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TRUE TO SIZE: CREATING AN INTERDISCIPLINARY SUICIDE AWARENESS AND PREVENTION EVIDENCE-BASED PROJECT IN A NONPROFIT ACADEMIC MEDICAL CENTER

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TRUE TO SIZE: CREATING AN INTERDISCIPLINARY SUICIDE AWARENESS AND PREVENTION EVIDENCE-BASED PROJECT IN A NONPROFIT ACADEMIC MEDICAL CENTER

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ABSTRACT

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Suicide is a serious health problem that continues to increase despite significant efforts to reduce suicide in vulnerable populations. High rates of suicide negatively impact individuals, families, and communities nationwide. The purpose of this project was to prepare the inpatient and outpatient clinical workforce at National Jewish Health (NJH) to care for patients who are suicidal.

This project included reviewing the literature on suicide awareness and prevention training across the continuum of healthcare, implementing an evidence-based training model, and evaluating the effectiveness of training. This project started in 2017 and throughout, this researcher was the lead for the Suicide Prevention Workgroup, Doctor of Nursing Practice student, and participated in every phase of evidence-based practice (EBP) development. The purpose of the Suicide Prevention Workgroup was to improve the quality of interventions, comply with regulations, and measure outcomes. The RE-AIM (2019) framework was used to guide a review of the literature and appraise validated training models. The Stetler (2001) model of research utilization implementation facilitated operational training details across the organization. Upon completion of the training, participants were asked to complete the Zero Suicide Workforce Survey (Suicide Prevention Resource Center, 2017) that measured

knowledge, confidence, and practice of suicide prevention. Analyses of the survey included investigating correlations between confidence in skill ability and intervention and conducting independent-samples *t*-tests on different disciplines.

Future implications of this project could provide healthcare organizations with best evidence-based practice for suicide awareness and prevention training that reaches all patients regardless of their admission status.

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CHAPTER I

INTRODUCTION

Central Theme/Background

"The question of suicide is a most perplexing one, one that calls to mind the very nature of human existence, one that reminds us of our vulnerability, our transient human dwelling place, and most of all, our search for meaning in life" (Fitzpatrick, 1983, p. 20). According to the National Center for Health Statistics (cited in Hedegaard, Curtin, & Warner, 2018), suicide rates in the United States have been steadily increasing from 2000 through 2016 with greater annual percent increases after 2006. This trend has been recognized by nursing and other healthcare professionals in all types of clinical settings. While suicide is often thought of as an individual problem, suicides might impact families, communities, and society in general (Knox, Conwell, & Caine, 2004).

Nurses are at the forefront of establishing a trusting and long-term relationship with patients and their families in health and in crisis. Therefore, nurses need the tools and language to engage with a patient showing suicidal ideation. For regulatory purposes, nurses are responsible for screening every new inpatient for suicide risk upon hospital admission. At the start of this project, no resources at National Jewish Health (NJH) supported initial training or quality measures to ensure clinical staff knew the warning signs of suicide, how to assess for suicide risk, and how to respond to a patient at risk of suicide. Suicide screening tools were implemented across hospitals around the nation but lacked any substantial conversation about the comfort level of the bedside

nurse performing the screening. Present-day practice assumes every clinical staff member can recognize suicidal ideation and initiate a clinical response. Research in the field of high-reliability healthcare has described this assumption as harmful and the most serious issue in health care today (May, 2013). The societal charge of the nursing profession is to be stewards of preventing suicide by recognizing the value of prompt and unbiased interventions to promote survival. This collective vision creates a total life-changing and healing health experience for patients and families.

From 2015 to 2019, the Joint Commission's (2020) National Patient Safety Goal (NPSG).15.01.01 required hospitals to find out which patients were at risk for suicide. Successfully addressing NPSG.15.01.01 included updating policies and procedures, screening inpatients for risk, providing staff with training, and constructing ligature safe care environments. Hospitals were surveyed on their ability to identify individuals at risk for suicide while in the hospital or following discharge from a behavioral healthcare setting. They encouraged screening patients with a recent diagnosis of a terminal illness, history of mental health diagnoses, and past traumatic experiences. Many healthcare organizations struggled with these recommendations due to inadequate resources, significant workflow disruptions, and low rates of identifying patients at risk. The Joint Commission's 2020 revision of NPSG.15.01.01 now requires reducing the risk for suicide instead of focusing on screening. There are fewer regulations for the outpatient setting and the Joint Commission does not require screening for patients who do not present for a behavioral health concern. It is up to organizations to know their patient populations and develop policies and procedures accordingly. Although the regulations have eased, there remains a need for a comprehensive suicide awareness response that

addresses the increasing numbers of patients who present to outpatient clinics with suicidal ideation.

Suicide prevention initiatives emphasize efforts to prevent violence (in this case, toward oneself) before it happens. This approach requires screening for factors that put people at risk for suicidal behavior and protect them in all settings. This project tested the following null hypothesis:

$H_0$1 There will be no difference in the level of knowledge, comfort, or confidence for suicide prevention variables between clinical staff that had suicide prevention training and clinical staff that had no training.

Statement of Problem

In 2017, the Joint Commission (2018) identified suicide of a patient while in a healthcare setting as the fourth most frequently reported sentinel event, down from number one in 2016. Colorado ranks ninth for the highest suicide rate in the United States. Suicide is the seventh leading cause of death for all Coloradans and among youth and young adults ages 10 to 24, suicide is the leading cause of death (Colorado Department of Public Health and Environment [CDPHE], 2019).

The gap in overall healthcare delivery for suicidal patients is the result of vulnerable patients falling through the cracks in a fragmented healthcare system. Ahmedani et al. (2014) found 80% of those who died by suicide had been seen by a healthcare provider the prior year and most did not have a mental health diagnosis. Another review by Luoma, Martin, and Pearson (2002) reported close to one-half of those who died by suicide visited a primary care provider in the month before their death. The Joint Commission (2019 formalized that death by suicide is considered a sentinel event if the patient was receiving care, treatment, and services in a staffed around-the-

clock care setting or within 72 hours of discharge including from the hospital's emergency department. In the Joint Commission's 2016 annual sentinel event report, a root-cause analysis concluded many suicides were confounded by weaknesses in the assessment process.

A Suicide Prevention Workgroup was convened in 2017 based on the new regulations and the need for interprofessional collaboration. At the onset, staff from the Quality Department, Patient Advocacy, Nursing, Palliative Care, Infectious Disease, Nursing Informatics, Adult Care Unit, Oncology, Behavioral Health, Social Work, and Pediatrics participated in this initiative. Their first task was to adopt a screening tool; a review of literature was done and the ASQ (National Institute of Mental Health, 2019) tool was selected for use on inpatients. Simultaneously, policies were under review for accuracy and procedure development for patients who screen positive for suicidal ideation.

Upon implementation of the inpatient suicide screening tool at NJH, nurses implementing the screening tool described feeling unprepared for a positive result of acute suicidal ideation. A wide range of clinical staff at this organization described a lack of confidence and being ill-prepared for such a critical situation. Most of the nurses interviewed had no or minimal training related to preventing suicide. Very few articles have discussed suicide prevention instruction in nursing curriculum even though many models recognized nursing initiatives to address suicide prevention. They also remarked about lack of resources at night and on the weekends when social workers and behavioral health were not available for support.

Purpose of the Project

Healthcare organizations value taking the time to know patients and understand their conditions and concerns. With suicide rates continuing to increase, we need to understand this issue further and work toward a solution. To start reducing suicide in our communities, the purpose of this project was to ensure staff are prepared and competent to prevent suicide by assessing acute risk and offering help. With this concept, all patient-facing staff could be capable of providing prompt and unbiased interventions to assess for, intervene, and prevent suicide. From the knowledge gained in an evidence-based practice (EBP) training, staff could increase the reach of their influence by recognizing suicide risk behaviors not only in patients but also within their families and community. A suicide awareness and prevention EBP must easily align with nursing values and be meaningful to nurses' daily work. This project could achieve two aims: (a) an effective EBP in suicide care and (b) meet or exceed all federal and state regulations with regard to suicide prevention.

Need for Project

The clinical workforce plays an essential role in suicide prevention because they are a trusted source when seeking help. The question is, are they prepared for these conversations and interventions? In 2019, the staff at NJH (E. Langhoff, personal communication, January 15, 2020) responded to 48 clinic patients with suicidal ideation—one was placed on a psychiatric hold and one patient was transferred to an emergency department during a night shift. These patients were initially considered to be outpatients at the time of their expressed ideation. If the regulations remain to be inpatient focused, there is a risk that outpatients could be missed. Staff must have the

resources to properly evaluate and respond to potential suicide risk in all types of patients. In an insightful article, Bolster, Holliday, O'Neal, and Shaw (2015) identified that "most registered nurses have little or no training in how to assess, evaluate, treat, or refer a suicidal patient. Because of this lack of training, RNs feel ill-prepared and afraid to talk to patients about suicide" (p. 10). Responsibility is a heavy burden if the nurse or provider has no competence or confidence in this challenging situation. Bolster et al. proceeded to suggest that once RNs received training in suicide assessment, "they realize it is no different than assessing for any other type of illness and are then able to help those with suicidal tendencies" (p. 10).

A literature review revealed no regulatory requirements for a specific suicide prevention training. Regulatory agencies included the Joint Commission, Centers for Medicare and Medicaid Services, and the CDPHE. At the most, regulatory literature contained validated suicide screening and assessment tools along with a short list of recommended resources for training programs specific to a behavioral health setting or emergency department. The gap in training was left to healthcare organizations to address in their specific settings. There was no clear delineation on the resource list between tools and training. The review included a variety of trainings offered by licensing entities, community resources, and educational institutions. Unexpectedly, no training could fully support the ambulatory needs of this organization.

Population, Intervention, Comparison, Outcome, and Time Questions

Two population, intervention, comparison, outcome, and time (PICOT) questions guided this project. The first question asked if there is a validated training in clinical practice that meets the regulatory, clinical competence, and patient outcomes desired:

population (P)—clinical staff, intervention (I)—suicide awareness and prevention training, comparison (C)— regulatory compliance, outcome (O —measure compliance, and (T)— before next regulatory survey. The second question asked how an academic medical center could provide clinical staff working in inpatient and ambulatory care with a high-quality suicide awareness and prevention training program: population (P)—clinical staff; intervention (I)—suicide awareness and prevention training; comparison (C)—no training; outcome (O)—measure knowledge, attitude, and skills; and time (T)—least time away from patient care.

Objectives of the Project

The objectives of the project involved preparing the staff to care for patients at risk for suicide. Three objectives comprised this project: (a) review the literature for evidence-based training, (b) integrate suicide prevention training into organizational activities, and (c) prevent suicide by changing knowledge, attitudes, and behaviors.

A review of the literature included evaluating suicide awareness and prevention education and training for clinical staff with published reviews of outcomes. The reach, effectiveness, adoption, implementation, and maintenance (RE-AIM) framework guided the critique of training programs resulting in the identification of a best practice. The goal of best practice is to increase knowledge, confidence, and capability to provide quality interventions. Training outcomes would continue to be measured over time by a cohesive workgroup of clinical and administrative professionals at NJH. The EBP also allowed the organization to meet compliance and regulatory recommendations for the Joint Commission's (2019) National Patient Safety Goal 15.01.01: Find out which patients are at risk for suicide.

Definition of Terms

Clinical workforce. Professions with a license to practice or with oversight by a licensed medical professional. For the staff the guidelines targeted, see Appendix A.

Death by suicide. When people direct violence at themselves with the intent to end their lives and they die because of their actions. It is best to avoid the use of terms like "committing suicide" or a "successful suicide" when referring to a death by suicide as these terms can be confusing.

National Patient Safety Goals. The purpose of the National Patient Safety Goals (Joint Commission, 2020) is to improve patient safety. The goals focus on problems in healthcare safety and how to solve them.

Suicidal ideation. Also called suicidal thoughts or thinking about or planning suicide. Thoughts could range from a detailed plan to a fleeting consideration. This term does not include the final act of suicide.

Vulnerable populations. Defining vulnerable populations is vague because there is no typical suicide victim. Data regarding suicide victims and attempts collected by The Joint Commission (2020) included populations such as military veterans and men over the age of 45. The zero suicide (Suicide Prevention Resource Center, 2017) initiative highlights that individuals with risk factors associated with a suicide (such as depression) should be considered the target population rather than individuals within a specific demographic group (such as men over the age of 65). Focusing on only a demographic could be dangerous because individuals with many risk factors associated with suicide who do not fit that demographic would

likely be overlooked. A focus on screening all inpatients for risk factors that are associated with suicide would instead lead to improved identification and response to patients at risk for suicide.

Risk factors include

- mental or emotional disorders, particularly depression and bipolar disorder;
- previous suicide attempts or self-inflicted injury;
- history of trauma or loss, such as a child, a family history of suicide, bereavement or economic loss;
- serious illness, or physical or chronic pain or impairment;
- alcohol and drug abuse;
- social isolation or a pattern/history of aggressive or antisocial behavior;
- recent (within a few months) discharge from inpatient psychiatric care; and
- access to lethal means coupled with suicidal thoughts (Joint Commission, 2016).

CHAPTER II

REVIEW OF THE LITERATURE

Historical Background

Nurses' attempts to understand suicide first appeared in the literature around the 1930s. Increased writings about suicide around this time were presumed to be in relation to the "Great Depression" when suicide rates were at a new high and notably increasing. In 1934, L.P. Yale, a psychiatric nurse, published an article entitled "Nurses and Suicide Prevention"; she claimed depression was the motivating cause for suicide. She also made the first risk assessment assertion to "never leave a person with possible suicidal trend alone; not even momentarily" (p. 886). This practice remains the basis for safe care environments. At the time of Yale's work, psychological nursing, public health nursing, and case management were more likely to be involved with suicide prevention efforts. Current nursing literature emphasizes inpatient and emergency department nurses are more likely to provide interventions in a suicidal crisis.

In a recent costs and policy implications study (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016), the financial cost of suicide and suicidal attempts in the United States was estimated to be $93.5 billion. The average societal cost of one suicide was calculated to be $1,329,553. More than 97% of this cost was due to lost productivity and the remaining 3% were costs associated with medical treatment (Shepard et al., 2016). These costs did not include the pain and suffering of the victim or survivors. The economic toll of suicide in the United States is almost $70 billion per year in lifetime

medical and work-loss costs alone. According to the Office of the Surgeon General and the National Action Alliance for Suicide Prevention's (2012) *National Strategy for Suicide Prevention: Goals and Objectives for Action*, for every person who dies by suicide, more than 30 others attempt suicide.

The current state of training focuses on screening for suicidal ideation as the key for preventing suicide. In 2015, the Joint Commission (2016) mandated that all accredited hospitals screen inpatients for suicide risk and soon afterward, other regulatory agencies followed with similar requirements. Within the literature and through interviews with Joint Commission surveyors, the expectation was all patients, inpatient and outpatient, would be screened with validated tools. This initiative created conflict in the ambulatory care community because screening every patient impacts clinical time with the patient. With this feedback, the 2020 Suicide Risk Recommendations from the Suicide Risk Reduction Expert Panel, were changed to state that ambulatory settings can limit screening to patients who are being evaluated or treated for behavioral health conditions as their primary reason for care. The 2020 version of the Joint Commission's NPSG 15.01.01.EP2 did not require organizations to routinely screen outpatients, which meant no longer requiring universal screening for suicidal ideation.

Universal screening would increase the amounts of patients identified at risk of suicide, forecasting a back log of referrals into behavioral health. Present declarations from providers suggest there is not enough access to behavioral health care to meet the need. According to the Colorado Health Institute (2019), more Coloradans (13.5%) reported they did not get needed mental health care in the past year because they had a hard time getting an appointment (32.9%) compared with 20.5% one year ago. Those

who did not get needed mental health care were more likely than in prior years to report barriers related to stigma and lack of coverage (Colorado Health Institute, 2019). Health insurance for mental health services could have high co-pays and deductibles making services unaffordable to some.

In the article, "A Broken Mental Health System," Brown (2019) stated the average waitlist in Denver to see a psychiatrist is about five months. Although Colorado's suicide rate is ninth in the nation, it is in the bottom half in per-capita state and federal spending in mental health (Brown, 2019). National Jewish Health's (2017) clinical response to an acutely suicidal patient is to make every attempt to get them further assessed by their primary mental health provider, transferred to a psychiatric service, or transferred to the emergency department.

The following keywords were searched: suicide prevention, suicidal ideation, suicide screening, evidence-based practice, knowledge, skills, attitudes, nursing, inpatient, outpatient, and ambulatory.

Synthesis of the Literature

An extensive literature review included a range of evidence from quantitative and qualitative research to clinical and patient experiences. The RE-AIM (2020) model was utilized for gathering evidence and analyzing the research related to the most commonly cited training programs. Each training module was evaluated on its reach, efficacy, adoption, implementation, and maintenance.

National Strategy for Suicide Prevention

In 2001, the first *National Strategy for Suicide Prevention* (National Strategy) was published by the Center for Mental Health Services and Office of the Surgeon General.

Overall, the mission of the National Strategy was a call to action to prevent suicide in the United States over the next decade. The latest iteration was published in 2012 and was a joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. It outlined interventions that providers and community members could use to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery. The National Strategy stated suicide prevention efforts should

- foster positive public dialogue, counter shame, prejudice, and silence;
- build public support for suicide prevention;
- address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- promote changes in systems, policies, and environments that would support and facilitate the prevention of suicide and related problems;
- bring together public health and behavioral health;
- promote efforts to reduce access to lethal means among individuals with identified suicide risks; and
- apply the most up-to-date knowledge base for suicide prevention (Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Joint Commission

To achieve Joint Commission accreditation status, healthcare organizations are responsible for providing an evaluation of patients for risk of suicide and, when needed, monitoring and transferring patients in need of immediate psychiatric treatment for suicidality to higher levels of care. If a patient does not meet the criteria for transfer, they must leave with a handout containing valid suicide outreach resources with phone numbers. The Joint Commission's (2016) sentinel event alert recommended giving all patients with suicide ideation (crisis or lower risk) the number to the National Suicide Prevention Lifeline, current local crisis, and peer support contacts. The measures are continuously changing and not well-defined. Specific training for the clinical workforce is absent from the measures and there is little guidance in the supporting documents.

Zero Suicide

The zero suicide model is fundamentally a system-wide approach (Suicide Prevention Resource Center, 2017). When a patient is in crisis, they might share their struggle with housekeeping or scheduling; therefore, everyone in the organization is involved. The Zero Suicide program was developed and supported by the Universal Health Services and the Substance Abuse and Mental Health Services Administration (Mokkenstorm, Kerkhof, Smit, & Beekman, 2017). Mokkenstorm et al. (2017) described the initiative as having three core elements: a direct approach to suicidal behaviors, continual improvement of the quality and safety of care processes, and an organizational commitment to the aspirational goal of zero suicides. The entire organization needs to be aware of the initiative and, at a minimum, know how to initiate a response for further evaluation. Measures of success include a reduction in severe safety events, reduction of

preventable harm, reduction in mortality rate, and a reduction in estimated harm-related hospital costs (Mokkenstorm et al., 2017). Zero suicide is not an independent training but a framework for system-wide transformation. Training is attained through a list of evidence-based training that organizations need to contact independently.

One criticism of the Zero Suicide program from local pediatricians in a children's emergency department is the program focuses on behavioral health professionals and not those at the bedside (Williams, 2019). The National Action Alliance for Suicide Prevention (2014) described the initiative as successful but not without concerns, objections, and consequences. The program gets organizations to a certain strategic point but there is no direct support for training. Mokkenstorm et al. (2017) pointed out the pursuit of Zero Suicide within its message implies fault, guilt, and blame if something goes wrong. The initiative does not address provider resiliency for staff who had experience with suicide, whether personally or through work.

Mental Health First Aid

Mental Health First Aid (MHFA; Kitchener & Jorm, 2006) is community-focused training for any individual to recognize signs of mental health crisis and substance-use issues, and then connect to support. Similar to the basis for cardiopulmonary resuscitation, this training intends to preserve life until advanced support becomes available. The course itself is eight hours and taught by a certified instructor within the community in the setting of a like-minded organization (school, healthcare setting, Fire Department). Studies have shown participants were more informed and had less stigmatizing attitudes. Participants felt confident they could help someone in crisis and serendipitously improve their own mental health. Clinical outcomes for MHFA staff

training include increased health care quality, increased patient and staff satisfaction, and reduced harm (Kitchener & Jorm, 2006). At this time, evidence does not support an overall improved response to suicide or increased referrals for treatment. Kitchener and Jorm concluded that "although MHFA training has been found to change knowledge, attitudes and helping behaviours, and even benefit the mental health of participants, there has not yet been an evaluation of the effects on those who are recipient of the first aid" (p. 6).

