 - 5
		Minor Tranquilizers (anxiolytics)	2.9	2 - 5
		Major tranquilizers (opiates)	2.9	2 - 5
	Mental health diagnoses			
		Anxiety	3.2	2 - 5
		Depression	3.5	2 - 5
		Psychosis	3.3	2 - 5
	Suicidal behavior		3.5	2 - 5
			Comparison mean	Comparison range
			3.3	2 - 5
			Suicide mean	Suicide range
			3.5	2 - 5

Table 13
Self-Perceived Irritation with Somatic Diagnoses, Substance Misuse Diagnoses, Mental Health Diagnoses and Suicidal Behavior (N = 12)

Attitude	Broad category	Specific condition	Mean	Range
Irritation Scale range: 1 (very low) to 5 (very high)				
	Somatic diagnoses			
		Heart disease	1.2	1 - 2
		Cancer	1.2	1 - 2
		Infectious disease	1.2	1 - 2
		Diabetes mellitus	1.4	1 - 2
	Substance misuse			
		Alcohol	2.9	2 - 5
		Minor Tranquilizers (anxiolytics)	2.7	2 - 5
		Major tranquilizers (opiates)	2.9	2 - 5
	Mental health diagnoses			
		Anxiety	2.2	1 - 4
		Depression	2.1	1 - 4
		Psychosis	2.2	1 - 4
	Suicidal behavior		2.0	1 - 4
			Comparison mean	Comparison range
		(Reverse)	2.0 (4.0)	1 – 5 (1 – 5)
			Suicide mean	Suicide range
		(Reverse)	2.0 (4.0)	1 – 4 (2 – 5)

Self-perceived attitude.

Calculating the first four items, Items 11 through 14, the average of the nurses' self-report of competence of the comparators of somatic, psychiatric and substance misuse diagnoses are 3.3 as opposed to 3.0 for the suicidal patient. With consideration that the item that asked about "irritation" is written in reverse, the mean of their self-report of attitude, measuring commitment, empathy and irritation is 3.5 for both the comparators and the suicidal patient.

Self-report of ideation.

The next eight items, all within No. 15, looked at the individual's self-report of ideation about suicide: of their competence (two questions), so identified by concepts of training; commitment (three questions), so identified by concepts on sympathy, wanting to help and willingness to help; empathy (one question); and irritation (one question). One item asks about risk factors which would be an indicator of understanding. Items were again scored on the 5-point Likert scale. The themes with more than one question were averaged to give a final rating. The five reversed items were so scored.

Table 14 shows that for the markers of attitude, (competence, commitment and empathy), on Item 15 the mean scores all fell just above the third option defined as "neither agree nor disagree." Notice, again, that the "irritation" score is noticeably higher. When compared and then merged with the mean from Items 11 through 14, the average remains consistent but below a more favorable score of 4. The concept of understanding is reversed and is included in Table 14 but will be factored in the next section of Understanding.

Table 14
Attitude Markers from the Quantitative Section (N = 12)

	No. 15 Mean	No. 15 Range	Comparators	Suicide	Ongoing mean of subjective self-report
Competence	3.3	2 - 5	3.3 (per Table 10)	3.0 (see Table 10)	3.15
Commitment	3.1	2 - 4	3.3 (Table 11)	3.1 (Table 11)	3.1
Empathy	3.2	2 - 5	3.3 (Table 12)	3.5 (Table 12)	3.35
Irritation	3.6	2 - 5	4.0 (Table 13)	4.0 (Table 13)	3.8
Understanding (Reverse)	1.5 (4.5)	1 – 3 (3 – 5)			**Overall attitude 3.35**

Qualitative assessment of understanding.

The first part of the quantitative section showed that nurses had an intermediate self-perceived competence, as rated as a 3.0. The second portion of the quantitative survey showed that the participants overall agreed that their training provided them with adequate skills to care for suicidal patients and that no further training was needed, as rated as a 3.3. At this point the nurses are assessed for objective knowledge and understanding.

Item 16 asks about the number of suicides in Kansas during the most recent year of available data. If the individual respondent answered from 461 to 563, or within 20 percent of the actual number of 512 for the year 2016, they were given a point for that knowledge. Replies ranged from "no idea," and from as low as 28 to as high as 60,000. One came close with a response of 450.

Item 17 inquired about risk factors for suicide. Individuals were asked to name four risk factors, one of which is "prior attempts," as asked in the last question of the quantitative section. Although eight of the 12 or 66% completely agreed that a person who had made several suicide attempts was at great risk of committing suicide (Item 15), only two of the 12 or 16% wrote that previous attempt was a risk factor for suicide (Item 17). Nine of the 12 (75%) recognized that substance misuse was a risk. Ten of the 12 (83%) wrote that mental health was a risk factor.

Item 16 was allotted one point for knowledge of the number of suicides. No nurse was able to gain that point.

Item 17 was given a total of four points possible, one for each risk factor listed. While two nurses were not able to list one risk factor, two nurses were able to list three risk factors. None were able to list four. The average was 1.6 risk factors listed per nurse. The list consisted primarily of those with mood disorders and substance use.