National MHFA instructor courses occur around the United States on a monthly basis for adults and pediatrics (Kitchener & Jorm, 2006). In 2019, there were no trainings scheduled in the Rocky Mountain region and therefore costs were increased for travel and lodging. There were no substitutions for receiving the certification outside of the eight-hour instruction timeframe or outside of the mandated curriculum. Many of the community trainings provided by MHFA Colorado (2020) were geared toward emergency care, schools, or psychiatric facilities. Outside of the initial instructor training, there were no anticipated additional costs for instructor fees. Externally certified instructors were available through MHFA Colorado, though costs ranged from the instructor ($500 to $2,000) and the number of classes requested (one or two-day). These accredited instructors were obligated to provide the one or two-day training and maintain the curriculum of MHFA (Kitchener & Jorm, 2006).

Online Training Models

Kognito (2020) is an online program that presents healthcare staff with an avatar-based scenario in suicide behavior. The provider then is given resources, education, and tools to intervene in a variety of scenarios. The applications are comprehensive and

accessible; providers can readily access the resources in a crisis. Limitations include lack of stimulating conversation and participation of the subject. Feedback from online trainings in the organization include low quality content, lack of motivation, seen as more work, and less accountability. The literature warned the cost of the training is significant considering staff only use one or a few of the features of the program.

QPR (QPR Institute, 2019) online training includes a three-step process intervention: question, persuade and refer. The goal of the training is to increase knowledge of warning signs and develop skills in crisis intervention. The QPR training is offered online or face-to-face at an organizational or individual level. Fees varied by the number of attendees. Training outcomes included significant gains in self-efficacy to identify, intervene, and refer. Criticism indicated knowledge decreased over time and was susceptible to no behavior change.

Within the literature reviews, no statements considered the cost of lost provider time, personal revenue, and organizational revenue. Presently, NJH providers state there is no structure or incentive in place for them to participate in training. At this medical center, human resources estimates 1,300 clinical and affiliate staff need training. To decrease the impact on clinic flow, evening and weekend training is a possibility.

Summary of the Literature Review

The literature revealed gaps in suicide care within the outpatient setting were considerable given the high number of patients with suicidal ideation that enter the healthcare system in the ambulatory or non-mental health route. Throughout the literature, universal screening for inpatients was well established because the evidence supported that this patient population was considered vulnerable. Vulnerability is further

associated with inpatient diagnosis that includes comorbid behavioral health conditions, recent medical diagnosis, a change in clinical status that carries a poor prognosis, or psychosocial issues (Joint Commission, 2018). Outpatient screening models and interventions in clinical settings were limited because they emphasized having in-house mental health providers.

Models

This scholarly project involved using two models to translate the research into practice: the RE-AIM (2020) framework and the Stetler (2001) model. The RE-AIM framework was used to organize and review the literature on suicide prevention training modules for clinical staff. The RE-AIM framework consists of five elements that relate to health behavior interventions. The goal of the RE-AIM framework is to encourage health care to look at health initiative elements that could improve the sustainable adoption and implementation of effective, generalizable, evidence-based interventions. Using RE-AIM was ideal for evaluating the training models in the field of suicide assessment and prevention.

Application of RE-AIM (2020) raised further research questions and did not support the study hypothesis. There was no validated suicide prevention training that applied to this organizational setting. The Stetler (2001) model of research utilization was used to validate RE-AIM results, planning, and implement a variety of best evidence-based practices. It facilitated the organizational coordination that is needed to implement the EBP.

Reach, Evaluate, Adoption, Implementation, and Maintenance

Reach. Reach is the first step of the RE-AIM process. It is defined as the absolute number, proportion, and representativeness of individuals who are utilizing the service to be evaluated. The target population is clinical staff; however, reach should be beyond clinical staff for future phases. Many training models are designed to increase knowledge; in this case, recognize suicidal ideation and then activate the appropriate response.

The reach of suicide training should include the patient population and the healthcare workforce. Screening tools included in the program could reach multiple populations in a variety of settings, i.e., pediatric behavioral health. The initial reach of training recommends an organization-wide workshop that evolves into a permanent agenda item within new employee orientation. In-person training is preferred because of the sensitive and emotional nature of the issue. In smaller organizations, an online curriculum is available and constructed to be as interactive as possible. The most resource neutral option is the train-the-trainer concept. Selected staff are trained to be the instructors and then return to the organization to provide departmental training.

Effectiveness. The RE-AIM (2020) framework states effectiveness as "the impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes" (p. 1). Effectiveness was evaluated on the training's ability to reach outpatient and inpatient settings. An effect training should emphasize the importance of leaders empowering the staff with the tools and time to meet the needs of a suicidal patient and their family. The reach of screening interventions

varies in healthcare settings, i.e., the 20-minute outpatient visit as compared to the two-day hospital stay. Many primary care settings already have challenges with bottlenecking at the intake portion of the visit. Hospitals are at an advantage as they can spend more time on the admission process to ask these questions. In both settings, the questions are only as good as healthcare workers' comfort and confidence in asking them. The researcher often saw medical assistants rushing through these questions so patients glossed over the response in tandem. A reason for the medical assistant moving so quickly through the questionnaire is so they do not have to deal with the work that goes along with a positive response.

Adoption. The acceptance, willingness, and knowledge of the intervention are vital to the implementation and maintenance of the intervention. Adoption is defined as "the absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program" (RE-AIM, 2020, p. 1). Testimonials and clinical experiences in larger organizations that practice these models would be considered successful adoption. Endorsement by well-established professional associations and governmental agencies were also considered.

The screening questionnaire recommended for the first general screening is the ASQ Suicide Risk Screening tool created by the National Institute of Mental Health (2019). The initial screen contains four questions and has been validated for patients 12 years old and older. Having a short and succinct tool should contribute to high rates of adoption. Documenting positive screens could further understanding of risk factors and how to address them. Additionally, staff could evaluate the data for initiative effectiveness.

Implementation. Implementation is the time, cost, and consistency of delivery of an intervention. Training is available online and in-person; these considerations were included. For healthcare organizations who want to maintain their Joint Commission accreditation and payments from the Centers for Medicare and Medicaid Services, they must implement the basic components of suicide prevention by identifying individuals at risk in the inpatient setting and a process to access appropriate treatment (RE-AIM, 2020).

Maintenance. Maintenance is the extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies (RE-AIM, 2020). The length of time the training has been in practice with measurable outcomes was evaluated.

Suicide prevention in healthcare is the goal of all healthcare workers and training staff is the most comprehensive approach to this one issue. Similar initiatives are broadly designed around mental health, which could work for an organization that needs to start somewhere; having a high quality and effective suicide prevention program gives the staff a solid direction. Mental health initiatives that have suicide as a component of the model require the staff to also think about addiction, psychiatric diagnosis, and much more.

The RE-AIM (2020) for all models of training includes identifying patients who have suicidal ideation and intervening. Regulatory agencies allow hospitals to select their own training as long as it has been validated. However, validation is difficult to prove during a survey visit. Most models are based on preceding interventions, i.e., screening. For every life saved from implementation of screening practices, the initiative

quickly becomes resource neutral. Criticisms of many training models are they can lead to disappointment when clinical efforts fail (RE-AIM, 2020).

Stetler Model

The Stetler (2001) model is a structure for using the research conducted and create a vehicle for changing policies and procedures. Individual nurses such as practitioners, educators, and policymakers summarize research and use the knowledge to influence educational programs, make practice decisions, and impact political decision making (Stetler, 2001). This model has guided the inquiry of relevant research in the field of suicide prevention and nursing. The Stetler model of research utilization consists five decision-making steps or phases:

Phase I. Phase I, the preparation stage, consists of identifying the purpose and the need to solve a problem or revise a policy. This phase included exploring significant research literature regarding successful suicide prevention training in practice or tools to guide nurses and advanced practice nurses. The literature pointed to training modules that targeted school personnel, community health workers, emergency department staff, and behavioral health staff.

Phase II. The validation phase examines the credibility of findings and the potential for application. A review of literature was done on suicide prevention training that evaluated the pattern of knowledge outcomes for clinical staff in all types of ambulatory care settings and hospitals, excluding emergency department and behavioral health. Mental Health First Aid (Kitchener & Jorm, 2006) and Zero Suicide (Suicide Prevention Resource Center, 2017) appeared in the literature as the most used frameworks in the healthcare setting for assessing and reducing suicide. The review of

literature concluded no one size fits all. Although a crucial regulatory topic, no explicit models were discovered to affect clinical staff in multiple clinical settings that care for patients. This phase included identifying the needed elements elicited from relevant literature and development of suicide prevention training for expressed ideation or risk for suicide.

Phase III. This phase included evaluation through surveying ambulatory and hospital clinical staff about the feasibility, likability, and appropriateness of a training. Surveys administered elicited comments, suggestions, and expert opinions from medical assistants to practitioners. The NJH (E. Langhoff, personal communication, January 15, 2020) suicide awareness and prevention workgroup had an opportunity to comment on the training curriculum.

Phase IV. This translation and application phase allowed for writing of the final curriculum and evaluation survey. Cumulative findings from both literature research and survey responses created the final curriculum for clinical staff, dependent on their discipline.

Phase V. This phase anticipated evaluation of the final training where participants could provide feedback on whether the training was effective in their clinical practice and patient outcomes. Figure 1 provides a visual representation of the phases of the Stetler (2001) model to show the relationship of concepts and phases of the project.

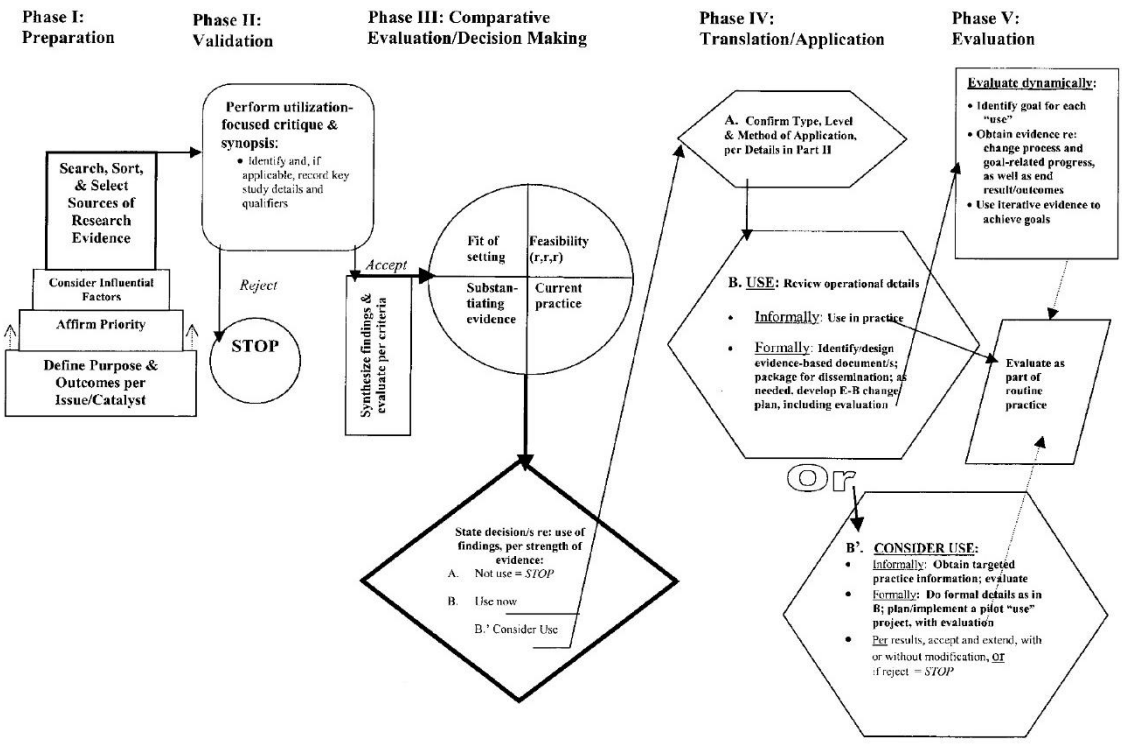

Figure 1. Relationship of concepts and phases of the Stetler model to the project.

CHAPTER III

METHODOLOGY

This DNP scholarly project included implementation of an evidence-based suicide prevention training that applied to clinical staff in both ambulatory and hospital settings. This project was developed using descriptive research that involved surveying participants who attended the MHFA (Kitchener & Jorm, 2006) training, organizational training, or completed the provider survey. Quantitative data were obtained from the Clinical Workforce Survey that measured knowledge, skills, and attitudes with regard to providing suicide care. Qualitative data were obtained using a survey asking providers for expert opinion and topics of interest.

At the onset, this researcher was involved in the planning of the Suicide Awareness and Prevention Program at NJH (2017). The suicide prevention workgroup at NJH was highly suspicious of a suicide awareness knowledge gap upon implementation of a mandated suicide screening tool but did not understand the extent of that deficit. Due to the immediate need for inpatient suicide screening and demands from nursing for corresponding training, initial trainings were started before an evaluation method was complete. The preliminary trainings were exploratory in nature. The instructors committed to using MHFA (Kitchener & Jorm, 2006) concepts in the training that happened to parallel the guidelines for training prepared by the clinical workforce preparedness task force of the National Action Alliance for Suicide Prevention (2014). The review of literature revealed shared stakeholders, which could explain the similarities

in training structure. The guidelines were also designed to be universal and easily adoptable by a range of clinical staff.

Lessons learned from the trainings so far included low participation from providers and clinical leaders, which was assumed to be due to perceived impractical topics, time commitment, and lack of incentive. The pay structure for providers is highly dependent on patients seen during hours of operation; without protected training time, they must choose between using vacation or dealing with the consequence of lower numbers. This project formalized the organizational training and was built for the provider participant with a busy schedule. Clinical leadership received a report of the provider's survey and evaluated the need to provide protected time for training. Once the training guideline was established with measurable outcomes, topics in suicide assessment and prevention could be easily tested for future courses.

Design

Staff could enroll in a full-day MHFA (Kitchener & Jorm, 2006) training, a two-hour organizational training, or complete the provider survey. Parallel instruments were in use: the Clinical Workforce Survey for training participants and the provider survey. The Clinical Workforce Survey was optional for training participants. The instructors felt there would not be enough time or resources for a pre-survey. The post-survey results informed the instructors if the content, style, and curriculum were effective in increasing staff knowledge. Outcomes included altering activities that were ranked ineffective.

At the onset of introducing the training, providers expressed concern that they did not have the time for training nor was the curriculum appropriate for their practice. To

understand their concerns further, providers participated in a provider-only study. The provider survey was used to gather expert opinion, provide an opportunity to communicate that worked with varied schedules, and avoided motives of power and status. The first round of open-ended questions was sent as a survey link via email on a Tuesday and closed after one week. For any unanswered survey, a reminder was sent on Friday. The first round of responses was analyzed in preparation for a second round of questions. The second round survey further explored common trends and outliers to find a consensus. Results were shared with the participants, directors, and managers.

Setting

National Jewish Health is a nonprofit academic medical center that focuses on research and treatment in respiratory, cardiac, immune, and related disorders. Clinical operations include both inpatient and ambulatory patient services for pediatrics and adults with five satellite clinic locations throughout the Denver Metro area. The average daily inpatient census is two while the outpatient daily census is 300; many are from out-of-state.

The training occurred in a classroom setting that was safe and conducive to learning. Confidentiality was assured and discussed at the beginning of the training. For participants who might be emotionally impacted by the content during the course of the training, the instructors created a hand-signal that let them know the participant needed some time away from the content but was safe. There was an option for individual training if the participant felt they could not participate in a classroom setting. Resources for professional help were available to every participant in a hand-out or through referral.

The curriculum was a template from the *Guidelines for Training* prepared by the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention (2014). The training guidelines were applicable for employer-based training, either in-house or as an initial effort. The Task Force's guidelines were inclusive of inpatient and ambulatory staff who connected with patients in person, on the phone, and via the patient portal. The curriculum included sharing the philosophy, evidence, goals, and limitations of the training (see Appendix B for curriculum). The subject content included essential components of MHFA (Kitchener & Jorm, 2006). The teaching methodology combined classroom discussion, case study review, simulations, and coaching. Simulations included role-play, risk identification, and intervention development.

Sample

The sample for this DNP scholarly project was clinical staff working within an organization in both inpatient and ambulatory settings. Small sample sizes were anticipated based on the premise that suitable results could be obtained by a comparatively small group of homogenous experts. Providers with clinic hours had a general understanding of patient flow to develop reliable intervention that was relatable to other busy providers. Although this project started with nursing as the focus, once the project was presented to the project site supervisor, there was keen interest to include all patient-facing staff. The roll out included nursing as the first group to receive training, providers were next, and were followed by all other ancillary staff. Nurse practitioners could attend with either group because they would be with their peers in both settings.

All staff were able to attend training and there were multiple opportunities to participate. The structure of the training enrollment followed the process set by the Diversity and Inclusion Council of NJH. Once the current staff received training, all new employees received training during orientation. Nursing leadership determined the curriculum was sound and the training was opportune and essential; therefore, all nursing staff were required to attend the initial organizational training.

Project Mission, Vision, and Objectives

Suicide is a public health problem that continues to increase across many communities. The mission of this project was to prevent suicide across all healthcare settings. The vision was to implement evidence-based training that prepared the clinical workforce to serve persons at risk for suicide. Three objectives comprised this project: (a) review the literature for evidence- based training, (b) integrate suicide prevention training into organizational activities, and (c) prevent suicide by changing knowledge, attitudes, and behaviors.

Project Plan

Preparing for the project required approval from the Hospital-wide Quality Improvement Committee, Quality Subcommittee of the Board, and the Suicide Awareness and Prevention workgroup. Collaboration with experts in the workgroup guided understanding of training and instruction capabilities. Obtaining NJH Institutional Review Board (IRB) exemption required the identification of a principal investigator with appropriate certifications and credentials. Nursing was not approved to submit their own application. The NJH IRB approved the exemption and supported

submission to the University of Northern Colorado's IRB (see Appendix C for approvals).

National MHFA instructor courses occur around the United States monthly for adults and pediatrics (Kitchener & Jorm, 2006). The first NJH attendees committed to receiving the training in MHFA in preparation for assuming additional duties as the NJH adult and pediatric instructor. Using *the Suicide Prevention and the Clinical Workforce Guidelines for Training* (National Action Alliance for Suicide Prevention, 2014), the designated instructors developed a curriculum specific to our inpatient/outpatient adult and pediatric population needs. The NJH staff could attend the adult, pediatric, or both population trainings. After completion of the training, instructors asked the participants to participate in an online survey. They received an invitation to participate in an optional survey via e-mail with an embedded link. The survey measured knowledge, attitude, and practice of suicide assessment and interventions since taking the training. Financial support and time away the unit were justified since the return on investment included a trained staff that resulted in total health experience for patients and families that recognized the value of prompt and unbiased interventions to prevent suicide. Thus, NJH met and exceeded compliance and regulatory recommendations for the Joint Commission's 2019 inpatient and ambulatory *National Patient Safety Goals.* Also, this project had the potential to reduce liability for the organization, providers, and nurses.

A licensed clinical social worker and psychologist at NJH qualified in suicide counseling received instructor certification in MHFA (Kitchener & Jorm, 2006). They coordinated and conducted multiple training opportunities in MHFA or the organizational

training that included components of MHFA. Sustainment plans included the identification and training of back-up instructors.

National Jewish Hospital started the initiative with two NJH employees who became certified and trained back-up instructors to maintain the permanence of the program. National Jewish Hospital was the proprietor of tailored curriculum unique to hospital and ambulatory patient populations with whom the researcher connected to in-person, on the phone, and via the patient portal.

Instrumentation

The Zero Suicide Workforce Survey (Suicide Prevention Resource Center, 2017) was available for use by the researcher with permission with some adaptions as directed by the NJH Suicide Awareness and Prevention Workgroup. No fees, restrictions, or training were required for the use of the instrument. The results informed the instructors if the content, style, curriculum were effective in increasing staff knowledge. Because of previous concerns raised by the providers at the onset of the training, a separate provider survey provided insight into their training preferences. The more specific survey was a method of gaining expert opinion on tools needed for suicide prevention. Participants who completed the training received an email containing the survey link distributed through REDCap software. The survey tool was developed, distributed, and maintained in REDCap. A request for exempt determination was submitted to the National Jewish Health IRB for approval (see Appendix C) and a consent for participation statement led the surveys (see Appendix D).

The provider survey was a result of initial responses from clinical providers who desired a more specific training and in a different format. These requests were wide-

ranging from an online acknowledgment to a full-day workshop. The provider survey was used to gain insight into what topics related to suicide prevention were of interest, outcomes anticipated, and the format for presenting the material. The participants were identified by the same workgroup based on vested interest and expertise. The first questionnaire was collected and responses analyzed by the workgroup. Based on the responses, a second questionnaire was sent out summarizing results and requesting agreement, disagreement, and insights.

Analysis

Non-experimental data analysis determined the effectiveness of the EBP. Qualitative data were gathered from the provider survey, clinical experience, and patient experience. Quantitative data were obtained from the Workforce Survey that measured knowledge, skills, and attitudes with regard to providing suicide care. Research results were shared with the Hospital Quality Improvement Committee as part of their quality improvement (QI) dashboard and continued for 2020. The QI dashboard is analyzed by the Quality and Safety Subcommittee of the Board on an annual basis. This subcommittee could make further recommendations based on survey results.

The Workforce Survey was developed and maintained in REDCap. REDCap is a secure, web-based software administered by NJH and developed by the REDCap Consortium. Data were exported into Microsoft Excel and SPSS for analysis. Responses were analyzed using frequency tables and *t*-tests. The provider survey was collected in two phases: analyses of the first-round of responses determined the second-round of questionnaires. A report with the responses was prepared and shared with the instructors and workgroup.

Duration of the Project

Institutional Review Board approval was sought in December of 2019; in February of 2020 upon inquiry, the IRB at NJH was prioritizing COVID-19 related applications. The application was determined as Not Human Subjects Research on May 19, 2020 (see Appendix C). Upon receipt of the determination letter, an IRB application was sent to the University of Northern Colorado IRB who exempted it as Not Research (see Appendix C for approval). The survey was sent out to staff who had already participated in training and new respondents received the survey within one week of training. The provider survey was sent upon IRB approval; the workgroup had developed the questions. Project completion was anticipated eight weeks from sending out the survey through data analysis and completion of final written work. At the organizational level, the suicide workgroup monitored the first year of the initiative and the quality department provided logistics and data support. This project was developed with consideration for longevity and sustainability after the research was complete. The licensed clinical social worker instructor oversaw the monthly adult training and the pediatric behavioral health psychologist managed the quarterly pediatric training.

Ethical Considerations

The topic of provider mental health challenged the workgroup to think about whether staff in a mental health crisis could be vetted before attending the training and referred to employer assistance programs (EAP), primary care provider, or a crisis resource center. Healthcare professionals are near the top of occupations with the highest risk of death by suicide. Burnout, depression, and suicidality exceeded age-matched peers in medical school and in practice (Kalmoe, Chapman, Gold, & Giedinghagen,

2019). The workgroup decided to have a statement on the training invitation that suggested the training might be inappropriate at this time for someone with active depression and active suicidal thoughts. The message would also contain the EAP number and suicide hotline numbers. Previous feedback from providers recommended that due to the sensitive nature of the training, the physicians on the workgroup opted for a face-to-face training.

Some of the research showed there were still some questions about limited benefits for persons with mental illness or little increase in referrals of persons with mental illness and in a state of crisis. No research has been done on whether suicide training resulted in a referral that resulted in a long-standing relationship with a mental health provider. Clinical experiences included more confidence to refer a patient for screening and possible immediate hospitalization but then the referral became disconnected from the discharge and follow-up treatment process, especially if the patient was transferred to a different facility. Are we throwing a vulnerable patient into an already disjointed system?

Summary

This scholarly project was developed to review evidence-based models of suicide prevention training and implement a model into an academic medical center that provided care for patients in a variety of clinical settings. This researcher theorized a model already existed that could accommodate this setting. With suicide rates continuing to rise, prevention efforts in every clinical setting are vital. Using the diffusion of innovations change theory (Orr, 2003) allowed clinical staff to enrich their work through new skills and knowledge in recognizing suicide risks in their patients, own lives, family,

and community. At the end of the day, “suicide prevention is about creating safeguards with patients and their relatives that promote their recovery, that help them have a life worth living, and protect them from self-harm when they are unable to protect themselves” (Mokkenstorm et al., 2017, p. 7).

CHAPTER IV

DATA ANALYSIS AND RESULTS

The transformation of data into meaningful outcomes occurred at this phase in the project. The outcomes to measure in the original PICOT question were first to identify a suicide prevention training that met regulatory requirements and organizational settings. The secondary outcomes were to measure the knowledge, attitude, and skills of staff in preventing suicide after training.

Objective One Outcome

Applying the RE-AIM (2020) framework for searching the literature helped determine what models were appropriate and cost-effective for this specific setting (see Appendix E). Seven commonly cited training modules were evaluated within the dimensions of RE-AIM: reach, efficacy, adoption, implementation, and maintenance. This approach allowed the workgroup to share their impressions of models using the same evaluation criteria. The significance of using the framework is numerous scientific applications of assessing health promotion program impact.

By consensus, the workgroup selected the MHFA (Kitchener & Jorm, 2006) program to lead to training development. The MHFA had the endorsement of the National Action Alliance for Suicide Prevention (2014) and contained all the elements within the guidelines for clinical workforce training. The MHFA stood out to the workgroup because it offered convenient and low-cost instructor training. In contrast, the other models provided the trainer and did not advertise instructor training or costs on

their websites. Having an internal instructor would allow NJH to have more flexibility and opportunities to provide training to staff. Online training had comparable content but lacked the face-to-face option, which became apparent after two of the workgroup members completed the online modules in Kognito (2020) and QPR (QPR Institute, 2019) and found unsatisfactory results.

Objective Two Outcome

Zero Suicide Workforce Survey

Distributing the Zero Suicide Workforce Survey (Suicide Prevention Resource Center, 2017) was done via a web link to an organizational-wide distribution e-mail list (see Appendix F). The invitation asked respondents to select a survey link based upon their role: non-provider or providers (licensed independent practitioners). All data were exported to and analyzed using IBM SPSS (Version 24). A total of 135 staff responded—104 considered themselves a non-provider and 31 identified as a provider.

Staff input was low considering an organizational-wide suicide prevention approach. The survey was sent out during the COVID-19 pandemic when hospitalizations were starting to decrease. One hundred four staff responded to the Suicide Awareness and Prevention Training survey (see Appendix G). The survey conflicted with many other organizational initiatives and research concerning COVID-19. No reminder e-mails and other typical messaging that encouraged participation were done due to competing studies.

Suicide Prevention and Training Survey

The survey contained branching logic that further focused on the knowledge and skills of clinical staff as they progressed in the complexity of suicide care. Comment

sections at the end of the survey offered respondents a space to share ideas for improvement. This survey targeted staff who were part of the care team but not licensed independent practitioners (see Appendix H). Provider staff were thought to have different concerns to be addressed in a separate survey discussed later in the project.

Demographics. The demographic section of questions asked respondents to describe characteristics based on their work environment and role. Analyses focused on respondents with direct patient interaction as part of their job. Not enough nurse respondents were available to compare against other clinical staff.

Location. The most common locations respondents worked in are reflected in Table 1; all other departments listed in the survey had one or two respondents.

Table 1

Work Environment Locations

Location	Frequency
Administration	11
Research	11
Pediatrics	8
Adult Clinic	7
Occupational Medicine	6
Health Initiatives	5
Pulmonary	5
Adult Care Unit	4
Radiology	3

Note. $n = 104$

Other Departments not listed on the survey drop down included 63 entries; two each were in Development, Health Information, Sleep, and Information Service Technology. All of the other departments listed had one respondent: Academic Affairs, Center for Genes, Environment and Health, Clinical Affairs, Clinical Education, Finance, Marketing, Medical Library, Security, Center for Health Promotion, Utilization Management, and other.

Respondents. Staff were asked to identify their primary professional role according to NJH job categories (see Table 2). Nurses and management participated in equal numbers; the design did not differentiate if the nurse was also a manager.

Table 2

Primary Professional Roles

Group	Frequency
Nursing—Staff	21
Management (Administrators, Supervisors, Managers, Coordinators)	21
Business, Administrative, and Clerical (Accounting, Patient Services, Human Resources, Billing, Records, IST, Scheduling)	13
Researcher	9
Support Staff (Certified Nursing Assistants, Medical Assistants)	7

Note. $n = 102$.

One or two respondents included behavioral health clinician, facility operations, radiology, and rehabilitation. Others included two each of administrative assistants, scientist, customer care representatives, tobacco cessation health coaches: one of each biomedical engineer, data processor, employee assistance program, epidemiologist, fundraising, laboratory animal technician III, marketing specialist, patient advocate, pharmacist, release of information, teacher, and student.

Patient care. All staff was asked if they directly interacted with patients during their day-to-day work. Most respondents answered "yes" to interacting directly with patients either in person or from a distance during daily duties within NJH. Of the 100 respondents who replied to the question, 76 answered yes and one person was unsure. As expected, the majority of the staff worked in outpatient operations within NJH. National Jewish Hospital has significantly more outpatient visits than inpatient visits. One nurse worked exclusively with inpatients. This person was assumed to be a night nurse because it was the only job in this medical center that did not cross over into outpatient care. This cross-coverage was represented by 29 respondents who worked in both settings (n = 83).

Training. This section of the survey was a two-part question examining previous training on suicide awareness and prevention. Only respondents who responded to receiving training were asked to identify the type of training they received (see Table 3). Of 100 responses, more respondents had received some kind of previous training on the topic of suicide prevention, intervention, or assessment (64), than those who had not (36). All of the nurses responded they had participated in some form of training. Some respondents had multiple sessions. Comments regarding other training included a

nursing school mental health class and an in-service at St. Joseph Hospital. Another five respondents had had additional training but did not specify the name.

Table 3

Type of Previous Training

Type of Training	All Respondents	Nursing
Inservice at NJH	52	20
Training at Different Organization	21	4
Mental Health First Aid Certification	13	4
Other	5	2

Results. A 5-point Likert scale was used to measure variables in suicide prevention topics associated with the physical environment, work culture, warning signs, screening, assessment, transitions in care, and support. The scale ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Frequency distribution tables were done in SPSS on the nursing for each variable. Independent *t*-tests were run through SPSS to confirm the null hypothesis:

Ho1 There will be no difference in the level of agreement for suicide prevention variables between clinical staff that had NJH training and clinical staff that had no training.

A significance level was defined as greater than α-level of .05 for all variables. Only staff who interacted with patients were considered for this part of analysis; the sample size varied across variables because some questions were missing a response.

Environment. This set of questions referred to the environment where suicide care takes place; results are presented in Table 4. The first question ranked awareness regarding formal policies specific to suicide care. Staff who completed the training had an increased understanding of the policy by a mean difference of 1.22 over non-trained clinical staff. The actual *p*-value was < .001, concluding there were significant differences between the two groups.

The next question in this section assessed knowledge of potential means for suicide within the facility. For example, a suicidal patient could hang themselves using the exam curtain in the exam room. Staff who completed the training had decreased knowledge by a mean difference of 1.15 over non-trained clinical staff. The actual *p*-value was 0.006, concluding there were no differences between the two groups (see Table 4).

Table 4

Physical Environment Where Patients Received Care

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I know the NJH policy for ensuring a safe physical environment for patients at risk for suicide.	4 (4.0)	19 (19.0)	12 (12.0)	41 (41.0)	24 (24.0)	100	3.58
I know what to do when I have concerns about potential means for suicide in the physical environment in our facility.	5 (5.1)	12 (12.1)	19 (19.2)	36 (36.4)	27 (27.3)	99	2.86

Work culture. This section assessed perceived organizational culture and support related to prevention. Responses informed the workgroup about the degree of organizational culture change needed to advance this initiative (see Table 5). This set of variables assessed the role of the work culture in suicide prevention included a ranking of organizational traits. In this section, staff who completed the training had an average ranking of 3.89 (min. = 1, max = 5). Staff who did not participate in training ranked 2.94 in this set of variables. The actual *p*-value was consistently lower than the α-level of 0.05 in all variables, concluding there was a significant difference between the two groups. The highest ranking was 4 in the trained group who agreed to the statement: "I believe suicide prevention is an important part of my professional role."

Table 5

Respondents' Reflections on Suicide Prevention Within the Work Culture

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I understand my role and responsibilities related to suicide prevention within NJH.	4 (4.0)	6 (5.9)	18 (17.8)	51 (50.5)	22 (21.8)	101	3.15
I believe suicide prevention is an important part of my professional role.	7 (6.9)	5 (5.0)	15 (14.9)	45 (44.6)	29 (28.7)	101	3.71
The leadership at NJH has explicitly indicated that suicide prevention is a priority.	7 (6.9)	20 (19.8)	22 (21.8)	28 (27.7)	24 (23.8)	101	3.66
NJH has clear policies and procedures in place that define each employee's role in preventing suicide.	4 (4.0)	15 (14.9)	30 (29.7)	33 (32.7)	19 (18.8)	101	3.54
NJH provides me access to ongoing support and resources to further my understanding of suicide prevention.	6 (6.0)	15 (15.0)	29 (29.0)	33 (33.0)	17 (17.0)	100	3.64
I feel that NJH would be responsive to issues that I bring up related to patient safety.	2 (2.0)	5 (5.1)	16 (16.2)	43 (43.4)	33 (33.3)	99	3.45

Warning signs. Questions in this section assessed knowledge and comfort related to recognizing when a patient might be at elevated risk for suicide and the ability to follow procedures (see Table 6). In this section, staff who had training had an average ranking of 3.91 compared to 3.37 of staff with no training. These results inferred most staff felt confident and comfortable in recognizing warning signs. The actual *p*-value was consistently lower than the α-level of 0.05 in all variables, concluding there were significant differences between the two groups.

Table 6

Respondents' Knowledge and Comfort Related to Recognizing When a Patient Might Be at Elevated Risk for Suicide

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I have the knowledge and training needed to recognize when a patient may be at elevated risk for suicide.	11 (11.0)	18 (18.0)	10 (10.0)	43 (43.0)	18 (18.0)	100	3.64
I am knowledgeable about warning signs for suicide.	6 (6.2)	9 (9.3)	13 (13.4)	48 (49.5)	21 (21.6)	97	3.54
I know what NJH procedures to follow when I suspect that a patient may be at elevated risk for suicide.	9 (9.0)	20 (20.0)	15 (15.0)	37 (37.0)	19 (19.0)	100	3.63
I am confident in my ability to respond when I suspect a patient may be at elevated risk for suicide.	9 (9.0)	17 (17.0)	14 (14.0)	42 (42.0)	18 (18.0)	100	3.53
I am comfortable asking patients direct and open questions about suicidal thoughts and behaviors.	10 (10.1)	19 (19.2)	21 (21.2)	33 (33.3)	16 (16.2)	99	3.38

Screening. Due to smaller inpatient operations, this question was inherently not applicable to most staff. It was not expected that outpatient staff routinely screened patients for elevated risk for suicide. The message communicated via policy and procedure, training, and electronic medical record access to screening tools was screening was only required for inpatients. The approach to outpatient screening was to recognize warning signs and notify a provider, social worker, or behavioral health professional. This had proven difficult in the past because of staffing, provider resistance, and lack of rapid response systems for behavioral health. Most respondents in the survey declared they were not responsible for conducting screening for suicide risk: 73 selected no, 23 selected yes, and eight were unsure. Eleven respondents were responsible for both ASQ (National Institute of Mental Health, 2019) screening and assigned to an inpatient unit (registered nurse and providers). In actuality, this set of questions was only applicable to those staff; however, there were 28 responses. The average response for staff without training was 2.05 and for staff with training, the average was 2.19. This section had the lowest percentages in knowledge and comfort (see Table 7).

Table 7

Respondents' Knowledge About Screening Patients Who Might Be at Elevated Risk for Suicide

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I have the knowledge and skills needed to screen patients for suicide risk.	1 (3.6)	3 (10.7)	5 (17.9)	11 (39.3)	8 (28.6)	28	3.78
I know the NJH procedures for screening patients for suicide risk.	1 (3.6)	4 (14.3)	4 (14.3)	11 (39.3)	8 (28.6)	28	3.75
I am comfortable in my ability to use the Asking Suicide-Screening Questions (ASQ) to screen patients for suicide risk.	2 (7.7)	3 (11.1)	6 (22.2)	9 (33.3)	7 (25.9)	27	3.59
I am comfortable screening patients for suicide risk.	1 (3.7)	3 (11.1)	6 (22.2)	11 (40.7)	6 (22.2)	27	3.66

Assessment. Most respondents in the survey declared they were not responsible for conducting assessing suicidal patients: 89 selected no, five selected yes, and five were unsure. This section of statements contained branching logic only for respondents who were responsible for suicide assessment (see Table 8).

Table 8

Respondents' Knowledge About Clinical Decision-Making and Assessing Patients Who Are Suicidal

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I have the knowledge and skills needed to conduct a suicide risk assessment.	0 (0)	1 (12.5)	3 (37.5)	3 (37.5)	1 (12.5)	8	3.50
I obtain information about risk and protective factors when conducting suicide risk assessment.	0 (0)	1 (12.5)	2 (25.0)	4 (50.0)	1 (12.5)	8	3.62
I assess the patient's access to lethal means as part of a suicide risk assessment.	0 (0)	3 (37.5)	3 (37.5)	3 (37.5)	3 (37.5)	8	3.50
I know what NJH procedures exist regarding suicide risk assessments.	0 (0)	1 (4.3)	0 (0)	5 (71.4)	1 (14.3)	7	3.83
I am confident in my ability to conduct a Columbia Suicide Severity Rating Scale (CSSRS).	1 (12.5)	1 (12.5)	4 (50.0)	2 (25.0)	0 (0)	8	2.87
I know the clinical workflow to follow when a suicide risk assessment indicates the patient needs additional clinical care.	1 (12.5)	0 (0)	2 (25.0)	4 (50.0)	1 (12.5)	8	3.50

Transitions in care. Since NJH does not have an emergency department or inpatient mental health service, this section provided information about the hospital's care transition process (see Table 9). Most respondents in the survey declared they were not responsible for care transitions of suicidal patients: 79 selected no, 11 chose yes, and six were unsure. Respondents' level of knowledge, confidence, and comfort patient care staff had in safely discharging or transitioning patients following acute suicidal ideation averaged 3.27. A platform error occurred for the question, " I am confident in my ability to work with family members or other support persons who may be involved during a patient's transitions in care."

Table 9

Level of Knowledge, Confidence, and Comfort Patient Care Staff Had Discharging or Transitioning Patients to a Higher Level of Care

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Responses	*M*
I have the knowledge and skills needed to work with patients during their transitions in care.	1 (6.3)	2 (12.5)	6 (37.5)	6 (37.5)	1 (6.3)	16	3.25
I am familiar with NJH procedures for working with patients during their transitions in care.	1 (6.3)	3 (18.8)	5 (31.3)	6 (37.5)	1 (6.3)	16	3.18
I am confident in my ability to work with patients during their transitions in care.	1 (6.3)	2 (12.5)	5 (31.3)	7 (43.8)	1 (6.3)	16	3.26
I am familiar with NJH procedures for sharing PHI during a patient's transition in care.	1 (6.3)	4 (25.0)	1 (6.3)	9 (56.3)	1 (6.3)	16	3.31
I am comfortable working with patients during their transition in care.	1 (6.3)	2 (12.5)	4 (25.0)	8 (50.0)	1 (6.3)	16	3.37

Organizational support. This section informed the workgroup about staff attitudes and perceptions about support related to patient suicide deaths. A no-blame culture is essential to a successful suicide prevention program (see Table 10).

Table 10

Staff Experience with Patient Suicide

While working at NJH, I have directly or indirectly interacted with a patient who ended his/her life by suicide.	All Respondents
Yes, it has happened once	5
Yes, it has happened more than once	3
No	74
I don't know	15
Prefer not to answer	0

Note: n = 97

Table 11 illustrates how the organization supported staff following a suicide. Branching logic applied to respondents who reported they interacted with a patient who ended his/her life by suicide.

Table 11

Support After a Suicide

Question	Strongly Disagree # (%)	Disagree # (%)	Neutral # (%)	Agree # (%)	Strongly Agree # (%)	Not Applicable # (%)	Responses
I felt supported by NJH when a suicide occurred.	3 (3.1)	1 (1.0)	9 (9.3)	0 (0)	1 (1.0)	83 (85.6)	97
I felt blamed when a patient died by suicide.	4 (4.2)	1 (1.0)	6 (6.3)	0 (0)	0 (0)	85 (88.5)	96
NJH has practices in place to support staff when a suicide occurs.	2 (2.1)	4 (4.1)	28 (28.9)	9 (19.6)	7 (7.2)	37 (38.1)	97
I am aware of the Employee Assistance Program.	3 (3.1)	8 (8.3)	9 (9.4)	35 (36.5)	33 (34.4)	8 (8.3)	96

Three staff members felt they were not supported by NJH when a suicide occurred and one person out of 14 felt supported. Five staff felt there was no blame when a patient died by suicide and six were neutral about blame. The question about having practices in place to support staff had a normal distribution curve, and 11 were unaware of the Employee Assistance Program (n = 96).