Item 18 asked the nurse if they believed that people who are thinking about suicide express warning signs. Knowing risk factors and warning signs are the tenets of suicide prevention. Only seven of the 12 (58%) believed that people who are thinking about suicide express warning signs. This part of the question was scored one point.

Item 18 was then given a total of two more points possible, one for each warning sign listed. While five nurses were not able to list one warning sign, three nurses were able to list one risk factor. Four were able to list two. The average of 0.92 shows that most nurses were not able to list one warning sign.

Item 19 asked "What do you think about people who present with cutting or other self-harm?" It is known that these patients are in distress and, left unchecked, are at

increased risk of repeated and more severe injury, up to and including increased risk of death. Three individuals did not respond to the question. Three nurses used the phrase "attention seeking," with no further explanation. Six respondents replied with evidence of understanding of the phenomenon.

Basis of assessment of knowledge and understanding are itemized by item number and concept in Table 15. The table also includes the calculation process with the aggregate mean of the possible 10 points possible in this qualitative section. If placed on the same scale as the quantitative section, the Likert scale, the mean score would be half of the mean score of 4.1, or 2.0.

Table 15
Understanding of Suicide and Qualitative Assessment Scoring (N = 12)

Item Number	Knowledge / Understanding	Calculation	Mean Score / Possible
16	Number of suicides	0 / 12	0 / 1
17	Risk factors for suicide	listed 20 risks total / 12 nurses	1.6 / 4
18	Warning signs	7 / 12	0.58 / 1
18	Warning signs of suicide	listed 11 warnings / 12 nurses	0.92 / 2
19	Self-harm	6 / 12	1.0 / 2
			4.1 mean / 10 point possible

Table 16 then gives the four scores of understanding, three from the quantitative section and four from the qualitative section. The subjective responses were considerably higher as compared to the assessed and objective responses. In fact, the self-report was almost twice what was assessed.

Table 16
Understanding of Suicide and Aggregate Assessment Scoring (N = 12)

Item Number	Type	Knowledge / Understanding	Mean Score / Possible
12	Quantitative	Self-perceived competence	3.0 / 5
15	Quantitative	Attitude marker for competence	3.3 / 5
15	Quantitative	Attitude marker for understanding	4.5 / 5
			Average quantitative 3.6 / 5
16 - 19	Qualitative	Knowledge	4.1 / 10
			Average qualitative 2.0 / 5

Item 21 asked "How do your experiences affect your work with suicidal patients?" Three did not reply. Of the nine who did reply, the responses are listed exactly, with categorization into one of the four categories of attitude or as not helpful:

■ Hardened because so many say suicidal for attention not because they are.
(Irritation)

■ Empathize with these patients more often than not. I spend a little more time with these patients and like to let them know that someone does care, and I am happy that they are there getting the treatment they need.
(Not helpful)

■ How to care for them.
(Competence)

■ I don't think it does.
(Not helpful)

■ Continued education.
(Not helpful)

■ More compassionate towards those suffering.
(Empathy)

■ I feel I am a very empathetic person.
(Not helpful)

■ It varies by situation.
(Not helpful)

■ My empathy.
(Not helpful)

Six replies were not helpful to the study. The remaining four responses are categorized as competence (1), commitment (0), empathy (1), and irritation (1). Overall, This question is not helpful to the survey.

Item 22 asked "What is required for the prevention of suicides?" The same three did not reply. Of the nine who replied, the responses are listed verbatim with categorization into one of the four categories of attitude:

■ Teaching.
(Competence)

■ I think the large majority of issues stem from social media these days. Especially with my age group. I don't think we'll ever be able to fully prevent suicides, but if we could somehow do away or decrease use of social media, I believe we'd see a significant drop in suicide rates.
(Commitment)

■ Risk factors.
(Competence)

■ Blank.
(Commitment – lack of)

■ Increased mental health evaluation, inpatient support.
(Commitment)

■ Better access to mental health.
(Commitment)

■ Knowledge of warning signs and ways to keep patients safe.
(Competence)

■ Education.
(Competence)

■ Understanding and support.
(Commitment)

One reply suggested a lack of commitment. The remaining eight responses are categorized as competence (4), commitment (4), empathy (0), and irritation (0). Central concepts used under the category of competence include "education," "risk factors," "teaching," and "warning signs." Key words used under the category of commitment include "access," "media," "mental health," and "support." Overall, this question was helpful to the survey. At a minimum, the survey is prompting some to think of risk factors and warning signs and perhaps share their struggles in helping the patients when the patients lack access to the care they need and see suicides occurring almost daily in the media.

Item 23 asked about honesty in the questionnaire. Of the 12 who replied to this survey, eight designated that their responses should be "accepted as fully honest." Two indicated that their responses should be "accepted but with some reservation." Two did not select a response to this item. The indirect questioning by referencing a third person may have helped elicit an honest reply in two of the cases, however two still elected not to answer this question.

Item 24 inquired about comment, concern or question. Every survey was blank and had no reply.

Item 25 queried nurses as to whether they would like a copy of the results. Six replied to this item. Three did not want a copy while three indicated that they did want a copy of the survey findings.

Analyses of Project Questions / Hypotheses

The project questions are:

■ How do emergency department nurses working at Ascension Via Christi Hospital, Pittsburg, Kansas, caring for patients with circumstances of suicidality perceive their understanding of and attitude toward patients who have attempted suicide?

■ What level of understanding do emergency department nurses have toward patients who have attempted suicide?

■ What attitudes do emergency department nurses have toward patients who have attempted suicide?

As seen in Table 16, scoring of the aggregate quantitative self-report responses for understanding was 3.6 / 5. With "1" being "very low" understanding and "5" representing "very high" understanding, the 3.6 score would be considered "average" to "high." A reasonable short-term goal would be understanding with a rating of 4 or more. A reach-goal would be a score of 5.

Table 14 shows the scoring of the aggregate quantitative subjective responses for attitude was 3.35 / 5. The nurses continued with the modest reporting of themselves and the overall average of the four markers of 3.35 / 5 would be considered neither negative or positive. As with understanding, a rating of a "4" would be a more favorable rating.

The second question guiding the project is of the nurses' understanding of suicidal patients. Table 16 not only gives the aggregate quantitative subjective score of 3.6, but then compare that score with the aggregate qualitative objective score of 2.0. This equates to a "low" score and is essentially half of what the nurses self-reported. Perhaps the nurses are falsely confident.

The final question guiding the project is of the nurses' attitudes toward suicidal patients. In review of Items 21 and 22, there are overall qualitative themes of competence and commitment, with little empathy and with little irritation of these patients. The announced attitudes however will not carry the lack of understanding. Understanding in fact impacts attitudes. For example, consider that mental health diagnoses and substance misuse are leading risk factors for suicide. Reflect on the warnings signs of suicide which include displaying extreme mood swings and increasing the use of alcohol or drugs. This is important as for the three markers of attitude in the quantitative section (commitment, empathy and irritation), the level was always rated higher for the somatic diagnosis, less for suicidal behavior, even less for mental health diagnoses and least with substance misuse, holding of course that the irritation item was reversed and was so considered and still held to the same pattern. There was the least irritation for the somatic diagnosis, more for suicidal behavior, even more for mental health diagnoses and most with substance misuse. These patients may be the ones who are dismissed only to go home and commit suicide within hours or days.

Summary of Chapter

The nurses reported neutral to high understanding (3.6 / 5.0) and a neutral attitude (3.35 / 5) toward the suicidal patient. With qualitative assessment, understanding was

low (2.0 / 5) and qualitative assessment of attitude showed a theme of competence and commitment, with little empathy and with little irritation. Commitment and empathy continually decreased as the diagnoses moved from somatic complaint, suicidal behavior, mental health diagnoses and substance use. Likewise, irritation continually increased at the diagnoses moved from somatic complaint, suicidal behavior, mental health diagnoses and substance use.

Chapter V

Discussion

The aim of this project was to survey ED nurses to discover their attitudes and understanding of suicide. Understanding will influence and affect attitude. The attitude of the healthcare professional is mirrored by the experience of the suicidal patient (Saunders, Hawton, Fortune, & Farrell, 2012). A positive attitude will be one of helpfulness. This approach can make the difference in patient outcomes. The negative attitude will reinforce the patient's feelings of hopelessness. This attitude has a greater potential of ending in another statistic.

Relationship of Outcomes to Research

The purpose of the study was to better understand the phenomenon and guide education initiatives, as nurse professionals are in a key position when working with suicidal patients. The aggregate quantitative self-report responses for understanding was 3.6 / 5, an average score. Collective quantitative subjective responses for attitude was 3.35 / 5, considered neither negative nor positive. The overall qualitative objective score of understanding was 2.0 / 5, a low score. Qualitative themes of competence and commitment were present with little empathy and with little irritation noted.

The project questions are:

■ How do emergency department nurses working at Ascension Via Christi Hospital, Pittsburg, Kansas, caring for patients with circumstances of suicidality, perceive their understanding of and attitude toward patients who have attempted suicide?

■ What level of understanding do emergency department nurses have toward patients who have attempted suicide?

■ What attitudes do emergency department nurses have toward patients who have attempted suicide?

This research generally supports previous findings as found on review of the literature as well as in the following three studies. In the systematic review by Saunders, Hawton, Fortune, and Farrell, 2012, a total of 74 quantitative and qualitative studies were reviewed to examine the attitudes and knowledge of clinical staff regarding patients who self-harm. In the majority of the studies which examined attitudes, general staff expressed negative attitudes. In this current study, the quantitative section, nurses self-report of attitude was aggregated at 3.35 / 5 so was not negative but not positive. The qualitative section shows themes of competence and commitment, with some empathy of those who replied and so had a tendency toward a positive attitude. Unfavorably, the concept of irritation was also noted, showing a tendency for a negative attitude.

The 2012 research revealed that over half of emergency staff acknowledged intolerance of self-harm patients with multiple visits. The quantitative section of the present study demonstrates that while overall feelings of irritation related to those with somatic diagnoses is rated at very low, irritation related to those with suicidal behavior rose to a rate of low. Irritation related to those with mental health diagnoses, a risk for

suicidal behavior, scored even less favorably, while those with substance misuse scored even more negatively, with an overall intermediate amount of irritation. Overall, the recent study supports the findings in this 2012 study.