All respondents were asked about their training, resources, and support needs (see Table 12). A total of 20 areas included the *Other* section where respondents could write in additional training and resource needs.

Table 12

Training and Resource Needs

More Training/Resources/Support	Responses	%
Suicide awareness and prevention	39	54.2
Staff roles and responsibilities within your work environment	38	52.8
Identifying warning signs for suicide	36	50.0
Communicating with patients about suicide	34	47.2
Procedures for communicating about potentially suicidal patients	31	43.1
Policies and procedures within your work environment	31	43.1
Crisis response procedures and de-escalation techniques	29	40.3
Understanding and navigating ethical and legal considerations	23	31.9
Managing suicidal patients	22	30.6
Epidemiology and the latest research findings related to suicide	19	26.4
ASQ Screening Questions	19	26.4
Family, caregiver, and community support	19	26.4
Determining appropriate levels of care for patients at risk for suicide	15	20.8
Collaborative safety planning for suicide	15	20.8
Creating a safe physical environment for patients at risk for suicide	14	19.4
Reducing access to lethal means outside the care environment	13	18.0
Columbia Suicide Severity Rating Scale (CSSRS)	12	16.7
Suicide-specific treatment approaches	11	15.3
M-1 Hold	11	15.3
Aftercare and follow-up	11	15.3

Note: n = 72

Comments. The next set of questions was designed in free text so respondents could have a space to share additional thoughts outside of the structured survey. This feature was requested by the workgroup.

Training. Do you have any concerns or comments about suicide awareness and prevention training? Additional comments were offered:

- While patient safety is a focus I also believe every person should be aware for employee safety too, patients are not the only ones to show signs.
- I think that this needs to be looked at even in the departments that don't have direct patient care. We get a lot of interaction with the laboratory staff down in the BRC, we also have a lot of stuff present in our department that could be used if someone was pushed to a suicidal mind frame.
- Training on the signs of suicidal thoughts for co-workers, not just patients, would be great.
- Just how to keep a patient calm and on the line until you are able to transfer the call to the appropriate person.
- I attended the Suicide Awareness training at NJH but felt like it was designed for professionals (i.e., nurses, MA's, PA's etc) and did little to nothing to help those of us who might be the first contact with a potentially suicidal patient. I have been involved in two situations where I had potentially suicidal patients on the telephone and in each case was required to keep the person on the phone until a co-worker could get someone to help me. Simply stating that as a non-professional my job is to get a professional to help is not enough. I struggled to keep this person on the phone in order

to get them help. We need to be able to feel more comfortable in this sort of interaction so we don't feel like we might do or say something that will make the situation worse.

- Although I don't work in a patient-care area, it's useful to keep updated on the procedures and techniques.
- I would like more training.
- I think it would be nice to specifically tailor a suicide training towards the pediatric population for those of use who work in pediatrics.
- I had an employee express suicidal comments while at work and I called 5555. I understand this is focused on patients, but I would also like to know what to do with staff, (as well as patients), as far as procedure or next steps when this is occurs.
- We need a more open discussion regarding patient or staff suicide. I feel there is still a stigma attached to Mental Illness.
- More training specific to the pediatric department.
- Our area is communal and does not offer much in the way of privacy and is not conducive to addressing suicide risk. How can we manage this?

Providing care. Do you have any comments or concerns about providing care to a patient who is suicidal? Additional comments were offered:

- It’s a delicate situation unsure of how I would handle when put to the test.
- I often speak with patients on the phone, and would want to provide them resources if it became clear they were in crisis or danger.

- Without Mental Health Care, we will get nowhere with their medical care! It has to be blended on all patients.
- Unsure about next steps if I am the first one the patient communicated with. What do I do for the patient in the moment and who is my first contact?
- I would like to have a better understanding of resources available to either patients or staff.

Additional comments. Please elaborate on any item above and/or additional comments regarding the survey. Additional comments were offered:

- I believe it's everyone's responsibility to know the signs, not only for the workplace but home life too. There is such a stigma around suicide and the more people know the uncomfortableness and stigma can decrease.
- I am very far removed from interacting with patients, but I would be interested in knowing what the standard operating procedures are.
- While I realize as a non-professional it is not my responsibility to treat or counsel a suicidal patient. I am sometimes the first point of contact for that patient. I need to be trained on the possible ways to keep a patient calm, de-escalate the situation and provide assistance to get them help. My one experience with this left me feeling helpless and completely inadequate when it came to providing assistance to the patient. I struggled just to keep the patient calm and on the telephone long enough to get them the help they needed.
- It's good to stay informed.
- Our department has a procedure for crisis calls, that I have used before.

- The process for identifying and treating a suicidal patient in the pediatric department is vague. I don't feel we have as much support as the adult departments in regard to available resources like social workers that are available.

Suicide Prevention Survey for Providers

The survey for the providers was designed differently out of respect for different variables that impacted their concept of suicide prevention. The workgroup suspected there were additional barriers to training other staff did not encounter. Providers within the workgroup expressed serious concern about whether a two-hour training was feasible with their busy clinic schedules. Suggestions for training included division meetings, grand rounds, and e-learning. The workgroup agreed that having all clinical staff in full-day training was not practicable because of clinic commitments. This survey was designed to capture some of the issues unique to various practices in the hospital.

Demographics. Table 13 provides a summary of the locations where participants worked in the hospital.

Table 13

Work Locations

Location	Frequency
Pediatrics	5
Pulmonary	4
Adult Clinic	3
Infectious Disease	2
Oncology	2
Social Work	2
Asthma Allergy	1
Behavioral Health	1
Cardiology Clinic	1
Occupational Medicine	1
Nutrition	1
Palliative	1
Radiology	1
Rehabilitation	1

Patient care. Providers were asked if they cared for patients in an outpatient or inpatient capacity. Most provider respondents provided care in the outpatient setting (14, 56%) within the medical center, 12 (48%) provided care in both inpatient and outpatient settings, while three (12%) strictly cared for inpatients.

Provider role. Respondents were asked to select a category that best described their professional role; the responses included 12 Medical Doctors, two Family Nurse

Practitioners, and one each of Doctor of Philosophy, physician assistant, clinical nurse specialist, adult care nurse practitioner, Doctor of Nursing Practice, licensed clinical social worker, registered nurse, social work intern, Doctor of Osteopathic Medicine, registered dietitian nutritionist, and occupational therapist. Most of the 26 providers declared they were actively providing direct care to patients: Yes (24, 32.3%), No (2, 7.7%).

Leadership. It was important for the workgroup to appeal to leaders within the provider role to understand their perception of barriers. Seven of the 26 respondents were in a Director, Department Chair, or Division Head role.

Current state. This section of questions provided information about current knowledge and comfort performing actions related to suicide prevention (see Table 14). The question header, as directed by the workgroup, included "if Social Work or Behavioral Health was unavailable." This statement was assumed to encourage thinking past a resource that was not always available.

Table 14

Current Knowledge and Comfort Performing Actions Related to Suicide Prevention

Question	Yes # (%)	No # (%)	Unsure # (%)	Responses
Do you feel comfortable screening?	21 (84.0)	2 (8.0)	2 (8.0)	25
Do you feel comfortable with assessment?	13 (54.2)	8 (33.3)	3 (12.5)	24
Do you feel comfortable with interventions?	6 (24.0)	15 (16.0)	4 (16.0)	25
Do you feel comfortable following-up?	6 (24.0)	13 (52.0)	6 (24.0)	25
Are you familiar with the NJH policy and procedure for suicide assessment and intervention?	10 (38.5)	10 (38.5)	6 (23.1)	26
Have you had any previous training on the topic of suicide prevention, intervention, or assessment?	16 (61.5)	8 (30.8)	2 (7.7)	26
I would be willing to participate in and learn more about suicide and its prevention.	20 (76.9)	0 (0)	6 (23.1)	26

The following question indicated where clinical staff rated their suicide care today (see Table 15). The workgroup focused primarily on clinical care with these responses and discussed if there needed to be more provider-specific education and training for suicide. A majority of the providers felt they had the knowledge and skills to prevent suicide; results were normally distributed.

Table 15

Self-Rating of Knowledge and Skills

Question	Poor # (%)	Fair # (%)	Good # (%)	Excellent # (%)	Uncertain # (%)	Responses
How would you rate your knowledge and skills to prevent suicide?	2 (8.0)	12 (48.0)	9 (36.0)	1 (4.0)	1 (4.0)	25

Comments. Do you have any additional comments related to the questions above? Additional comments were offered:

- The screening and assessment are easier, it's the questions about when/how to put someone on a hold and how to set up a plan following hospital discharge that I'm not clear on. My immediate thought would be, "Call the social worker!"
- I am comfortable discussing suicidal ideation with patients, but I am less comfortable with deciding the need for intervention based on plan/no plan or risk level.
- We are understaffed in social work and behavior health. This is the only oncology group that I have ever worked with that doesn't have a dedicated social worker and behavioral health professional.
- I have had a number of patients who I screened for suicidality, including one who (weeks later) tried to commit suicide (shot himself in the jaw, was disfigured, but survived) and another who was admitted for inpatient care. I am sure there are things I can learn about how to do a better job.
- My discomfort is due in part to lack of time with patients—my encounters are require time for the medical interview, exam, counseling and education.

I am willing to screen, but do not have time or training to do the rest of the interventions.

- Not exactly clear what other interventions are except for referring for INPT eval.
- I have been a clinical research nurse role for 14 years, to be honest I would not be confident with my ability to intervene—unless it was short term until a more experienced provider arrived.

The workgroup wanted responses to the question "Given your role, briefly list your responsibilities related to the Suicide Assessment and Intervention Policy" to determine if providers were familiar with the current policy and procedure for suicide assessment and intervention. They also wanted to know if the current policy was clear and if it met their clinical needs. The answers to the question are listed below:

- Identifying patient needs and referring to social work.
- My role is to alert nursing and social work if my patient voices suicidal thoughts, and to ensure the patient is not left unattended.
- Since I am a psychologist, this often comes up.
- Suicide Assessment.
- This is a brand new role for me, I've viewed the NJH policy but have not had any experience with this yet.
- Identify risk factors during H&P or daily interaction with patient. Contact SW or psychologist.
- Screen patients for suicidality and take appropriate actions depending on results including safety contracting, M-1 holds, continuation of care.

- Screening.
- Primarily as a provider, to recognize warning signs and risk factors, ask patients about suicide and depression, and refer/act when appropriate.
- Keeping the patient safe in the clinical are and asking for assistance

Answers to the question "Do you have any comments or feedback regarding this policy and procedure" are listed as follows:

- Unclear what P&P has to do with the purpose/goal of this research.
- Since the one social worker handles most of the suicide assessment, she is usually responsible for the M-1 holds. However, I would love a refresher on how we go about M-1 holds here at NJH, everything from patient transportation to the hospital, forms to fill out, and general process by which we should be doing this if it comes up. It is also useful to know what we should do in the case of telehealth if we are in session with them and we can keep them on the line. Should we be doing the full assessment with them, or should we immediately be calling 911 so emergency services can be sent to their house, or perhaps some combination of both? Thankfully none of my patients have been imminently a danger to themselves or others, but I would like to make sure that I know NJH's procedures and flow for placing an M-1 hold both in-person and remotely since I am eligible to do so (although most of the time our one social worker will be handling these).
- When the issue came up with a patient during the last year, I was able to contact and mobilize support from Behavioral Health. I don't know if this procedure is still in place.

- One situation where I have found myself is being the next provider to talk with a patient after he/she had some sort of intervention (including M1 hold). These patients were angry at the other providers for taking action, to the degree one never wanted to see her longtime MD again, and the other was mad at me for the referral from the concerned MD who did the intervention.
- Will look at it.

Training. How many hours of previous training have you had on the topic of suicide prevention, intervention or assessment (course, seminar, CME, etc.)? Figure 2 provides a visual representation of the hours of previous training.

Total Count (N)	Missing*	Unique	Min	Max	Mean	StDev	Sum	Percentile						
								0.05	0.10	0.25	0.50 Median	0.75	0.90	0.95
15	16 (51.6%)	11	0.50	0.00	4.83	6.02	72.50	0.83	1.00	1.00	2.00	7.25	13.50	16.75

Lowest values: .5, 1.0, 1, 1, 1
Highest values: 8, 10, 15, 20, x

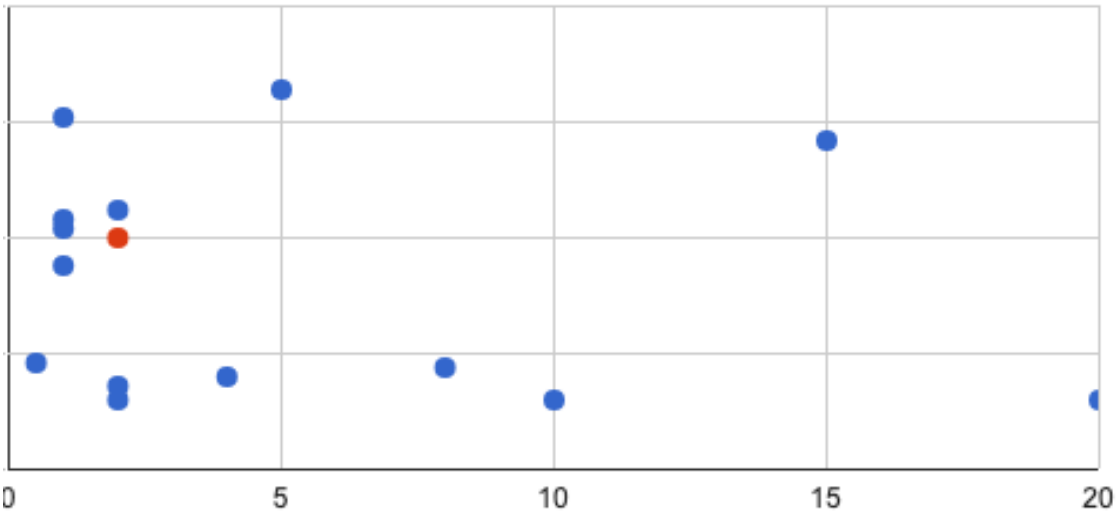

Figure 2. Hours of training.

To identify types of training the providers participated in, the following question was asked: “What was the name of the training you received?” Respondents listed the following trainings: the suicide awareness class at NJH, cannot recall, training for telehealth, mandatory provider class at NJH, a recent Grand Rounds on safe gun storage and some of the data presented were relevant to suicide risk factors, over the years I have read articles on the epidemiology and risk factors for suicide, the required staff training, graduate coursework in assessment and intervention in children and adolescents, NJH Net-learning course of suicide prevention and intervention, Army ACE Suicide Intervention (ACE-SI) Program Army Suicide Prevention Program Colorado Army National Guard Suicide Prevention Program, usually in form of grand rounds, training during medical school and residency, a small bit of refresher with the recent Telehealth net learning module on safety, do not recall, it was a work place training, Mental Health First Aid, and Suicide Awareness and Prevention Training.

When all respondents were asked whether they should have some duty to assist suicidal patients and, therefore, some legal exposure, they responded as follows: $N = 26$ True (80.8%), False (4, 15.4%), and Unsure (1, 3.8%).

The next section of questions compared current skills to areas in which providers might have liked more training, resources, or support. Tables 16 and 17 provide participant responses to those questions.

Table 16

Training, Resources, and Support Needs

More Training/Resources/Support	In which of the following areas do you feel confident in your ability to care for patients with suicide risk? # (%)	I which of the following areas, would you like more training, resources, or support # (%)
Suicide awareness and prevention	19 (79.2)	10 (40.0)
Creating a safe physical environment for patients at risk for suicide	10 (41.7)	6 (24.0)
Staff roles and responsibilities within your work environment	9 (37.5)	9 (36.0)
Identifying warning signs for suicide	20 (83.3)	11 (44.0)
Communicating with patients about suicide	12 (50.0)	11 (44.0)
Identifying risk factors for suicide	14 (58.3)	9 (36.0)
Procedures for communicating about potentially suicidal patients	4 (16.7)	8 (32.0)
Policies and procedures within your work environment	0 (0)	0 (0)
Crisis response procedures and de-escalation techniques	0 (0)	11 (44.0)
Understanding and navigating ethical and legal considerations	3 (12.5)	8 (32.0)
Managing suicidal patients	0 (0)	11 (44.0)
Epidemiology and the latest research findings related to suicide	4 (16.7)	8 (32.0)
ASQ Screening Questions	6 (25.0)	9 (36.0)
Family, caregiver, and community support	7 (29.2)	10 (40.0)
Determining appropriate levels of care for patients at risk for suicide	0 (0)	9 (36.0)
Collaborative safety planning for suicide	0 (0)	4 (16.0)
Reducing access to lethal means outside the care environment	2 (8.3)	6 (24.0)
Columbia Suicide Severity Rating Scale (CSSRS)	1 (4.2)	6 (24.0)
Suicide-specific treatment approaches	1 (4.2)	5 (20.0)
M-1 Hold	5 (20.8)	12 (48.0)
Aftercare and follow-up	3 (12.5)	10 (40.0)
Legal Implications	1 (4.2)	8 (32.0)
NJH policies and procedures		8 (32.0)

Table 17

Preference for Delivery of Training

Type of Training	Responses	%
A face-to-face professional seminar or presentation	12	50.0
Multi-media online tutorial	13	54.2
Multi-media online tutorial and face-to-face review/Q&A	9	37.5

Based on shortened time for provider training, this portion of the survey informed the instructors on which topics they should focus. Providers were asked to rank training topics from most important to least important (see Table 18).

Table 18

Training Topic Ratings

Topic	Most Important: 1 # (%)	More Important:2 # (%)	Neutral 3: # (%)	Less Important: 4 # (%)	Least Important: 5 # (%)	Responses
NJH Policy and Procedure	5 (20.8)	8 (33.3)	7 (29.2)	1 (4.2)	5 (12.5)	24
Screening Tools	18 (72.0)	5 (20.0)	1 (4.0)	1 (4.0)	0 (0)	25
Legal Implications	0 (0)	3 (13.6)	10 (45.5)	19 (19.6)	4 (18.2)	22
M-1 Hold	2 (8.0)	0 (0)	3 (12.0)	11 (44.0)	9 (36.0)	25
Suicide Severity Rating	1 (3.8)	10 (38.5)	4 (15.4)	5 (19.2)	6 (23.1)	26

The following were responses to the question “Do you have any concerns or worries about suicide assessment and prevention training?

- It would be good to get an annual refresher, sort of like BLS is good for 2 years, suicide assessment and prevention training could use a refresher.
- Time commitment, relative importance of content to a wide group (provider specific training would be helpful).
- I am unaware what an M-1 hold is.

The following were responses to the question “Do you have any concerns about providing care to patients who are suicidal?”

- Making sure I am given the proper tools to address this independently, if needs be.
- What happens if the social worker isn't available. The first steps I can do and in fact those conversations come up from time to time in palliative care conversations.
- Communication tools and de-escalating techniques.
- Concern around legal liability when letting someone go and then they attempt suicide.
- I don't encounter these patients enough to remember what to do when I am concerned about it.
- Requires multidisciplinary coordination with psychology, psychiatry, and social work. There seems to be little support for pediatrics.
- Yes, I do not feel I am qualified.
- Deescalating them if the need presented.

- I don’t know what to do regarding care other than referring to SW and am not sure that I would have time to perform the action adequately.
- I would seek the support of our social worker or psychologist.

CHAPTER V

DISCUSSION

Summary

This EBP project started with the recognition that there were not enough mechanisms to meet regulatory requirements or keep patients safe from suicide while in the healthcare system. The RE-AIM (2020) framework was used to evaluate clinical training models as a tool for preventing suicide. A modification of the MHFA model (Kitchener & Jorm, 2006) was identified as applicable to inpatient and outpatient staff. The Stetler (2001) model was used to implement EBP. Phase IV of the Stetler model (translation/application) involved presenting the EBP training plan to the Quality Department and Executive Leadership of NJH. The workgroup requested support in training staff under the model of the Zero Suicide (Suicide Prevention Resource Center, 2017) with a curriculum developed by MHFA that was specific to inpatient and ambulatory practices. This process was Phase III—The comparative evaluation/decision-making phase of the Stetler model. Phase IV—Translation/application involved administering the Zero Suicide Workforce Survey to learn about staff knowledge, comfort, and confidence in suicide care. Phase V—Evaluation informed the suicide awareness and prevention workgroup of the next steps.