In the same review, although underestimated, most staff acknowledged the risk of suicide in patients who self-harm. In this study, although eight of the 12 or 66% completely agreed that a person who had made several suicide attempts was at great risk of committing suicide (Item 15), only two of the 12 or 16% wrote that previous attempts was a risk factor for suicide (Item 17). Evidence of knowledge of this risk factor is inconsistent in the current study. Another finding of the 2012 study pertained to the effects of training on staff knowledge and attitudes. Not only was there a direct correlation between education and understanding, some studies described the improvement in competence and attitudes as significant. With the outcomes of this present study wanting, perhaps education is indicated for the improvement of quality of care.

In the qualitative research by Artis and Smith, 2013, interviewees saw self-harm as a coping mechanism, and within that, self-harm was "equally seen as being 'attention-seeking' along with being 'a cry for help'" (p. 40). In the current research, when nurses were asked about people who present with cutting or other self-harm, three individuals did not respond to the question. Three nurses used the phrase "attention seeking," with no further explanation. Six respondents replied with evidence of some understanding of the phenomenon. The recent study findings align with the findings of the previous study.

The current study significantly modified a set of questions from the survey used in the study by Grimholt, Haavet, Jacobsen, Sandvik, Ekeberg, 2014. In the same set of

questions, with modifications, responses in the earlier study showed that all physicians showed a positive attitude toward suicide attempters. The later study revealed that the mean score for nurses' attitudes was a 3.35 on the Likert scale, just above 3.0 or average.

The present study also but minimally modified another set of questions in the survey used in the original 2014 study of Norwegian physicians. In the same set of questions, with minimal changes, responses in the earlier study showed that the levels of competence correlated with the physician's field of expertise. Psychiatrists reported higher competence with the mental health diagnosed patients, and primary providers reported more competence with the somatic diagnosed patients.

The same holds true in this study. The ED nurses' self-perceived competence is higher for somatic diagnoses. When continuing comparison of the responses of the general practitioners and internists in the first study to the nurses in this recent study, the results closely mimic each other. There is a noticeable decline in commitment and empathy as one looks at the scores as they move from somatic diagnosis to suicidal behavior to mental health diagnoses and finally to substance misuse. An almost reverse pattern is true of irritation in both the 2014 and this 2019 study. There is a noticeable increase in irritation as one looks at the scores as they move from somatic diagnosis to suicidal behavior to mental health diagnoses and finally to substance misuse.

While 27% of the general practitioners and internists in the first sample had participated in courses or other forms of training in assessment and treatment of patients with suicidal behavior, only 25% of the nurses had participated in such education. All groups in the 2014 study reported a moderate interest in more training. The nurses in this 2019 study reported an overall small degree of interest in more training. In summary,

these three studies from the past reflect overall understanding and attitudes that could be more favorable, and the present study is consistent with these findings.

Observations

It does not seem unusual that the ED nurses reported they were highly competent in assessing and treating patients with somatic diagnoses, particularly those with heart disease, but only of intermediate competence in assessing and treating patients with suicidal behavior, mental health diagnoses and substance misuse. The present study found that nurses reported an intermediate to high understanding of the suicidal patient, but in the qualitative section of the survey the nurses demonstrated only a low scale of knowledge. If knowledge is reflected in attitude, it would be projected that these nurses have an intermediate to low or negative attitude.

The nurses reported an intermediate attitude toward the suicidal patient, and in the qualitative section, based on the 75% who responded, demonstrated an attitude with concern of competence and commitment, but with little empathy and with little irritation. As mentioned earlier in this chapter, there is a noticeable decline in commitment and empathy as one looks at the scores as they move from somatic diagnosis to suicidal behavior to mental health diagnoses and finally to substance misuse. Conversely, there is a noticeable increase in irritation as one looks at the scores as they move from somatic diagnosis to suicidal behavior to mental health diagnoses and finally to substance misuse. It is peculiar that the nurses report an intermediate attitude yet are increasingly irritated at the patients who are showing risk factors for suicide. Lack of knowledge is likely mirrored here. Perhaps the demonstration of positive attitude is skewed toward higher

values, as only 75% of the nurses replied to this section and this was not previously taken into consideration.

Only 25% of the 12 had participated in previous courses or other training about suicidality. Although the demographics were not used to describe the nature and distribution of the sample, this would be interesting to follow and compare to knowledge and attitude in future research. Also, of interest is that only 42% had some degree of interest in courses or training in suicidology, while 50% had little or no interest.

That two nurses did not respond as to their honesty in the survey and that two nurses indicated that their responses should be accepted but with some reservation is curious. That one has reservations may translate to mean that the nurse is not confident that his / her answers are correct. This is simply discussion, as there is no way to explain this with certainty.

Three nurses did not respond as to whether they would like a copy of the survey findings. Five did not want a copy and four did. Comparing these numbers to those who are interested in further education, it seems that at least one-third and up to one-half of the nurses are open to gaining further knowledge of the suicidal patient. This could be by way of formal or informal means.