Data analyses showed staff felt comfortable and confident in suicide awareness and less comfortable and confident in interventions leading to suicide prevention. It was significant to appreciate both responses of disagree/strongly disagree and strongly agree

to determine the success of an intervention (variable). As predicted, there were significant differences in knowledge, skills, confidence, and comfort between staff who attended training and those who did not. At a point in the survey, branching logic confirmed only staff who indicated it was their role to perform clinical interventions answered questions about those interventions. A majority of respondents requested additional training and resources.

There were glaring cost savings associated with this grow-your-own training curriculum. A curriculum specifically focused on NJH's patient population was preferable because we got content relevant to the researcher's care environment. The maintenance portion in the RE-AIM (2020) process highlighted that original training did not require long-term relationships with a vendor. If an instructor left NJH, other instructor plans could be discussed and implemented by the workgroup.

Suicide Prevention Survey Results for Staff

Respondents worked in a variety of departments or units and worked in an assortment of jobs. More clinical staff responded than non-clinical staff but not all clinical staff were actively providing care to patients.

Work Environment

Most respondents agreed they knew about NJH's policy for patients at risk of suicide and how to proceed in the physical environment. Acknowledgment of the institutional policy indicated staff knew their responsibilities in suicide care. If respondents were unaware of the policy, there was no remedy for this in the survey. Future versions of this survey should attach the policy as a document beside this question. More education around the policy and potential means for suicide in the

physical environment needs to occur. These topics are currently covered in the NJH training curriculum.

Work Culture

Many of the staff felt they had a role in suicide prevention. The adult clinic, pulmonology, and pediatrics staff had the highest rankings for these questions. As predicted, marketing, development, and administration did not feel they had a role in suicide prevention. Respondents were neutral around support for education and training. If leaders made the training mandatory for some departments, this would help staff feel supported as they encountered suicidal patients.

Warning Signs

The number of staff who felt knowledgeable about recognizing warning signs that a patient might be at elevated risk for suicide was higher than expected. There were significant differences between staff members who received training and those who had not received training on recognizing warning signs. It could be determined that the training was successful in recognizing warning signs and staff comfort talking about suicide.

Screening. Staff responsible for screening (RN, social worker, or provider) felt knowledgeable and comfortable screening suicidal patients. Based on role responsibilities, there should have been 11 responses corresponding to an inpatient assignment. However, there were 28 responses to this set of questions, which could have indicated that screening has a different meaning depending upon role and setting. The policy was unclear as to who was responsible for screening or screening was being done

on outpatients. Clinical workflow for staff to follow if they have a patient with warning signs of suicide remains a work in progress.

Assessment. The response rate for questions related to assessment was low. This result was in correlation to the small number of professionals trained to do a formal suicide assessment using an evidence-based tool. In retrospect, this section of questions should have been excluded from this survey and included in the provider survey. These questions applied to very few and might have confused the rest.

Transitions in care. Options for treatment were limited in this medical center as there is no emergency department or inpatient mental health service. Many training models reviewed in the literature included emergency and inpatient mental health professionals. National Jewish Hospital's procedure was to transfer patients to a higher level of care, which could vary dependent on the time of day or severity. Staff knew which clinical interventions were approved per the NJH procedure and were comfortable with procedures for care transitions to other facilities.

Organizational support. Ideally, all the answers in the section should have been strongly agree—that staff were supported in a manner consistent with a just, no-blame culture when a patient ended his/her life by suicide. Some respondents felt unsupported, blamed, and unaware of the Employee Assistance Program. The results highlighted some serious issues with the support that staff received from the organization. Issues related to organizational support should be a priority when the workgroup convenes. Feelings around blame could have a significant negative impact on the individual, clinical practice, and organization.

Training and resource needs. This section identified training priorities. The results showed more than half of the areas where more training and resources were requested were covered in the current NJH training curriculum. Topics included suicide awareness and prevention, staff roles and responsibilities, and identifying warning signs. With this outcome, instructors could further emphasize these areas in training.

Suicide Prevention Survey for Providers Results

This survey was designed differently than the non-provider survey as it contained more open-ended questions and had less of the framework from the Zero Suicide Workforce Survey. The workgroup was interested in specific questions related to the provider role. During the analysis, it became apparent that some of the questions were leading and forced. Specifically, one of the questions asked about familiarization with the policy and the next question asked about their role according to the policy. This question became awkward if their first answer was *no* or *not sure*. The workgroup wanted to know if providers would be willing to do some of the suicide care if the safety net resources were out of the equation. The question was very deliberate: "In your day-to-day practice, if social work or behavioral health was unavailable to assist, would you feel comfortable performing the following actions related to suicide prevention." This question might have invoked some thought for the first time about having less or no resources around to do a quality and safe intervention. Comments related to this question included issues with not having enough resources or time.

Most of the respondents were physicians and 25% were in a leadership position. The leadership question originated around having providers in an authority position understand the issues around suicide training.

Another question was found to be leading during the analysis phase: legal action in association with providers making reasonable and prudent steps to reduce suicide. The question asked respondents if they believed there were legal implications with regard to suicide care; 80% of the providers agreed. This question was phrased to assess providers' understanding of legal implications involved in suicide prevention; nonetheless, there are legal implications involved in all aspects of patient care. This question should be rephrased or excluded from future surveys.

Many of the providers had an average of five hours of previous training yet still felt they had training regarding needs in assessment and transitions in care. Individuals with more than five hours of training were more likely to report having assessment skills. The most requested topics for further training were in the Suicide Awareness Training curriculum. In even amounts, providers desired either training in a face-to-face format or multi-media online tutorial. The least amount of respondents wanted a combination of the two. Reoccurring comments included requests for de-escalation training.

Conclusions

The results of this evidence-based project showed that patient-facing staff could recognize suicidal ideation and offer resources and interventions to protect patients from themselves. Training was effective for staff who attended, yet additional training for patient-facing staff is needed to adequately make organizational change. There is a need for additional training and clarification regarding screening using the ASQ (National Institute of Mental Health, 2019) tool. The results were inconclusive regarding who should be doing screening and in what setting. Data and surveillance were inconsistent.

Implementation of a provider-specific training is needed to capture the assessment and transition to care components of suicide care. Ongoing support needs to be provided for staff who interacted with a patient who ended his/her life by suicide. A no-blame culture should be expanded into other areas concerned with patient safety.

Although the implementation phase of the EBP occurred during a pandemic, suicide remained a topic of concern. Thus, the workgroup needs to maintain momentum with interprofessional support and leadership commitment. Data and surveillance in the form of total screenings, assessments, and follow up could measure outcomes for interventions over time.

Limitations

The survey would have been more robust if more nurses participated; many of them were mobilized to different areas to care for higher acuity patients or COVID-19 patients. Heightened clinical operations during this time left less time for extraneous activities at work for some staff. Gathering the workgroup for discovery and planning will be different as pandemic social distancing measures remain in place. A summary of the findings was shared with the members of the workgroup via email. Some of the members remain working from home, furloughed, or have left the hospital. It would be challenging to convene at this time; however, the instructors and the Quality Department will have the results to discuss in the future.

Preliminary survey results showed improvements to the survey instrument and process are needed. First, the survey was distributed to all the staff at NJH, clinical and non-clinical; this was intentional since it was unknown who in the organization had contact with patients. The survey was not received well by staff who felt it was not

applicable to their job overall. The assessment questions were not necessary since very few non-provider staff had this responsibility. Some of the survey questions had low response rates and after careful review, it was discovered the wording of those questions was confusing.

Recommendations for Future Research

The literature was not clear about patient outcomes related to clinical staff who received training and those who did not. Some comments indicated suicide training made staff, leaders, and organizations feel better about themselves but did it not impact patient outcomes. There was no formal patient tracking of suicide interventions and outcomes. Therefore, follow up was inconsistent and there was no way to know what happened once the patient left the facility. The use of Behavioral Health ICD-10 codes could be encouraged, which would result in the ability to develop reports within the electronic medical record. Follow-up procedures could be developed and implemented.

It will be interesting to review suicide rates in the wake of the coronavirus pandemic. Isolation and loneliness contribute to suicide; consequently, the risk of suicide is increased during this time. Calls to suicide hotlines during the pandemic could also be studied. Post-pandemic research would also be valuable in a future public health crisis.

It is recommended that the workgroup repeat the surveys after implementation of recommendations from the initial survey. Much of the groundwork is done and the survey instrument remains in the NJH REDCap platform. A future survey could assist the workgroup in knowing if the issues around suicide were improving or worsening. Improvements in the survey instrument should include differentiation between nursing staff due to differences in scope of practice, i.e., RN, ADN, and LPN. Strategies to

increase the number of trainings need to be discussed while face-to-face activities remain discouraged by public health mandates for reducing coronavirus transmission.

The stigma around mental illness was a reoccurring theme in the survey comments. The stigma of mental illness was a well-researched area but future research could find ways the healthcare community can fight stigma. Perhaps bias within the healthcare team is felt by patients.

Many of the respondents mentioned they encountered staff with suicidal ideation and perhaps more within staff than with patients. The workgroup could further understand this issue by partnering with Human Resources and leadership to assist staff in reaching out for help without reprisal. Although many of the survey respondents acknowledged the Employee Assistance Program, future research could evaluate any barriers to accessing this resource.

Doctor of Nursing Practice Student Reflections

This scholarly project was the culmination of knowledge and skills acquired within the rigor of a graduate program. The DNP curricula were integral to the planning, implementation, and evaluation of the project. Learning and growth through this project occurred over many years; what was first a regulatory requirement as a job responsibility turned into a commitment to make a difference in the health of vulnerable persons. A review of the literature exposed significant gaps in the healthcare system where patients were dying by suicide while in a healthcare facility or within 72 hours of discharge. This failure was a call to action for this researcher.

Fortunately, some like-minded interprofessional colleagues also desired practice change. Each member of the suicide awareness and prevention workgroup contributed to

the development and execution of the project's components. This researcher had the opportunity to lead an organizational initiative while supported by experts in this area. This project served as a component of more extensive EBP that would continue to guide practice in suicide prevention.

Enhances, Culmination, Partnerships, Implementation, and Evaluation Framework Essentials

This scholarly project met the DNP essentials outlined by Waldrop, Caruso, Fuchs, and Hypes (2014) in their publication, *EC as PIE: Five Criteria for Executing a Successful DNP Final Project*. These five criteria required that a final project enhanced health or practice outcomes or healthcare policy; reflected a culmination of practice inquiry; required engagement in partnerships; implemented, applied, or translated evidence into practice; and required evaluation of health care, practice, or policy outcomes (Waldrop et al., 2014).

This project fit with the EC as PIE criteria to develop health or practice outcomes or healthcare policy by increasing knowledge and skills based on evidence to decrease deaths by suicide. The design of the project focused on meeting state and federal regulatory requirements for suicide prevention practice and training. The project supported the suicide awareness and prevention workgroup in understanding the current training needs of staff. The results informed leaders to support organizational policy and provided resources to promote regulatory requirements, patient safety, and outcomes.

The RE-AIM (2020) model for evaluation of intervention programs reflects "a culmination of practice inquiry" (Waldrop et al., 2014, p. 302). The RE-AIM process included assessing commonly cited suicide prevention training models on five dimensions: reach, efficacy, adoption, implementation, and maintenance. Also, hundreds of articles and public health guidelines were reviewed for application to this healthcare setting. As an initial

and ongoing member of the workgroup, access to experts, analytic resources, and historical references were readily available. Experience, comprehension, and competencies obtained throughout the doctoral program were used in this scholarly project. Application of nursing theory, data interpretation and analysis, evidence-based practice recommendations, population health strategies, leadership skills, and information technology utilization were needed for the implementation of this scholarly project. Based on the complexity of suicide and scholarly rigor of the project, all criteria in the EC as PIE framework were needed to execute a project worthy of making a difference. Upon presenting the findings to the workgroup, there was an anticipation of practice change that was as Waldrop et al. suggested "pragmatic, practical, [and] likely to be used in the real-world setting in a timely, reproducible, and sustainable fashion" (p. 302). Between the RE-AIM exercise and the survey, staff at this medical center could advocate for support and resources for improved training, resulting in safer patient care. The problem of suicide takes a multi-system approach to make a difference; in the case of acute suicidal ideation, staff could intervene with confidence using evidence-based techniques. This knowledge and skill are reproducible, overflowing into homes, schools, and communities.

Partnerships within the workgroup and interdisciplinary peers were required for the planning and implementation of the project. There was value and credibility in having multiple names and credentials associated with the survey; staff trusted this group of their peers based on previous interactions. The formal training provided by MHFA (Kitchener & Jorm, 2006) and the use of the Zero Suicide Workforce Survey (Suicide Prevention Resource Center, 2017) were essential collaborations.

Application of evidence into practice included a formalized and supported training that resulted in improved screening for suicide and responding appropriately. At the time of

this project, no other organization within the Denver Metro area focused on training outpatient and inpatient staff to be an active and essential part of the solution. As a result of the survey, training recommendations came directly from staff who are expected to care for suicidal patients. The respondents are now exposed to the evidence for suicide prevention and can anticipate a change in practice and policy.

Evaluation of suicide prevention training in practice resulted in the development of organizational training. That training was then evaluated for effectiveness and there was a significant difference in knowledge, comfort, and skill in staff who attended the training. The provider survey was an inquiry into current practice and desired training. Feedback from both surveys informed the workgroup about training effectiveness and recommendations for additional topics, resulting in improved patient outcomes. A patient once told this researcher that they were grateful for the question: “Are you safe at home?” since there was a time when she felt she was unable to protect herself from her self. Suicide prevention measures are useful in saving lives.

REFERENCES

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine, 29*(6), 870–877. https://doi.org/10.1007/s11606-014-2767-3

Bolster, C., Holliday, C., O'Neal, G., & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *Online Journal of Issues in Nursing, 20*(1), 81-87.

Brown, J. (2019). A broken mental health system. *The Denver Post*. Retrieved from https://extras.denverpost.com/mentalillness/index.html

Center for Mental Health Services and Office of the Surgeon General. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD: US Public Health Service.

Colorado Department of Public Health and Environment, Office of Suicide Prevention. (2019). *Suicide prevention in Colorado annual report FY 2018-2019.* Retrieved from https://drive.google.com/file/d/1HAmAYUGdcRQK2GM1BKV_wDM6AHCglsyX/

Colorado Health Institute. (2019). *Colorado health access survey: Behavioral health*. Retrieved from https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-behavioral-health

Fitzpatrick, J. J. (1983). Suicidology and suicide prevention: Historical perspectives from the nursing literature. *Journal of Psychosocial Nursing & Mental Health Services, 21*(5), 20-28.

Hedegaard, H., Curtin, S. C., & Warner, M. (2018). *Suicide rates in the United States continue to increase* (NCHS Data Brief, no. 309). Hyattsville, MD: National Center for Health Statistics.

Joint Commission. (2016, February 24). *Detecting and treating suicide ideation in all settings*. Retrieved from https://www.jointcommission.org/en/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-56-detecting-and-treating-suicide-ideation-in-all-settings/

Joint Commission. (2018). *National patient safety goal for suicide prevention*. Retrieved from https://www.jointcommission.org//media/tjc/documents/standards/r3reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf

Joint Commission. (2019). *Hospital national patient safety goals.* Retrieved from https://www.jointcommission.org/en/standards/national-patient-safety-goals/

Joint Commission. (2020). *Hospital national patient safety goals.* Retrieved from https://www.jointcommission.org/en/standards/national-patient-safety-goals/

Kalmoe, M. C., Chapman, M. B., Gold, J. A., & Giedinghagen, A. M. (2019). Physician suicide: A call to action. *Missouri Medicine, 116*(3), 211–216.

Kitchener, B. A., & Jorm, A. F. (2006). Mental health first aid training: Review of evaluation studies. *Australian and New Zealand Journal of Psychiatry, 40*, 6-8. doi:10.1080/j.1440-1614.2006.01735.x

Knox, K. L., Conwell, Y., & Caine, E. D. (2004). If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health, 94*(1), 37-45. doi:10.2105/AJPH.94.1.37

Kognito. (2020). *Products*. Retrieved from https://kognito.com/products?topics=Suicide%20Prevention

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909-916. doi:10.1176/appi.ajp.159.6.909

May, E. L. (2013). The power of zero: Steps toward high reliability healthcare. *Healthcare Executive, 28*(2), 16-18, 20, 22.

Mokkenstorm, J., Kerkhof, A., Smit, J., & Beekman, A. (2017). Is it rational to pursue zero suicides among patients in health care. *Suicide and Life-Threatening Behavior, 48*(6),745-754. doi:10.1111/sltb.12396

National Action Alliance for Suicide Prevention. (2014). *Suicide prevention and the clinical workforce: Guidelines for training*. Retrieved from https://www.sprc.org/resources-programs/suicide-prevention-and-clinical-workforce-guidelines-training

National Institute of Mental Health. (2019). *ASQ suicide risk screening toolkit*. Retrieved from www.nimh.nih.gov/news/science-news/ask-suicide-screening-questions-asq.shtml

National Jewish Health. (2017*). Institutional policy: Suicide assessment and intervention*. Denver, CO: Author.

Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *National strategy for suicide prevention: goals and objectives for action*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK109917/

Orr, G. (2003). Review. [Diffusion of innovations by Everett Rogers (1995)]. Retrieved from https://web.stanford.edu/class/symbsys205/Diffusion%20of%20 Innovations.htm

QPR Institute. (2019). *Online training*. Retrieved from https://qprinstitute.com/

RE-AIM. (2020). *What is RE-AIM?* Retrieved from http://www.re-aim.org/about/what-is-re-aim/

Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A., & Silverman, M. M. (2016). Suicide and suicidal attempts in the United States: Costs and policy implications. *Suicide Life Threat Behaviors, 46*(3), 352-362. doi:10.1111/sltb.12225

Stetler, C. B. (2001). Updating the Stetler model of research utilization to facilitate evidence-based practice. Nursing Outlook, 49(6), 272–279. doi:10.1067/mno.2001.120517

Suicide Prevention Resource Center. (2017). *Zero suicide*. Retrieved from http://zerosuicide.sprc.org

Waldrop, J., Caruso, D., Fuchs, M. A., & Hypes, K. (2014). EC as PIE: Five criteria for executing a successful DNP final project. *Journal of Professional Nursing, 30*(4), 300-306. Retrieved from http://www.professionalnursing.org/article/S8755-7223(14)00031-3/abstract

Williams, J. (2019, September). *Pediatric suicide screening*. Presentation at the Advanced Pediatric Nurse Practitioner meeting, Children's Hospital, Denver, CO.

Yale, L. P. (1934). Nurses and suicide prevention. *American Journal of Nursing*, *34*, 882-886.

APPENDIX A

STAFF THE GUIDELINES TARGETED

Mandatory	Recommended	Optional
Nursing	Front Desk	Research
Clinicians	Phones	Phlebotomy
Sleep	PPU	Radiology
Rehab	Security	
Staff required to report abuse by state law		

APPENDIX B

SUICIDE AWARENESS AND RESPONSE TRAINING

National Jewish Health®

Science Transforming Life®

Suicide Awareness and Response Training

Introductions:

- Name
- Role at National Jewish Health
- How long you've worked at National Jewish Health
- If you were to have a superpower, what would you want it to be?

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Ground Rules

- Be respectful and professional
- Wording
  - died by suicide vs. committed suicide
  - person with schizophrenia vs schizophrenic
  - avoid stigmatizing language (ex., “crazy”)
- Safe Environment
- Breaks

This might be hard.

If you are stepping out for a moment please give a wave to instructor to note you are emotionally ok.

Options for additional support

- Human resources can provide resources and support.
- Your supervisor
- Trusted co-worker

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Objectives

- Overview of suicide
- Talking and asking patients about suicide.
- ABC of suicide risk
- Written Test

Todays class will include

- Small group activities
- Large group activities
- Vital role playing and practice

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Why is this important?

Why are we here today?

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Fact/Fiction Exercise

Left Side of Room	Middle	Right Side of Room
Fiction	Somewhere in the Middle	Fact

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Suicide Facts

Suicide deaths have continued an upward trend since 2009[1].

Currently, Colorado is ranked ninth for highest suicide rate in the United States.

Nationally, among youth and young adults ages 10 to 24, suicide is the leading cause of death. [1]

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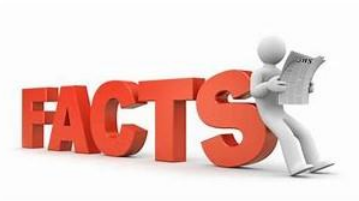
Suicide Facts

According to a Finnish study, over one fifth of people who actually died by suicide had discussed their aim with a doctor or other health care professional during their last session.