The instrument used performed as expected or better related to the mixed methodology. Calculation of the results of this survey was concerted and synergetic related to the manipulating and use of two different tools and then adding original questions for this study. Computation of the results was slowed by the combination of direct and reverse questions. Analysis in descriptive format was otherwise straightforward and included means, ranges and percentiles.

Attitudes were found to be less than high, and it follows that understanding was found to be low. It is reassuring that educational intervention can positively impact quality and safety of care. More stirring is that, overall, the nurses have some degree of interest in education in suicidology.

Evaluation of Theoretical Framework

Kurt Lewin's Field Theory served as the foundation for this project. Lewin wrote that "What an object is is now determined by the possibility of characterizing it by one combination of conceptual constructs" (Lewin, 1951, p. 36). The concepts of competence, commitment, empathy and irritation were used both separately and in combination to explain the phenomenon of attitude. In the quantitative section, the concepts were self-reported. In the qualitative section, the concepts were interpreted rather than directly observed. The tool used the same concepts in combination to explain the phenomenon of understanding. Again, the concepts were initially of self-report. In the qualitative section, the concepts were considered through direct observation of knowledge.

Not only did Lewin (1951) state that the mixed quantitative and qualitative approaches "complement each other" (p. 30), he wrote "To determine the nature of the forces which are the main variables in a given case… An analysis of both the cognitive ("subjective") and behavioral ("objective") aspects… requires a combination of methods which lays open the subjective aspects and permits conclusions concerning conduct which can be checked" (p. 222). This clearly explains the difference in the results of knowledge when comparing the self-report data of 3.6 / 5, yet the objective data generated a result of 2.0 / 5. Additionally, the subjective responses for attitude was 3.35 /

5. The objective data yielded results of competence, commitment, and empathy with little irritation. Consideration must be given that only 75% replied, leaving room for interpretation error.

Considering the less than desirable understanding and given the attitudes that could improve, Lewin (1951) states that learning is "doing something better than before" (p. 65). His theory is a method of approaching a task (p. *viii*). Lewin believed change was a continuous process and that solutions are neither absolutely right or wrong (p. vii). Lewin's change model consisted of three steps: "unfreezing, moving, and freezing" (p. 228).

The nurses' experiences are a force in the field of this ED. Evidence of unfreezing can be derived from one nurse's statement: "It is about time somebody does something. We had three of them last week." Further evidence of readiness for change can be derived from the fact that 42% had some degree of interest in courses and training in suicidology and three nurses desired a copy of the survey results. For those that did not want a copy, perhaps formal education would help achieve the desired result. Another force toward change could include discussion of the survey during the department's staff meeting. The force field theory is a supporting structure for this project and the process of change. Further, the results are a strong support of the theoretical framework.

Evaluation of Logic Model

The created logic model communicates the purpose of increasing nurses' awareness of their own attitudes, ideas and understanding toward the suicidal patient and increasing nurses' knowledge of how their attitudes, ideas, and understanding impact

patient outcomes. To serve as a hypothetic depiction of the chain of events that can promote suicide prevention, the logic model was presented in Chapter 1. The diagram shows the cause and effect relationship between nurses' understanding of and attitudes toward the patient with suicidal behavior and that impact on both the assessment of the patient for mental health conditions and the identification of the suicidal patient. The model places awareness of attitudes and understanding as a resource. If the nurse provider is knowledgeable, has a positive attitude and good communication skills, then with integration of best practice, the suicidal patient will be identified and assessed, managed, treated and followed up. Outcomes will include access to ongoing outpatient treatment and bio-psycho-social adaptation with dignity and integrity reached and maintained. Suicide numbers will ultimately be decreased.

The model backs the project's aim, to survey ED nurses to discover their attitudes and understanding of suicide, and it backs the project's purpose, to better understand the phenomenon and guide education initiatives. The model also shows the relationship between attitudes and understanding and suicide, but only the positive side. Although the logic model places attitudes and understanding as a possible constraint, it does not follow through and show that negative attitudes and poor understanding can allow for missed opportunities in suicide prevention. Highlighting the negative relationship between the concepts is likely not helpful.

Limitations

Question No. 15 of the survey was created by modifying the Understanding Suicidal Patients Questionnaire (USP). The USP was first developed for a 1997 study and contained 17 items (Samuelsson, Asberg, & Gustavsson, 1997). The original instrument had a high reliability with a Cronbachs alpha of 0.74, however the validity is

not mentioned (Kodaka, Postuvan, Inagaki, & Yamada, 2010). The current study used eight of the items, and of those five were rephrased and only three were verbatim. It is impossible to know what impact these changes have on the reliability of this part of the research. Of the already small population of 23 ED nurses, that only 50% responded only detracts from any existing reliability.

Items 11 through 14 were more directly borrowed from the study *of Attitudes towards patients with suicidal behavior* (Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014). The published paper states that "There is no available validated scale for this purpose… " (Methodological Considerations, para. 3). The current study was limited to RNs working in the ED. That the study was narrowed to these factors increased the validity of the research.

The proposed method for sampling did not introduce bias or error into the results. An anonymous electronic version was sent via company email to all emergency department RNs. To decrease concern, as modeled by the 2014 study by Grimholt et al., the questionnaire categorized demographic information of age, number of years practiced as a nurse and number of years worked in the ED rather than using specific values. Access to the questionnaire by way of the electronic version did not facilitate participation. Only half of the participants chose to answer in this manner. The other half responded by way of a hard copy and the reasonings are listed:

- One advised she was not technologically savvy and preferred a hard copy.
- Two reported that they could not access their hospital email.
- One told me they may have received the questionnaire but erased it.
- One told me that she only checks her home email.

On request, each of these individuals were provided a paper copy of the questionnaire. Apparently a duplicate was made, as another completed questionnaire was found under the clinic door where the primary researcher of this project works.

In the text *Epidemiology for the Uninitiated,* (Coggon, Rose, & Barker, 2018), statistics show that most people are willing to participate in surveys provided there is trust in the investigators. "In population studies, however, there has usually been no previous contact" (Coggon, Rose, & Barker, 2018), para. Recruiting Subjects). That the researcher of this project is somewhat familiar to the target population could also confound the reliability.

Closely linked to previous contact, socially desirable reporting is "the tendency for people to represent themselves in a favorable image" (van de Mortel, 2008, p. 41; Grimholt et al., 2014, p. 47). This also has the potential to muddle the collected data. When comparing the self-report data regarding attitude and understanding to quantitative questions asking for facts, discrepancies could be due to bias related to the influence of self-report (van de Mortel, 2008).

Although the manager of the department advised the nurses of the upcoming survey and of the expectation to participate, only half responded. It is possible that those who replied might have more interest in the topic of suicide. This may or may not represent a response bias. That 50% of those who replied reported little to no interest in courses and training in suicidology may reflect sampling bias. Of the 12 who replied to this survey, two indicated that their responses should be "accepted but with some reservation" and two did not select a response, which may also impact sampling bias. These potential biases can impact survey validity.

Implications for Future Projects and / or Research

The phenomenon of suicide and nurses' attitudes and understanding towards the suicidal patient are ethically challenging areas in which to conduct research. Overall, the created instrument does not include reliability or validity and the current study does not include a large sample. Nonetheless, the findings support other research which translates to its contribution to the research. Replication of this study could build reliability and validity, could help determine generalizability to other subjects, and could serve as the foundation of an educational opportunity.

Implications for Practice / Health Policy / Education

The relevance of the findings pertaining to both understanding and attitudes in this group of nurses is important due to its potential influence on the care of the patient. Care of the patient in turn will affect patients' experiences and can affect outcomes. The research reflects that understanding is lacking and attitudes follow close behind. If the attitudes in this clinical ED practice are consistent with the findings in this study, nurses are measurably less committed to and empathic for those at high risk for suicide – those with mental health diagnoses and even less so with those with substance use disorders. Conversely, the ED nurses are increasingly irritated with those at high risk – those with mental health diagnoses and even more so with those with substance use disorders.

What is the cause of the divide? Maybe the findings exist due to personal experience. Perhaps the nurses themselves are survivors. They themselves may have lost someone they deeply care about. The literature states that each person who dies of suicide leaves behind and intimately affects at least six suicide survivors (Harvard

Women's Health Watch (2018). This equates to an annual quarter million new suicide survivors (Suicide Awareness Voices of Education, 2018).

It is accepted that the lack of knowledge for the suicidal patient figures into the situation; but is education the be all end all? It is acknowledged that working with these patients is ostensibly ongoing if not seemingly never-ending, particularly if the patients do not receive the appropriate follow-up care that is required for any opportunity of improvement. Many times, the nurses may feel like they can make no difference and as if they are in positions of no-win situations. In fact, what difference can staff make?

The Department of Veterans Affairs and Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013), was published and organized around three algorithms. The first algorithm addresses the "Assessment and Management of Risk for Suicide in Primary Care". The care component detail states that "Any person who is identified as being at possible suicide risk should be formally assessed for suicidal ideation, plans, intent and behavior, the availability of lethal means, and the presence of risk factors and warning signs. A clinical judgment that is based on all the information should formulate the level of risk for suicide and the setting of care" (Department of Veterans Affairs, & Department of Defense, 2013, p. 8). To increase the nurses' competence in assessing these patients, educational forums pertaining to the assessment for suicidal risks and warning signs seems to be a reasonable step in improvement of the indicators of this study. Increased knowledge will further subsidize the following recommendation: "The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable

information in a collaborative way, and the patient to accept help" (Department of Veterans Affairs, & Department of Defense, 2013, p. 27).

The guideline development group of the National Institute for Health and Care Excellence (NICE) for "*Longer term management of self-harm,"* however cautions that as useful as the guidelines are, "just exhorting those involved in the care and management of such patients not to stigmatize them is simplistic" (Kapur, Kendall, Taylor, Chan, & Bhatti, 2011, p. 1). The authors accept the difficulty that is fundamental in the care of these patients. Rational management of the suicidal patient is trying. At the site of the current study, accomplishing collaborative care is a major task. Chapter 3, subheading Sample Access/ Target Population, outlined the statistics of the ED patients at risk for suicide. There is no inpatient psychiatric mental health unit within the hospital, nor is there a local addiction treatment center. The measures represent a picture of social and economic stressors. The facts show that there is an unanswered need in access to care, and this gap will only widen if left unchecked, to the further demise of the health of the community.