Suicide occurs across all classes of people.

A prior suicide attempt is a leading risk factor for later death by suicide.



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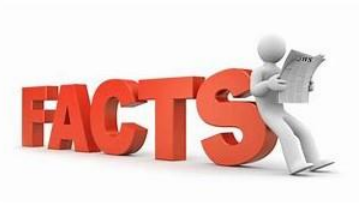
Suicide Facts

National data show individuals with a recent discharge from an emergency department are at risk for suicide, especially in the month following discharge.

Approximately 70 percent of individuals discharged from emergency departments after a suicide attempt do not attend a follow-up appointment with a mental health provider.



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Colorado's Suicide Facts

Deaths by Suicide in Colorado:

1,093 Total (2015) [1], 1,156 Total (2016) [1]

- 2016: 328 were people aged 19-34, 339 were people aged 44-59[1]
- 78% of firearm deaths are suicides. [1]
- Nearly half of all suicide deaths in Colorado involve the use of a firearm, making it the most common method of suicide death in the state. [1]

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Colorado's Suicide Facts

- 29.5% of high school students indicated feeling sad or hopeless almost every day for two weeks or more in a row during the previous 12 months. [2]
  - Nearly 17.5 percent reported considering suicide [2]
  - 7.8 percent reported making one or more suicide attempts in the previous twelve months. [2]

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Suicidal Thoughts/Ideation

- Thoughts about how to kill oneself.
- Range from a detailed plan to a fleeting consideration
- Does not include the final act of killing oneself.
- The majority of people who experience suicidal ideation do not carry it through. Some may, however, make suicide attempts.
- Some may be deliberately planned to fail or be discovered, while others might be carefully planned to succeed.

Examples of Passive Death Wishes:	**Examples of Suicidal Ideation:**
"Man, I wish I was just dead"	"I could take this whole bottle of pills to end it."
"Life is not worth living, nothing ever changes"	"I could shoot myself."
"I bet if I died today you would not come to my funeral"	"I could hang myself."
"I would be better off dead"	"If I end my life when no one is home, it will be easier for them."

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Suicide Crisis or Potential Suicide

A situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so.

It is considered by public safety authorities, medical practice, and emergency services to be a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

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Disability Weights Exercise

Arrange the diagnoses on the cards in order of smallest to largest "impact" on an individuals life the diagnosis may have.

Consider the impact on the amount of disruption a health problem causes to a person's ability to:

- Work
- Carry out daily activities
- Engage in satisfying relationships

Mental Health First Aid USA

National Jewish Health

Discussion

Do we view mental health diagnosises as real?

What diagnoses do we have community resources for?

What diagnoses is it acceptable to have?

What diagnoses do we reach out to help people with?

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Risk Factors

- **History of suicide attempt**
- Mental Health and/or Depression diagnosis
- Alcohol or drug abuse
- Family history of a mental health diagnosis
- Family history of alcohol or drug abuse
- History of suicide in family
- Domestic/Child Abuse, including physical or sexual abuse

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Risk Factors

- Having guns or other firearms in the home
- Being incarcerated (prison or jail)
- Exposed to another's suicidal behavior or death (including family member, peer, or media figure)
- Chronic or terminal medical diagnosis
- Being between the ages of 15 and 24 years or over age 60

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Signs and Symptoms

Physical

- Low energy
- Seems really tired
- Change in sleep (sleeping a lot more or a lot less)
- Change in appetite or eating (eating a lot more or a lot less; weight gain or loss)
- Constipation
- Headaches
- Stomach aches
- Irregular menstrual cycle
- Loss of sexual desire
- Body aches and pains

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Signs and Symptoms

Behavioral

- Crying a lot, easily, and/or uncontrollably
- Anger outbursts
- Spending more time alone
- Not following through with daily tasks
- Change in personal appearance, dress, and/or grooming
- Seeming less motivated or less interested in things
- Moving slower
- Alcohol and/or drug use (that is abusive and/or a change from one's regular use)

Psychological

- Sadness
- Anxiety
- Guilt
- Anger
- Mood Swings
- Lack of emotional responsiveness
- Feelings of helplessness
- Hopelessness
- Irritability
- Frequent self-criticism
- Self-blame
- Pessimism
- Impaired memory and concentration
- Indecisiveness and confusion
- Tendency to believe others see one in a negative light
- Thoughts of death and suicide

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Group Activity

Directions

- Get in groups of 2 to 3

- You will have 3 minutes to list as many signs and symptoms that someone may be going into a mental health crisis (e.g., suicide) as you can.

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Group Activity

Scoring

- *Only answers that are signs and symptoms that someone is going into a mental health crisis count*
- *Any overlapping answers will not count*
- *Any answers your team has that other teams do not have will count*
- *The team with the most answers wins!*

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Warning Signs of Suicide

- Threatening to hurt or kill oneself
- Seeking access to means
- Talking, writing, or posting on social media about death, dying, or suicide
- Feeling hopeless
- Feeling worthless or a lack of purpose
- Acting recklessly or engaging in risky activities

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Warning Sign of Suicide

- Feeling trapped
- Increasing alcohol or drug use
- Withdrawing from family, friends, or society
- Demonstrating rage and anger to seeking revenge
- Appearing agitated
- Having a dramatic change in mood

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Discussion

- How many have seen a patient with this in the last year? Last month? Last week?
- With warning signs- how many have had a patient with this but don't know because didn't want to ask in the last year? Last month? Last week?
- What makes it hard or uncomfortable to ask?
- What's the possible outcome of not asking?
- Do you think a person is more willing to discuss their feelings with a trusted provider/relationship or someone they meet for the first time who comes in to evaluate them for just this purpose?

Assess for safety concern.

Be sure patient is not left alone.

Call for evaluation.

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Assess for safety concern

When a patient is expressing suicidal ideations or has warning signs indicating they may be suicidal it is time to talk to them.

Everyone at National Jewish Health can/should initiate this conversation and do the initial assessment by asking.

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Asking about Suicide Discussion

When would you ask someone if they are thinking about suicide?

What are the risks of asking someone if they are suicidal?

What are the risks of not asking someone if they are suicidal?

What are your concerns to ask about suicide?

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Having the Conversation

A patient says to you,

"I really have been upset lately and crying, I really just don't see a point to going on anymore and plan on ending it"

Don't Say

- Pull yourself together.
- You'll get over it, you've just got to get your life back in order.
- It's such a beautiful day outside. How can you feel so sad?
- I'd like to stop and talk, but I've got to stay on schedule. I'll give you a call later.

Don't Do

- Agree to keep their comments a secret.
- Not react to the patient.

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Having the Conversation

A patient says to you,

"I really have been upset lately and crying, I really just don't see a point to going on anymore and plan on ending it"

Ways start the conversation:

- I am concerned you feel that way.
- It is hard for me to understand exactly what you are going through, but I can see that it's distressing for you.
- Can you tell me what you mean by "end it".

Then/Or ask the most important question.

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Licensed Staff (RN, MD, etc.)

Ask directly whether the person is suicidal:

- "Are you having thoughts of suicide?"
- "Are you thinking about killing yourself?"

If "yes" to either above, then…

Ask whether the person has a plan:

"Have you decided how you are going to kill yourself?"
"Have you decided when you would do it?"
"Have you collected the things you need to carry out your plan?"

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All other staff (MA, Admissions, PT/OT, etc.)

Ask directly whether the person is suicidal:

- "Are you having thoughts of suicide?"
- "Are you thinking about killing yourself?"

Inform patient you would like them to speak with someone further about how they are feeling.

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Adult patient over phone

After asking them if they are suicidal and getting a positive response:

- Stay on the phone with them.
  - Write down the number they are calling from.
  - Did they indicate where they are?
- Options to continue the conversation include:
  - "Will you please stay on the phone with me while I get someone to help you"
  - "Please let me help you by getting someone to speak with you"

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Adult patient over phone

- Alert a co-worker to call one of the following; if no answer move on to the next number.

  Elizabeth (Social Worker) 720-382-9976
  Kyle (Social Worker) 303-359-0389
  Nursing Supervisor 720-240-1477

❖ Discussion what plan do you have in your area for assistance?

- Live transfer to the extension provided by Social Worker or Nursing Supervisor.

You can opt to say I am transferring you to someone who can help or just transfer and let the Social Worker or Nurse begin speaking with the patient.

Pediatric parent/patient over phone

- Alert a co-worker to call
  Call Pediatric Care Unit at extension 1239

- Live transfer to the extension provided
  - You can opt to say I am transferring you to someone who can help or just transfer and let the Nurse begin speaking with the patient/parent.

❖ Discussion what plan do you have in your area for assistance?

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Inpatient Evaluation

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ○ Yes ○ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ○ Yes ○ No
3. In the past week, have you been having thoughts about killing yourself? ○ Yes ○ No
4. Have you ever tried to kill yourself? ○ Yes ○ No

If yes, how? _____

When? _____

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ○ Yes ○ No

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary. (*Note: Clinical judgment can always override a negative screen.*)
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

All inpatients (12 and older) are required to compete the ASQ Screening Tool.

- 5 question evaluation tool
- Documented in EMR
- Use same techniques as if having the conversation in person.

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Reminders when discussing Suicide

- Let the person know you are concerned and willing to help.
- Discuss your observations with the person.
- Ask the question(s) without dread.
- Do not express a negative judgement.
- Appear confident, as this can be reassuring.
- Asking directly about suicide will not cause suicide.

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Role Play Activity

Talking and Asking about Suicide

With a partner you will practice asking each other if they are suicidal.

- Use the script provided for assistance in discussion.
- Remember this might be hard so be respectful and considerate of each other.

*You may role play with the instructor after the course.

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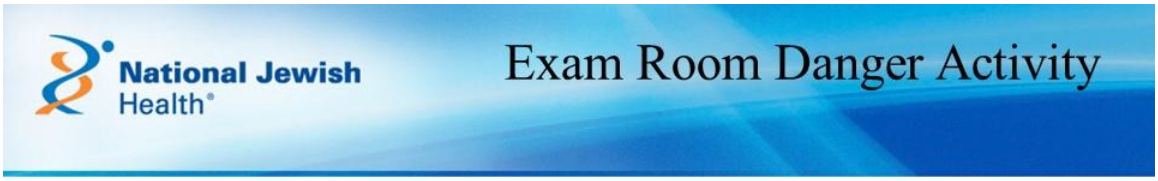
Be sure patient is not left alone

Patients who have expressed suicidal ideations can not be left alone until they have been evaluated further by:

- Medical Doctor
- Licensed Clinical Social Worker / Licensed Social Worker
- Licensed Psychologist.

Patients who are identified to be at-risk for suicide should be placed in an exam room or designated triage area, with a chaperone.



Why can't a patient be left in an exam room alone?

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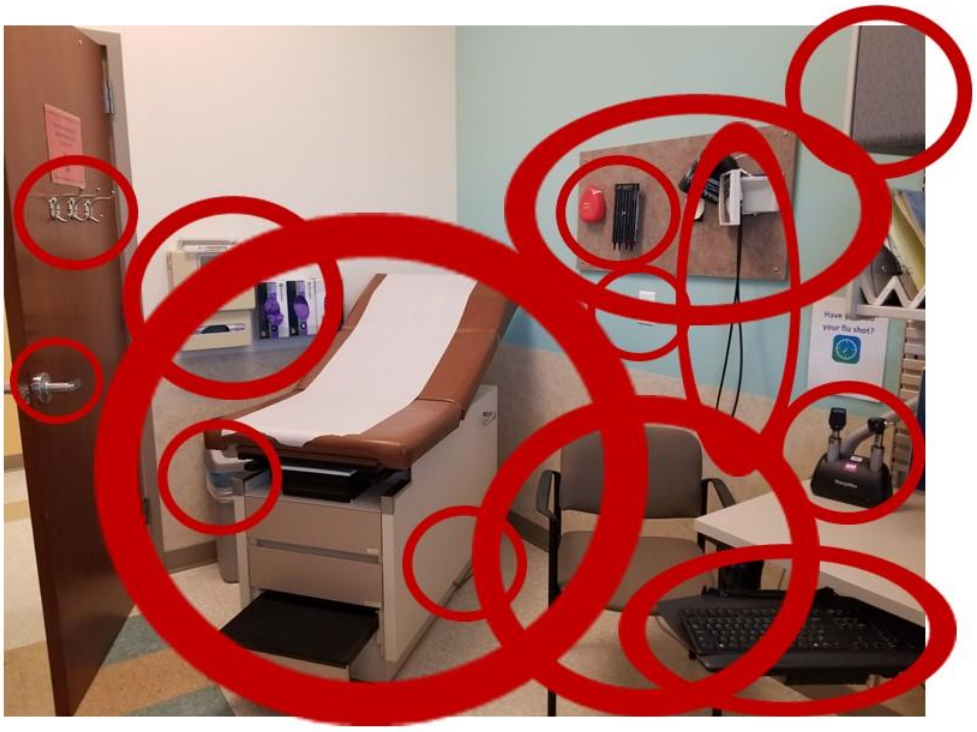

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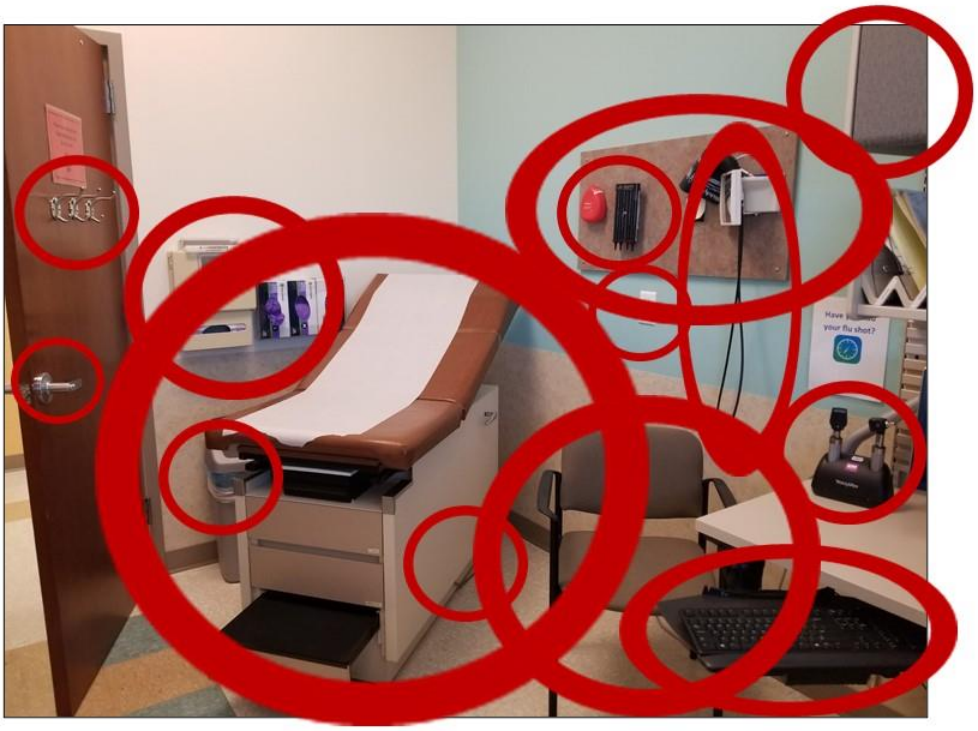

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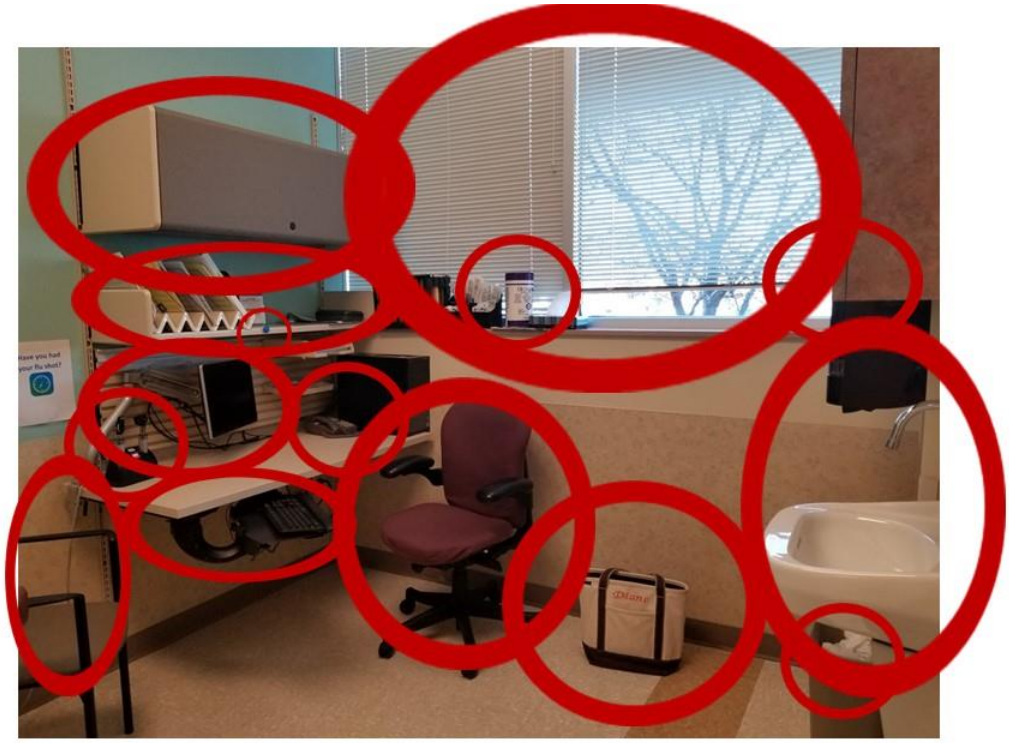

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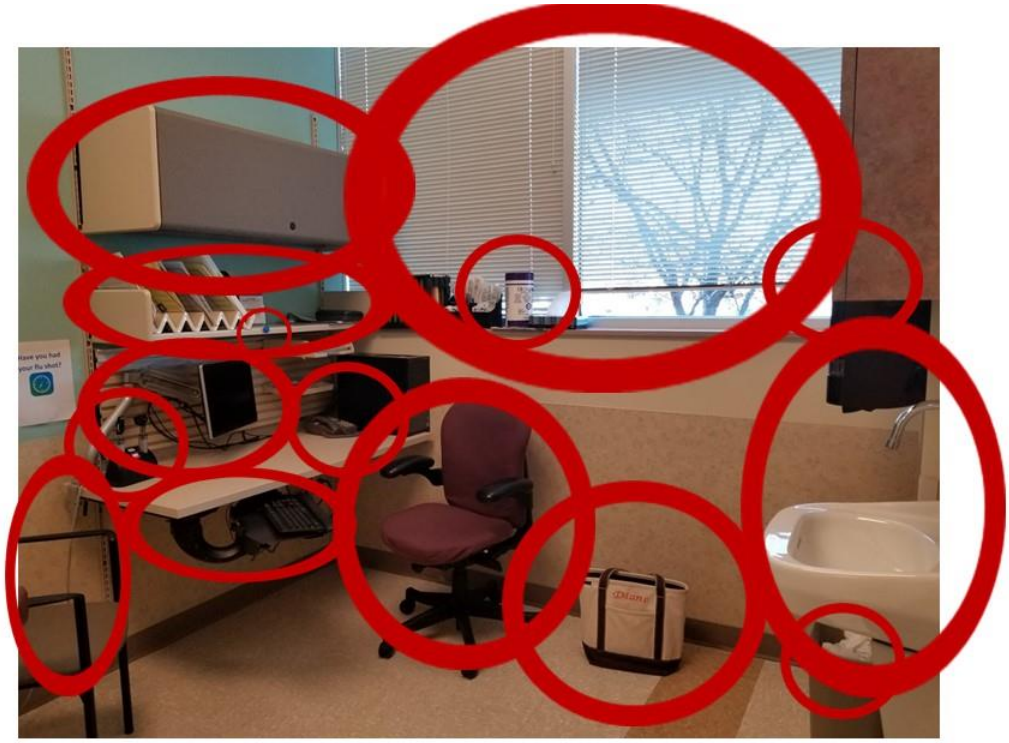

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Risks in a patient exam room

- Sheets and blankets
- Privacy Curtains
- Plastic Bags
- Cords and Tubing (call light cords, telephone cords, monitor cables, tubing)
- Objects with sharp edges (tables, cabinets, whiteboards)
- Chairs and other moveable furniture
- Unnecessary equipment (IV stands, rolling carts)

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Risks in a patient exam room

- Items that can be ingested (thumbtacks, magnets medications)
- Mirrors
- Ligature points at any heights (light fixture, above cabinets)
- Hand sanitizer dispensers
- TVs and Monitors with glass screens
- Exposed Electrical Outlets
- Patient's belongings

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What if they ask to go to the restroom?