Understanding and helping these patients is at the core of suicide prevention. The short-term recommendation is, at a minimum, a session to review the results of this study, followed by a brief review of the statistics, risks and warning signs of suicide. The time could also entail discussion of the healthcare worker's perspective to barriers and facilitators in the care of these patients. Access to ongoing outpatient treatment is soon to become a reality. The year 2020 is the projected opening date of a new and local 25-bed Addiction Treatment Center (Crawford County Health Department, & Mental Health Services, n. d; Southeast Kansas Health Committee, 2017). Perhaps knowing that these

ED patients will soon have accessible outpatient assistance will relieve some of the frustration and stress of the staff. It would be helpful to redress the topic of understanding and attitudes approximately three months after the opening of this treatment center. It is hypothesized that the understanding of these patients and the option of follow-up care will translate to increased understanding and more positive attitudes.

Conclusion

The Joint Commission's sentinel event alert followed by their National Patient Safety Goals has not been seminal in the statistics for suicide. Moreover, the statistics are unfavorably growing. A competent staff is primary to prevention. In this research, the understanding of the suicidal patient proved significantly less than positive. Although the reported attitudes toward the patient with suicidal behavior were midway between negative and positive, ED nurses were less committed, less empathetic and more irritated with patients who carried risk factors for suicide. The nurses had a more negative attitude toward patients with mental health diagnoses and an even more negative attitude toward patients with substance misuse diagnoses. Though the simple majority had some degree of interest in education in suicidology, half of the respondents identified as having no interest to little degree of interest. Education and discussion of current challenges may be discerning.

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APPENDIX

Friday
1 February 2019

Dear Participant:

My name is Cheryl Lemmon and I am a Doctor of Nursing Practice student at Pittsburg State University. For my final project, I am examining Emergency Department (ED) nurses' attitudes and understanding of the suicidal patient. Because you are a licensed RN in the setting of this study, I am inviting you to participate in this research by completing the attached survey.

The following questionnaire will require approximately 10 to 20 minutes to complete. There is no compensation for responding nor is there any known risk. To ensure that all information will remain confidential, please do not include your name. If you choose to participate in this project, please answer all questions as honestly as possible and return the completed questionnaires promptly. Participation is strictly voluntary, and you may refuse to participate at any time.

Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information regarding indicators for education that could result in increased quality and safety outcomes of ED patients. If you would like a summary copy of this study, please indicate accordingly on the last question of the survey. The appropriate number of copies will be left with your ED manager. Completion and submission of the questionnaire will indicate your willingness to participate in this study. If you have additional comment, concern or question about suicide or the survey, please answer accordingly on the next-to-last question of the survey, or please contact your manager or your Human Resources department.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Irene Ransom Bradley School of Nursing, 620-235-4431.

Sincerely,
Cheryl Lemmon
620-235-3514
Cheryl.lemmon@ascension.org

Cheryl Giefer, Director, University Professor and Project Chair
620-235-4438
cgiefer@pittstate.edu

Questionnaire

Nursing attitudes and understanding
of the suicidal patient.

This is not a test, but a survey of your opinions.
There are no right or wrong answers.
Only your honest opinion counts.

Please answer all questions one by one in sequence.
Always check the checkbox that best applies to you.

Thank you, for completing this questionnaire.

1. Age group:

30 or less	31 – 40	41 – 50	51 – 60	More than 60 years
□	□	□	□	□

2. Gender:

Male	Female
□	□

3. Religion:

Christian	Other religion	No religion
□	□	□

4. Education Level of Nursing:

Associate Degree	Bachelor Degree	Master Degree
□	□	□

5. How many years have you practiced as a nurse?

5 or less	6 – 10	11 – 20	21 – 30	More than 30 years
□	□	□	□	□

**6. Regardless of hours worked per week,
how many years have you worked in the ER?**

5 or less	6 – 10	11 – 20	21 – 30	More than 30 years
□	□	□	□	□

7. What are your current scheduled hours in the ER?

Full time	Part time	Float pool	PRN
□	□	□	□

8. Have you participated in courses or other training in assessment and treatment of patients with suicidal behavior during the last five years?

Yes		No
□		□
↓		
Course	Other training:	
□	_____	

9. If yes, approximately how many hours have you participated in course or other training in assessment and treatment of patients with suicidal behavior during the last five years?

	0 hours	1–10 hours	11–20 hours	> 20 hours	> 30 hours
Courses	□	□	□	□	□
Other training	□	□	□	□	□

10. To what degree are you interested in courses and training in suicidology?

Not at all	To a little degree	To some degree	To a rather high degree	To a very high degree
□	□	□	□	□

11. How do you rate your <u>personal commitment</u> to patient groups with various disorders?
(Grimholt, Haavet, Jacobsen, Sandvik, & Ekeberg, 2014).

	Very low commitment	Low commitment	Intermediate commitment	High commitment	Very high commitment

Heart disease	□	□	□	□	□
Cancer	□	□	□	□	□
Infectious disease	□	□	□	□	□
Diabetes mellitus	□	□	□	□	□
Mental health, Anxiety disorder	□	□	□	□	□
Mental health, Depression disorder	□	□	□	□	□
Mental health, Psychosis disorder	□	□	□	□	□
Suicidal behavior	□	□	□	□	□
Substance use disorder, Alcohol	□	□	□	□	□
Substance use disorder, Minor tranquilizers, (Anxiolytics)	□	□	□	□	□
Substance use disorder, Major tranquilizers, (Opiates)	□	□	□	□	□

12. How do you rate your <u>competence</u> to treat patients with various disorders?

	Very low competence	Low competence	Intermediate competence	High competence	Very high competence
Heart disease	□	□	□	□	□
Cancer	□	□	□	□	□

Infectious disease	□	□	□	□	□
Diabetes mellitus	□	□	□	□	□
Mental health, Anxiety disorder	□	□	□	□	□
Mental health, Depression disorder	□	□	□	□	□
Mental health, Psychosis disorder	□	□	□	□	□
Suicidal behavior	□	□	□	□	□
Substance use disorder, Alcohol	□	□	□	□	□
Substance use disorder, Minor tranquilizers, (Anxiolytics)	□	□	□	□	□
Substance use disorder, Major tranquilizers, (Opiates)	□	□	□	□	□

13. How do you rate your <u>feelings of empathy</u> in relation to patients with various disorders?

	Very low empathy	Low empathy	Intermediate empathy	High empathy	Very high empathy
Heart disease	□	□	□	□	□
Cancer	□	□	□	□	□

Infectious disease	□	□	□	□	□
Diabetes mellitus	□	□	□	□	□
Mental health, Anxiety disorder	□	□	□	□	□
Mental health, Depression disorder	□	□	□	□	□
Mental health, Psychosis disorder	□	□	□	□	□
Suicidal behavior	□	□	□	□	□
Substance use disorder, Alcohol	□	□	□	□	□
Substance use disorder, Minor tranquilizers, (Anxiolytics)	□	□	□	□	□
Substance use disorder, Major tranquilizers, (Opiates)	□	□	□	□	□

14. How do you rate your <u>feelings of irritation</u> to patients with various disorders?

	Very low irritation	Low irritation	Intermediate irritation	High irritation	Very high irritation
Heart disease	□	□	□	□	□
Cancer	□	□	□	□	□
Infectious disease	□	□	□	□	□

Diabetes mellitus	□	□	□	□	□
Mental health, Anxiety disorder	□	□	□	□	□
Mental health, Depression disorder	□	□	□	□	□
Mental health, Psychosis disorder	□	□	□	□	□
Suicidal behavior	□	□	□	□	□
Substance use disorder, Alcohol	□	□	□	□	□
Substance use disorder, Minor tranquilizers, (Anxiolytics)	□	□	□	□	□
Substance use disorder, Major tranquilizers, (Opiates)	□	□	□	□	□

15. In the following we want to determine your view of suicide, suicide attempt and your own need for training. (Understanding of Suicidal Patients Scale)

	I agree completely	I somewhat agree	Neither agree nor disagree	I somewhat disagree	I disagree completely
I think my present training has provided me with adequate skills to take care of	□	□	□	□	□

people who have tried to commit suicide.					
I am in need of further training to be able to work with people who have tried to end their life.	□	□	□	□	□
When I treat a person, who has tried to commit suicide, I sometimes show my irritation, especially considering other patients are fighting for their lives.	□	□	□	□	□
I am usually sympathetic towards a patient who has tried to commit suicide.	□	□	□	□	□
A person who has made several suicide attempts is at great risk of committing suicide.	□	□	□	□	□
I would like to help a person who has tried to commit suicide.	□	□	□	□	□
I treat patients who have tried to commit suicide as willingly as other patients.	□	□	□	□	□
I often find it difficult to empathize with a person who has tried to commit suicide.	□	□	□	□	□

16. Give an estimate of how many suicides you think occurred in Kansas during the last year of available data? _____

17. The most critical risk factors for suicide are

1. _____
2. _____
3. _____
4. _____

18. Do you believe people who are thinking about suicide express warning signs?

No	Yes
□	□

If so, can you name two warning signs?

1. _____
2. _____

19. What do you think about people who present with cutting or other self-harm?

_____
_____
_____
_____

20. What experience do you have with suicide?

	None	Thoughts	Attempt	Death by Suicide	Number of situations
Self	□	□	□		_____
Family	□	□	□	□	_____
Friend	□	□	□	□	_____
Work associate	□	□	□	□	_____
Patient	□	□	□	□	_____
Other	□	□	□	□	_____

21. How do your experiences affect your work with suicidal patients?

_____
_____
_____
_____

22. What is required for the prevention of suicides?

_____
_____
_____
_____

23. Finally, in answering a questionnaire like this, there are many reasons why some people may not be able or wish to be fully honest. In looking over your responses, should we:

Accept them as fully honest	Accept them but with some reservation	Probably disregard them	Disregard them as they are not valid
□	□	□	□

24. Is there any comment, concern and / or question that you have about suicide or this survey?

_____
_____
_____
_____

25. Would you like a copy of the survey findings?

No	Yes
□	□