Restroom privileges while the patient is under supervision, awaiting a formal assessment or transportation, must occur using a designated safe restroom.

Same-sex staff or a parent must escort the patient to a multi-stall restroom (available on every floor of the Smith building) or use the private restroom on the Pediatric Behavioral Health Unit (A207a).

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Call for Evaluation

- Tell the treating physician
  - May need to be done by a coworker
  - Don't leave the patient alone.
- Further evaluations can be done by calling:
  - Treating provider
  - Licensed Clinical Social Worker / Licensed Social Worker
  - Licensed Psychologist.
- If here for testing only, contact the MOD or Social Worker.

❖ Discussion what plan do you have in your area for assistance?

National Jewish Health

Call for Evaluation

When does security or police get involved?

•Call 911, immediately if the person has a weapon and/or is behaving aggressively

- One time you can leave a patient alone.
- Start removing other staff and patients from the area.

•Call hospital security if you have notified Denver Police

- Discussion what plan do you have in your area?
  - Can staff call PD and Security at the same time?

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Overview

Anyone, regardless of age, ethnicity, or class, can be at risk for suicide.

Warning signs of suicide can be

- Physical
- Behavioral
- Psychological

Your role at National Jewish Health is to use our ABC of Suicide

- A Assess for safety concern
- B Be sure patient is not left alone
- C Call for Evaluation

Asking a patient if they are suicidal will not make them suicidal.

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Overview

Any additional questions before we start the test portion?

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Test Time

Written Test

- Individual closed notes test
- Must pass with at least an 80%
- If you have any questions or concerns please ask the instructor

If you opted, not to participate during the role playing activity or would like to have extra practice, please stay after for one on one role playing.

National Jewish Health

Additional Questions

Alyssa Oland PhD
OlandA@njhealth.org
303-398-1516

Elizabeth Langhoff LCSW
langhoffe@njhealth.org
303-270-2743

Colorado Department of Public health and Environment. (November 1, 2017) Office of Suicide Prevention Annual Report – Suicide Prevention in Colorado, 2016-2017 Retrieved from: https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf

APPENDIX C

INSTITUTIONAL REVIEW BOARD APPROVALS

National Jewish Health®

Science Transforming Life®

DATE: May 19, 2020
TO: Alyssa Oland, PhD
FROM: National Jewish Health HRPP Office

SUBMISSION TYPE: Human Subject Research Determination
PROTOCOL TITLE: HS-3427-True to Size: Creating a Suicide Awareness and Prevention Program in a Nonprofit Academic Medical Center

IRB DETERMINATION: NOT HUMAN SUBJECTS RESEARCH
DETERMNATION DATE:

Thank you for your Human Subject Research Determination submission for the above-referenced study. Based on the information provided, it has been determined that the proposed activity does not constitute "human subjects research" as defined by the federal regulations. As such, IRB review is not required.

Please Note: Any alteration to the project that could potentially change this determination must be submitted for review prior to implementation.

Although IRB review is not required, be aware that other institutional requirements may apply to this activity.

If you have any questions or comments about this correspondence, please contact the NJH IRB Office at 303-398-1477.

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Date:	May 27, 2020
Principal Investigator:	Darci Martinez, BSN, RN, DNPc, FNPc
Research Advisor:	Kathleen Dunemn, PhD, ARPN, CNM-BC
Committee Action:	**NOT RESEARCH**
Action Date:	May 27, 2020
Protocol Number:	(Not Applicable, submitted via email)
Protocol Title:	True to Size: Creating a Suicide Awareness and Prevention Program in a Nonprofit Academic Medical Center

The University of Northern Colorado IRB has reviewed your protocol and determined that your submission does not meet the federal definition of research according to CFR 45 Part 46.

§46.102

(l) *Research* means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research:

(1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

Project activities as set forth in this submission do not require IRB oversight and approval. However, if your procedures change and/or you decide to generalize your findings, please contact the Office of Research & Sponsored Programs to further discuss if IRB approval would be needed.

Carter Hall 3002 | Campus Box 143 | Greeley, CO 80639 | Office 970-351-1910 | Fax 970-351-1934

If you have any questions, please contact the Research Compliance Manager, Nicole Morse, at 970-351-1910 or via e-mail at nicole.morse@unco.edu.

Sincerely,

Nicole Morse

Nicole Morse
Research Compliance Manager

University of Northern Colorado: FWA00000784

APPENDIX D

SURVEY PARTICIPATION REQUEST

Reply Reply All Forward

Survey Participation Request

Martinez, Darci

To: **ALLNJH**

Monday, May 25, 2020 11:47 AM

Dear Colleagues,

The Suicide Prevention Workgroup at National Jewish Health is kindly requesting your participation in a doctoral research study, *True to Size: Creating an Interdisciplinary Suicide Awareness and Prevention Evidence-based Project in a Nonprofit Academic Medical Center.*

This survey is part of NJH's approach to caring for patients who are at risk for suicide. Recognizing that variability exists in staff education and experience in treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

It is anticipated that it will take you 10-15 minutes to complete this survey.

All responses will be kept confidential. Participation is voluntary; you may stop or withdraw at any time. If you have any specific questions regarding the survey or the project, please email Darci Martinez at *mart4588@bears.unco.edu*.

Select one of the links below:

- non-provider staff https://redcap.njhealth.org/redcap/surveys/?s=7JTJDWYE4C
- providers (licensed independent practitioners) https://redcap.njhealth.org/redcap/surveys/?s=FHR33DPFCP

Thank you in advance for your participation.

Darci Martinez, DNP & FNP-candidate, BSN, RN
Alyssa Oland, PhD
Elizabeth Langhoff, LCSW

APPENDIX E

RE-AIM FRAMEWORK ON SUICIDE PREVENTION MODELS

RE-AIM framework on suicide prevention models

Definition	Activities	Measures
Mental Health First Aid		
Reach • Increases screening – at a baseline anyone can be asked if suicidal • Increases early intervention • Includes many demographics • Interdisiplinary	• Provides evidence-based screening tools appropriate to the healthcare setting • Provides training to all patient-facing staff on how to have these conversations • Improve care processes (instructions, procedures, communication)	• Number of mental health evaluations as a result of a positive screen • Number of patient safety events • Mortality
Effectiveness • Positive – can reach more at-risk persons, in addition to other mental health issues • Negative – may have no effect on rates, labels patient	• Model includes leadership commitment for organizational change • Create a culture to value and protect patients • Fully address suicidal ideation – follow all steps	• Harm-related hospital costs • Cost of training • Impact of delivery practices
Adoption • Interdisciplinary target • Acceptable for most healthcare settings • Most staff may willingly participate	• Use data to understand risk factors • Implement a low-complexity screening tool • observation	• Collect categorical data with positive screens in the EMR
Implementation • Meets the Joint Commission and therefore CMS requirements • Interventions are practical	• Staff will learn how to improve patient safety • Design ligature-free environments for individuals in crisis	• Staff trained • Number of staff that implement intervention • Part of orientation
Maintenance • Staff can carry over content into community • If no or infrequent screening, confidence and skill can decrease	• Create buy - in • Share stories and survey results • Survey every year in the beginning	• Re-certification every three years • Instructor certification maintenance • Tracking in MHFA • Tracking in Net Learning • Tracking in EMR
Zero Suicide		
Reach • Interdisciplinary target • Basic enough to cover a large number of staff •	• Provides a comprehensive toolkit to get started • Provides training to all patient-facing staff on how to have these conversations • Improve care processes (instructions, procedures, communication)	• Number of mental health evaluations as a result of a positive screen • Number of patient safety events • Mortality
Effectiveness • Positive – can reach more at-risk persons • Negative – may have no effect on rates	• Policy and resource changes • Implies failure if there is a suicide	• Evidence is difficult to collect – no trials • Has validated clinical workforce survey
Adoption • Serves diverse populations • Appropriate for all healthcare settings • Uses the familiar safety message	• Use data to understand risk factors • Implement a low-complexity screening tool in the EMR	• Track screening, assessment, and follow-up
Implementation • Meets the Joint Commission and therefore CMS requirements • Offers real solutions	• Staff will learn how to improve patient safety • Design and respondents can think about ligature-free environments for individuals in crisis	• Training modules include one-day workshop every quarter of the year • Needs support through man-power and financial support • All current staff trained and part of orientation for incoming staff
Maintenance • Will need to have longevity	• Organizational level supervision	• Renewal is recommended every three years
Question Persuade and Refer (QPR)		
Reach • Interdisciplinary target	• Need computer time for all clinical staff, non – patient time	• Can use platform to measure attendees

• comprehensive	• Individual commitment	
Effectiveness • Staff have increased knowledge, skills, comfort	• Improve policies and practice	• Develop post survey • Monitor safety events
Adoption • Training extends clinical setting • Cost associated with training and maintenance • Will be difficult to train face-to-face at frequency needed	• Online is more adaptable to busy schedules	• Online learning has potential to have less adoption than face-to face • Can run report in EMR • Measure time away from clinical care
Implementation • Face to face component has fees • Needs to be implemented to all patient facing staff	• Would need timeframe for completion upon hire • An annual refresher	• All current staff trained and part of orientation for incoming staff
Maintenance • Monitor through net-learning process	• Review content annually and partner with QPR for updates	• Measure documentation of Follow – up calls to patients
Kognito		
Reach • Avatar based – so can be off putting or take anxiety off real person role playing	• Mandatory • Need support for non-clinical time for training • Individual commitment	• Participation feedback • Length of time to complete training
Effectiveness • The practice scenarios were well written • Some respondent can adopt the language	• Changes to policies an procedures • Improve quality of patient encounters of suicidal ideation	• Survey respondent feedback
Adoption • Depends on learning style	• Work with Net-learning team for initial content and updates	• Feedback from social workers and nursing regarding patient encounters • Measure time away from clinical care
Implementation • Individual based • Requires less work for workgroup, HR, and instructors	• Work with Kognito platform for implementation plans	• Utilize Net Learning process for tracking participation
Maintenance •	• Work with Kognito platform	• Follow – up calls to patients

APPENDIX F

ZERO SUICIDE WORKFORCE SURVEY AND PERMISSION TO USE

Reply Reply All Forward

[POSSIBLE SPAM] RE: Webform submission from: Contact Us

Chu, Adam [AChu@edc.org]

To: Martinez, Darci

Friday, January 17, 2020 7:34 AM

Flag for follow up. Completed on Monday, February 24, 2020.

Good morning Darci,

You are welcome to utilize the Workforce Survey in your work and make adaptations as you need—we just ask that you both cite the original source material and make it easy for users and readers to find the original version of the survey (such as by linking to the Zero Suicide website). With respect to making changes—will you be reprograming it in a separate online format or are you administering via paper? I can send a Word version to make editing easier if that's the case.

If there are findings you'd like to share we are always interested in learning how folks are using the survey in whole, part, or as adapted to meet their needs. While we have lots of data on repossess to the standard edition, we don't often hear back from groups that tailor or change it.

Thanks for the offer and please let me know if you have any further questions.

Sincerely,
Adam

Please let us know why you are contacting us:
Other

Other Reason for Contact
Permission to use Zero Suicide Workforce Survey within institutional software (REDCap). We would like to collect additional demographic data. We can share raw data.

First Name
Darci

Last Name
Martinez

Title
Infectious Disease and Infusion Services Nurse Manager

System/Organization/Company Name
National Jewish Health

Email
martinezdarci@njhealth.org

Confirm Email
martinezdarci@njhealth.org

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE
www.zerosuicide.com

ZERO SUICIDE WORKFORCE SURVEY

The Zero Suicide Workforce Survey is a tool to assess staff knowledge, practices, and confidence.

This survey is part of our organizational mission to adopt a system-wide approach to caring for patients who are at risk for suicide. Recognizing that variability exists in staff education and experience treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

All responses are anonymous. Please answer honestly so that we can best serve both our staff and patients. Be thoughtful about your answers even if you do not work directly with suicidal patients. We believe that suicide prevention is a shared responsibility among everyone in our organization. Unless otherwise indicated, please mark only one answer. **It is anticipated that it will take you 10-15 minutes to complete this survey.** By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

We thank you in advance for your participation and for your dedication to this important issue!

SPRC | National Action Alliance for Suicide Prevention

Section 1. Your Work Environment

Thank you for participating in this survey. In the first series of questions we would like to learn more about your work environment and your role within that environment.

1. In which of the following settings do you work? [Required Item – used later for branching]
   ☐ Inpatient setting ☐ Outpatient setting ☐ Both

2. Please indicate your Department/Unit from the following list. [Customized to each organization]
   ☐ Custom Answer 1 ☐ Custom Answer 2 ☐ Custom Answer 3...

2a. Is this your first time taking part in the Zero Suicide Workforce Survey at your current organization? (choose one)
   ☐ No ☐ Yes

3. Please choose the one category below that ***best*** describes your primary professional role. (choose one)
   ☐ **Management** (Administrators, Supervisors, Managers, Coordinators)
   ☐ **Business, Administrative, and Clerical** (Accounting, Reception, Human Resources, Billing, Records, Information Technology)
   ☐ **Facility Operations** (Dietary, Housekeeping, Maintenance, Security, Transportation)
   ☐ **Behavioral Health Clinician** (Counselor, Social Worker, Substance Abuse Counselor, Therapist, Psychologist)
   ☐ **Adjunct Therapist** (Activity, Occupational, Physical, Rehabilitation)
   ☐ **Case Management**
   ☐ **Crisis Services**
   ☐ **Physical Health Care/Medication Management** (Physician, Nurse Practitioner, Physician's Assistant)
   ☐ **Nursing** (Nurse, Registered Nurse)
   ☐ **Psychiatry** (Psychiatrist, Psychiatric Nurse Practitioner)
   ☐ **Technician** (Mental Health Technician, Behavioral Technician, Patient Care Assistance, Residential Technician)
   ☐ **Patient Observer**
   ☐ **Support and Outreach** (Outreach, Faith, Family Support, Peer Support)
   ☐ **Education** (Teacher, Health Educator)

4. As part of this role, do you *directly interact with patients* either in person or from a distance during your day-to-day duties within the organization? This includes things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services. [Required Item]
   ☐ No ☐ Yes

Please indicate how much you disagree or agree with each of the following statements. [Only for Inpatient]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
5. I know the organizational protocols for ensuring a safe physical environment for patients at risk for suicide (including safety precautions around entry, visitors, patient belongings, and physical structures in the facility).	☐	☐	☐	☐	☐
6. I know what to do when I have concerns about potential means for suicide in the physical environment in our facility.	☐	☐	☐	☐	☐

Section 2. Suicide Prevention within Your Work Environment

The next series of questions ask you to reflect on suicide prevention within your work environment.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. I am familiar with the "Zero Suicide" initiative.	☐	☐	☐	☐	☐
8. I understand my role and responsibilities related to suicide prevention within this organization.	☐	☐	☐	☐	☐
9. I believe suicide prevention is an important part of my professional role.	☐	☐	☐	☐	☐
10. The leadership at this organization has explicitly indicated that suicide prevention is a priority.	☐	☐	☐	☐	☐
11. This organization has clear policies and procedures in place that define each employee's role in preventing suicide.	☐	☐	☐	☐	☐
12. I have received training at this organization related to suicide prevention.	☐	☐	☐	☐	☐
13. This organization provides me access to ongoing support and resources to further my understanding of suicide prevention.	☐	☐	☐	☐	☐
14. I feel that my organization would be responsive to issues that I bring up related to patient safety.	☐	☐	☐	☐	☐

15. While working at this organization, I have directly or indirectly interacted with a patient who ended his/her life by suicide. [Required Item]

☐ Yes, it has happened once ☐ Yes, it has happened more than once ☐ No ☐ I Don't Know

Please indicate how much you disagree or agree with each of the following statements. [Only if Yes to #15]

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
16. I felt supported by this organization when a suicide occurred.	☐	☐	☐	☐	☐
17. I felt blamed when a patient died by suicide.	☐	☐	☐	☐	☐
18. This organization has practices in place to support staff when a suicide occurs.	☐	☐	☐	☐	☐

Section 3. Recognizing When Patients May Be at Risk for Suicide

We are interested in learning about your knowledge and comfort related to recognizing when a patient may be at elevated risk for suicide.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
19. I have the knowledge and training needed to *recognize* when a patient may be at elevated risk for suicide.	☐	☐	☐	☐	☐
20. I am knowledgeable about warning signs for suicide.	☐	☐	☐	☐	☐
21. I know what organizational procedures to follow when I suspect that a patient may be at elevated risk for suicide.	☐	☐	☐	☐	☐
22. I am confident in my ability to respond when I suspect a patient may be at elevated risk for suicide.	☐	☐	☐	☐	☐
23. I am comfortable asking patients direct and open questions about suicidal thoughts and behaviors.	☐	☐	☐	☐	☐

24. Have you ever received training on how to *recognize* the warning signs that a patient may be at elevated risk for suicide?..... ☐ No [sent to #26] ☐ Yes [sent to #25] [Required Item]

25. Has your current organization provided you with training on how to *recognize* the warning signs that a patient may be at elevated risk for suicide?..... ☐ No ☐ Yes

Section 4. Screening and Assessing Patients for Suicide Risk [Only Those Who Interact with Patients Q4. All Other Respondents Are Sent to #66]

These next questions are about screening patients who may be at elevated risk for suicide.

26. You indicated earlier that you directly interact with patients either in person or from a distance during your day-to-day duties within the organization. Which of the following groups do you *primarily* work with?
☐ Children ☐ Adolescents ☐ Adults ☐ Elderly

27. Are you responsible for conducting *screenings* for suicide risk? .... ☐ No [sent to #32] ☐ Yes [sent to #28] [Req]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
28. I have the knowledge and skills needed to screen patients for suicide risk.	☐	☐	☐	☐	☐
29. I know our organizational procedures for screening patients for suicide risk.	☐	☐	☐	☐	☐
30. I am confident in my ability to screen patients for suicide risk.	☐	☐	☐	☐	☐
31. I am comfortable screening patients for suicide risk.	☐	☐	☐	☐	☐

Patients who screen positive for suicide risk should be assessed to inform clinical decision making. This is sometimes referred to as a suicide risk assessment.

32. Are you responsible for conducting *suicide risk assessments* for patients who screen positive for suicide risk?
☐ No [sent to #42] ☐ Yes [sent to #33] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
33. I have the knowledge and skills needed to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
34. I am knowledgeable about risk factors for suicide.	☐	☐	☐	☐	☐
35. I obtain information about risk and protective factors when conducting suicide risk assessments.	☐	☐	☐	☐	☐
36. I assess the patient's access to lethal means as part of a suicide risk assessment.	☐	☐	☐	☐	☐
37. I assess the patient's suicide plans and intentions as part of a suicide risk assessment.	☐	☐	☐	☐	☐
38. I know what organizational procedures exist regarding suicide risk assessments.	☐	☐	☐	☐	☐
39. I am confident in my ability to conduct a suicide risk assessment.	☐	☐	☐	☐	☐
40. I am comfortable conducting a suicide risk assessment.	☐	☐	☐	☐	☐
41. I know the clinical workflow to follow when a suicide risk assessment indicates the patient needs additional clinical care.	☐	☐	☐	☐	☐

Section 5. Training on Screening and Risk Assessment

These next questions are about any training you may have received on screening and suicide risk assessment – even if this is not part of your current professional duties.

42. Have you ever received training on conducting suicide screenings or conducting suicide risk assessments?..... ☐ No [sent to #45] ☐ Yes [sent to #43] [Required Item]

43. Has your current organization provided you with training on conducting suicide screenings or conducting suicide risk assessments?..... ☐ No ☐ Yes

44. Which of the following trainings, if any, have you taken on *screening* or *suicide risk assessment*? (select all that apply)
    - ☐ AMSR (Assessing and Managing Suicide Risk)
    - ☐ CASE Approach (Chronological Assessment of Suicide Events)
    - ☐ Commitment to Living
    - ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
    - ☐ QPRT Suicide Risk Assessment and Management Training (not basic QPR training)
    - ☐ RRSR (Recognizing and Responding to Suicide Risk)
    - ☐ suicide to Hope
    - ☐ An inservice or webinar training at my organization
    - ☐ An inservice or webinar training at a former organization
    - ☐ A different training on *screening* or *suicide risk assessment* (please specify): _____

45. Do you use a standard tool, assessment instrument, or rubric for suicide screening or risk assessment?
    ☐ No [sent to #47] ☐ Yes [sent to #46] [Required Item]

46. Which of the following tools, screening and assessment instruments, or rubrics, if any, do you use? (select all that apply)
    - ☐ Asking Suicide-Screening Questions (ASQ)
    - ☐ Beck's Suicide Intent Scale (SIS)
    - ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
    - ☐ National Suicide Lifeline Risk Assessment Standards
    - ☐ PHQ-3
    - ☐ PHQ-9
    - ☐ Risk Assessment Matrix (RAM)
    - ☐ Risk of Suicide Questionnaire (RSQ)
    - ☐ Risk Formulation with Risk Status and Risk State
    - ☐ SAFE-T
    - ☐ suicide to Hope
    - ☐ Suicide Ideation Questionnaire (SIQ or SIQ-JR)
    - ☐ A tool, instrument, or rubric developed by my organization
    - ☐ A different tool, instrument, or rubric (please specify): _____

Section 6. Providing Care to Patients at Risk

These questions are for staff responsible for providing care to patients determined to be at elevated risk for suicide.

47. Do you provide direct care to patients who have been identified as being at elevated risk for suicide based on their risk assessment?
☐ No [sent to #52] ☐ Yes [sent to #48] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
48. I have the knowledge and skills needed to provide care to patients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
49. I am familiar with the clinical workflows at this organization related to things such as safety planning, access to lethal means, documentation, and other procedures for caring for patients at elevated risk of suicide.	☐	☐	☐	☐	☐
50. I am confident in my ability to provide care to patients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐
51. I am comfortable providing care to patients who have been identified as being at elevated risk for suicide.	☐	☐	☐	☐	☐

52. Have you taken the *Safety Planning Intervention for Suicide Prevention* course on the Zero Suicide website?
☐ No ☐ Yes

53. Have you taken the *Counseling on Access to Lethal Means* (CALM) course either online or in person?
☐ No ☐ Yes

Section 7. Use of Evidence-Based Treatments That Directly Target Suicidality

These questions are for individuals who deliver *clinical treatment* (e.g. CAMS, CBT-SP, DBT) to patients identified as being at elevated risk for suicide.

54. Do you deliver clinical treatment (e.g. CAMS, CBT-SP, DBT) to patients who have been identified as being at elevated risk for suicide?
    ☐ No [sent to #59] ☐ Yes [sent to #55] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
55. I have received training on suicide-specific evidence-based treatment approaches (e.g. CAMS, CBT-SP, DBT).	☐	☐	☐	☐	☐
56. I am confident in my ability to provide treatment to patients with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐
57. I am comfortable providing treatment to patients with suicidal thoughts or behaviors.	☐	☐	☐	☐	☐

58. In which of the following suicide-specific evidence-based treatment approaches, if any, have you received training? (select all that apply)
    ☐ CAMS (Collaborative Assessment and Management of Suicide)
    ☐ CBT-SP (Cognitive Behavior Therapy for Suicide Prevention)
    ☐ DBT (Dialectical Behavior Therapy)
    ☐ Another training (please specify): _____

Section 8. Care Transitions

These questions are for individuals responsible for ensuring that patients identified as being at elevated risk for suicide are supported during transitions in care.

For the following questions, ***transitions in care*** include safely discharging and/or transitioning patients following acute care admissions or changes in care.

59. Are you responsible for ensuring safe care transitions for patients who have been identified as being at elevated risk for suicide?..... ☐ No [sent to #66] ☐ Yes [sent to #60] [Required Item]

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
60. I have the knowledge and skills needed to work with patients during their transitions in care.	☐	☐	☐	☐	☐
61. I am familiar with organizational procedures for working with patients during their transitions in care.	☐	☐	☐	☐	☐
62. I am confident in my ability to work with patients during their transitions in care.	☐	☐	☐	☐	☐
63. I am confident in my ability to work with family members or other support persons who may be involved during a patient's transitions in care.	☐	☐	☐	☐	☐
64. I am familiar with organizational procedures for ensuring that patient health information is shared during a patient's transitions in care.	☐	☐	☐	☐	☐
65. I am comfortable working with patients during their transitions in care.	☐	☐	☐	☐	☐

Section 9. Training and Resource Needs

Staff members should have the necessary skills, appropriate to their role, to provide care and feel confident in their ability to provide caring and effective assistance to patients with suicide risk.

66. In which of the following areas, if any, would you like more training, resources, or support? (select all that apply)

- ☐ Suicide prevention and awareness
- ☐ Epidemiology and the latest research findings related to suicide
- ☐ Identifying warning signs for suicide
- ☐ Communicating with patients about suicide
- ☐ Suicide screening practices
- ☐ Identifying risk factors for suicide
- ☐ Suicide risk assessment practices
- ☐ Determining appropriate levels of care for patients at risk for suicide
- ☐ Crisis response procedures and de-escalation techniques
- ☐ Managing suicidal patients
- ☐ Collaborative safety planning for suicide
- ☐ Suicide-specific treatment approaches
- ☐ Aftercare and follow-up
- ☐ Family, caregiver, and community supports
- ☐ Procedures for communicating *about* potentially suicidal patients
- ☐ Understanding and navigating ethical and legal considerations
- ☐ Policies and procedures within your work environment
- ☐ Staff roles and responsibilities within your work environment
- ☐ Reducing access to lethal means outside the care environment
- ☐ Creating a safe physical environment for patients at risk for suicide

APPENDIX G

SUICIDE AWARENESS AND PREVENTION TRAINING SURVEY: PROVIDER

Confidential

Survey

This survey is part of NJH's approach to caring for patients who are at risk for suicide. Recognizing that variability exists in staff education and experience in treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of clinicians.

Your participation will involve responding to two different questionnaires, the first one is to understand any training needs, responses from the first questionnaire will be summarized to form the basis of the second survey

It is anticipated that it will take you 10-15 minutes to complete this survey.

All responses will be kept confidential. Participation is voluntary; you may stop or withdraw at any time. If you have any specific questions regarding the survey or the project, please email Darci Martinez at mart4588@bears.unco.edu.

Thank you in advance for your participation.

Participant ID _____

Name _____
(First Last)

e-mail _____

Your Work Environment

In which of the following settings do you work?

☐ Inpatient ☐ Outpatient ☐ Both

Please indicate your Department/Unit from the following list.

- ◯ Administration
- ◯ Adult Care Unit
- ◯ Adult Clinic
- ◯ Asthma Allergy
- ◯ Behavioral Health
- ◯ Call Center
- ◯ Cardiology Clinic
- ◯ Cardiology Procedure
- ◯ Chemo/Onc Infusion
- ◯ ENT
- ◯ Environmental Services
- ◯ GI
- ◯ Health Initiatives
- ◯ Highlands Ranch
- ◯ Human Resources
- ◯ Infectious Disease
- ◯ Infusion Room
- ◯ Laboratory
- ◯ MIDC
- ◯ Morgridge
- ◯ Northern Oncology
- ◯ Nursing Pool
- ◯ Nursing Supervisors
- ◯ Nutrition/Food Services
- ◯ Occupational Medicine
- ◯ Oncology
- ◯ Palliative
- ◯ Pediatrics
- ◯ Pharmacy
- ◯ Pulmonary
- ◯ Pulmonary Physiology
- ◯ Radiology
- ◯ Rehabilitation
- ◯ Rheumatology
- ◯ Scheduling
- ◯ Social Work
- ◯ South Denver
- ◯ Western Oncology
- ◯ Other

Other Department/Unit, please fill in

_____

Please choose the one category below that best describes your primary professional role. (choose one)

- ◯ PhD
- ◯ MD
- ◯ FNP
- ◯ PA
- ◯ LCSW
- ◯ RN
- ◯ Other

Other role, please fill in

_____

Are you also in a Director, Department Chair, Division Head role?

◯ Yes ◯ No ◯ Not Sure

Current State

Do you provide direct care to patients?

◯ Yes ◯ No ◯ Not sure

In your day-to-day practice, if Social Work or Behavioral Health was unavailable to assist, would you feel comfortable performing the following actions related to suicide prevention?

	Yes	No	Not Sure
Screening	◯	◯	◯
Assessment	◯	◯	◯
Intervention	◯	◯	◯
Follow-up	◯	◯	◯

Please share any additional comments or concerns related to the scenario described above:

How would you rate your knowledge and skills to prevent suicide (select one):

◯ Poor
◯ Fair
◯ Good
◯ Excellent
◯ Uncertain

In which of the following areas do you feel confident in your ability to care for patients with suicide risk? (select all that apply)

- ☐ Suicide awareness and prevention
- ☐ Epidemiology and the latest research findings related to suicide
- ☐ Identifying warning signs for suicide
- ☐ Communicating with patients about suicide
- ☐ ASQ screening Tool
- ☐ Identifying risk factors for suicide
- ☐ Columbia Suicide Severity Rating Scale (CSSRS)
- ☐ Determining appropriate levels of care for patients at risk for suicide
- ☐ Crisis response procedures and de-escalation techniques
- ☐ Managing suicidal patients
- ☐ Collaborative safety planning for suicide
- ☐ Suicide-specific treatment approaches
- ☐ M-1 Hold
- ☐ Aftercare and follow-up
- ☐ Family, caregiver, and community support
- ☐ Procedures for communicating about potentially suicidal patients
- ☐ Understanding and navigating ethical and legal considerations
- ☐ Staff roles and responsibilities within your work environment
- ☐ Reducing access to lethal means outside the care environment
- ☐ Creating a safe physical environment for patients at risk for suicide
- ☐ Legal Implications
- ☐ Other (please specify):

Other (please specify):

Are you familiar with the NJH policy and procedure for suicide assessment and intervention?

☐ Yes ☐ No ☐ Not Sure

Given your role, briefly list your responsibilities as related to the Suicide Assessment and Intervention Policy:

Do you have any comments or feedback regarding this P&P:

Have you had previous training on the topic of suicide prevention, intervention or assessment (course, seminar, CME, etc.)?

◯ Yes ◯ No ◯ Not Sure

How many hours of previous training have you had on the topic of suicide prevention, intervention or assessment (course, seminar, CME, etc.)?

What was the name of the training you received:

In my clinical role, I beleive I have some duty to assist suicidal patients and, therefore, some exposure to legal action if I fail to take reasonable and prudent steps to reduce the risk of a suicide.

◯ True ◯ False ◯ Unsure

Future State

I would be willing to participate in and learn more about suicide and its prevention.

◯ Yes ◯ No ◯ Unsure

In which of the following areas, would you like more training, resources, or support? (select all that apply)

☐ Suicide prevention and awareness
☐ Epidemiology and the latest research findings related to suicide
☐ Identifying warning signs for suicide
☐ Communicating with patients about suicide
☐ ASQ screening tool
☐ Identifying risk factors for suicide
☐ Columbia Suicide Severity Rating Scale (CSSRS)
☐ Determining appropriate levels of care for patients at risk for suicide
☐ Crisis response procedures and de-escalation techniques
☐ Managing suicidal patients
☐ Collaborative safety planning for suicide
☐ Suicide-specific treatment approaches
☐ M-1 Hold
☐ Aftercare and follow-up
☐ Family, caregiver, and community support
☐ Procedures for communicating about potentially suicidal patients
☐ Understanding and navigating ethical and legal considerations
☐ NJH policies and procedures
☐ Staff roles and responsibilities within your work environment
☐ Reducing access to lethal means outside the care environment
☐ Creating a safe physical environment for patients at risk for suicide
☐ Legal Implications
☐ Other (please specify):

Given my current professional role, duties, and commitments to continuing education and skill enhancement, I could commit the following time to suicide prevention training:

_____
(Hours)

My preferred educational platform for suicide prevention training would be (select all that apply):

☐ A face-to-face professional seminar or presentation
☐ Multi-media online tutorial
☐ Multi-media online tutorial and face-to-face review/Q&A
☐ Other

Please specify:

Please rank the following topics in suicide assessment and prevention training from 1= most important to 5 = least important (one selection allowed per column).

	Most Important1	2	3	4	Least Important5
NJH Policy and Procedure	○	○	○	○	○
Screening Tools	○	○	○	○	○
Legal Implictions	○	○	○	○	○
M-1 Hold	○	○	○	○	○
Suicide Severity Rating	○	○	○	○	○

Do you have any concerns or worries about suicide assessment and prevention training?

Do you have any concerns or worries about providing care to patients who are suicidal?

Please elaborate on any item above and/or additional comments regarding this survey.

If we may quote any of your comments, please sign here.

APPENDIX H

SUICIDE AWARENESS AND PREVENTION TRAINING SURVEY: STAFF

This survey is part of NJH's approach to caring for patients who are at risk for suicide. Recognizing that variability exists in staff education and experience in treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

It is anticipated that it will take you 10-15 minutes to complete this survey.

All responses will be kept confidential. Participation is voluntary; you may stop or withdraw at any time. If you have any specific questions regarding the survey or the project, please email Darci Martinez at *mart4588@bears.unco.edu*.

Thank you in advance for your participation.

Suicide Awareness and Prevention Training

Online Designer

Create snapshot of instruments VIDEO: How to use this page

Last snapshot: 02/04/2020 9:09am

This page allows you to build and customize your data collection instruments one field at a time. You may add new fields or edit existing ones. New fields may be added by clicking the Add Field buttons. You can begin editing an existing field by clicking on the **Edit** icon. If you decide that you do not want to keep a field, you can simply delete it by clicking on the **Delete** icon. To reorder the fields, simply **drag and drop** a field to a different position within the form below. NOTE: While in development status, all field changes will take effect immediately in real time. Are you using Action Tags yet? If not, learn about Action Tags here.

Return to list of instruments Survey settings

Current instrument: **Survey** Return to edit view

NOTE: Please be aware that branching logic and calculated fields will not function on this page. They only work on the survey pages and data entry forms.

Participant ID

Demographics

Please indicate your Department/Unit from the following list.

Variable: enviorn_location_other *Branching logic:* [environ_location] = '36'

Other Department/Unit, please fill in

Please choose the one category below that best describes your primary professional role. (chose one)

Other role, please fill in

As part of this role, do you directly interact with patients either in person or from a distance during your day-to-day duties within NJH? This includes things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services.

○ Yes ○ No ○ Not Sure

reset

Which of the following groups do you primarily work with (select all that apply)?

☐ Children ☐ Adolescents ☐ Adults ☐ Elderly

In which of the following settings do you work?

☐ Inpatient ☐ Outpatient ☐ Both

Have you ever received training on suicide awareness or prevention?

○ Yes ○ No ○ Not Sure

reset

Which of the following trainings, if any, have you taken on suicide awareness and prevention? (select all that apply)

☐ An inservice at NJH
☐ An inservice or webinar training at a different organization
☐ Mental Health First Aid
☐ Other (please specify):

Name of training :

Expand

Please indicate how much you disagree or agree with each of the following statements about the physical environment patients receive care in.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I know the NJH Policy for ensuring a safe physical environment for patients at risk for suicide.	○	○	○	○	○
reset					
I know what to do when I have concerns about potential means for suicide in the physical environment in our facility.	○	○	○	○	○
reset					

The next series of questions ask you to reflect on suicide prevention within your work culture .

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understand my role and responsibilities related to suicide prevention within NJH.	○	○	○	○	○
reset					
I believe suicide prevention is an important part of my professional role.	○	○	○	○	○
reset					
The leadership at NJH has explicitly indicated that suicide prevention is a priority.	○	○	○	○	○
reset					
NJH has clear policies and procedures in place that define each employee's role in preventing suicide.	○	○	○	○	○
reset					
NJH provides me access to ongoing support and resources to further my understanding of suicide prevention.	○	○	○	○	○
reset					
I feel that NJH would be responsive to issues that I bring up related to patient safety.	○	○	○	○	○
reset					

We are interested in learning about your knowledge and comfort related to recognizing warning signs that a patient may be at elevated risk for suicide.

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have knowledge and training needed to recognize when a patient may be at elevated risk for suicide.	○	○	○	○	○
reset					
I am knowledgeable about warning signs for suicide.	○	○	○	○	○
reset					
I know what NJH procedures to follow when I suspect that a patient may be at elevated risk for suicide.	○	○	○	○	○
reset					
I am confident in my ability to respond when I suspect a patient may be at elevated risk for suicide.	○	○	○	○	○
reset					
I am comfortable asking patients direct and open questions about suicidal thoughts and behaviors.	○	○	○	○	○
reset					

We are interested in learning about your knowledge and comfort related to screening a patient that may be at elevated risk for suicide.

Are you responsible for conducting screening for suicide risk?

○ Yes ○ No ○ Not Sure

reset

Please indicate how much you disagree or agree with each of the following statements regarding screening .

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have the knowledge and skills needed to screen patients for suicide risk.	○	○	○	○	○
I know NJH procedures for screening patient for suicide risk.	○	○	○	○	○
I am confident in my ability to use the Asking Suicide-Screening Questions (ASQ) to screen patients for suicide risk.	○	○	○	○	○
I am comfortable screening patients for suicide risk.	○	○	○	○	○

reset

Patients who screen positive for suicide risk should be assessed to inform clinical decision making. This is sometimes referred to as a suicide risk assessment.

Are you responsible for conducting suicide risk assessments for patients who screen positive for suicide risk?

○ Yes ○ No ○ Unsure

reset

Please indicate how much you disagree or agree with each of the following statements regarding assessment .

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have the knowledge and skills needed to conduct a suicide risk assessment.	○	○	○	○	○
I obtain information about risk and protective factors when conducting suicide risk assessment.	○	○	○	○	○
I assess the patient's access to lethal means as par of a suicide risk assessment.	○	○	○	○	○
I know what NJH procedures exist regarding suicide risk assessments.	○	○	○	○	○
I am confident in my ability to conduct a Columbia Suicide Severity Rating Scale (CSSRS).	○	○	○	○	○
I know the clinical workflow to follow when a suicide risk assessment indicates the patient needs additional clinical care.	○	○	○	○	○

reset

For the following questions, transitions in care include safely discharging and/or transitioning patients following acute care status or changes in care.

Are you responsible for ensuring safe care transitions for patients who have been identified as being at elevated risk for suicide?

○ Yes ○ No ○ Not Sure

reset

Please indicate how much you disagree or agree with each of the following statements regarding transitions in care .

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have the knowledge and skills needed to work with patients during their transitions in care.	○	○	○	○	○
I am familiar with NJH procedures for working with patients during their transitions in care.	○	○	○	○	○
I am confident in my ability to work with patients during their transitions in care.	○	○	○	○	○

reset

I am confident in my ability to work with family members or other support persons who may be involved during a patient's transitions in care.	○	○	○	○	○	reset
I am familiar with NJH procedures for sharing PHI during a patient's transitions in care.	○	○	○	○	○	reset
I am comfortable working with patients during their transitions in care.	○	○	○	○	○	reset

We are interested in learning if you feel organizational support in a manner consistent with a just, no-blame culture when a patient ended his/her life by suicide.

While working at NJH, I have directly or indirectly interacted with a patient who ended his/her life by suicide.

○ Yes, it has happened once ○ Yes, it has happened more than once ○ No ○ I Don't Know ○ Prefer Not to Answer

reset

Please indicate how much you disagree or agree with each of the following statements regarding support.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable	
I felt supported by NJH when a suicide occurred.	○	○	○	○	○	○	reset
I felt blamed when a patient died by suicide.	○	○	○	○	○	○	reset
NJH has practices in place to support staff when a suicide occurs.	○	○	○	○	○	○	reset
I am aware of the Employee Assistance Program.	○	○	○	○	○	○	reset

In which of the following areas, if any, would you like more training, resources, or support? (select all that apply)

- ☐ Suicide awareness and prevention
- ☐ Epidemiology and the latest research findings related to suicide
- ☐ Identifying warning signs for suicide
- ☐ Communicating with patients about suicide
- ☐ ASQ Screening Questions
- ☐ Identifying risk factors for suicide
- ☐ Columbia Suicide Severity Rating Scale (CSSRS)
- ☐ Determining appropriate levels of care for patients at risk for suicide
- ☐ Crisis response procedures and de-escalation techniques
- ☐ Managing suicidal patients
- ☐ Collaborative safety planning for suicide
- ☐ Suicide-specific treatment approaches
- ☐ M-1 Hold
- ☐ Aftercare and follow-up
- ☐ Family, caregiver, and community support
- ☐ Procedures for communicating about potentially suicidal patients
- ☐ Understanding and navigating ethical and legal considerations
- ☐ Policies and procedures within your work environment
- ☐ Staff roles and responsibilities within your work environment
- ☐ Reducing access to lethal means outside the care environment
- ☐ Creating a safe physical environment for patients at risk for suicide
- ☐ Other (please specify):

Other (please specify):

Do you have any concerns or comments about suicide awareness and prevention training?

Expand

Do you have any comments or concerns about providing care to a patient who is suicidal?

Expand

Please elaborate on any item above and/or additional comments regarding this survey:

Expand

If we may quote any of your comments, please enter your name here:

First Name Last Name