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Walden University

College of Nursing

This is to certify that the doctoral study by

Renea Crawford

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2022

Abstract

Identification, Treatment, and Management of Patients with Suicidal Ideation on the Medical-Surgical Unit for Nurses

by

Renea' Crawford

MSN, Walden University, 2016

BSN, Wright State University, 2008

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2022

Abstract

Suicide and suicidal ideations are among the leading causes of death in the United States. The Joint Commission identifies inpatient suicide as a sentinel event that should never happen. Nurses working on the medical/surgical (M/S) unit in a hospital located in the midwestern region of the United States voiced their concern that they were not prepared to recognize the signs that may indicate an escalating emotional situation in patients with suicidal ideation; in addition, there were no guidelines in the hospital to use as a resource. The purpose of this project was to determine whether an evidence-based (EB) clinical practice guideline (CPG) could serve as a resource for nurses when providing care to patients who are admitted to an M/S unit who are at risk for suicidal ideation. The theory that guided this project was Orlando's nursing process discipline theory. Orlando's theory assumes that if the problem is unknown, it cannot be solved. A panel of six professionals provided formative evaluation of an EB CPG using the AGREE II instrument, a guideline development tool. Using a scale of 1-7 (1 = *strongly disagree* to 7 = *strongly agree*) to rate the individual elements of the CPG, the panelists' average score of each element ranged from 5.2 to 7. The overall quality of the guideline was a score of 6.7 out of 7, which represents a 95% quality score. All six panel members indicated that they would recommend the guideline for use. This EB CPG has the potential to positively impact social change for patients, nurses, the hospital, and the community served. Providing this EB CPG to nurses to use as a resource can empower them to develop holistic care plans that incorporate this CPG for patients admitted to the M/S unit with suicidal ideation.

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Dedication

I would first like to dedicate this project to my children. The three of you have been on this entire journey with me and sacrificed your mom a lot so that I could focus and be successful. Even though you all are different ages, during your lifetimes, you have never known me to not be in school and have been understanding of my school commitments. I would also like to dedicate this to my mom, who has stepped in to help with my children as I focused on schoolwork. To the rest of my family and friends, you are amazing, and I appreciate all your support. To those who have lost a loved one due to suicide, this work is also for you.

Acknowledgments

I want to thank both committee chairpersons I had throughout this project, Dr. Cynthia Fletcher and Dr. Barbara Barrett. Thank you for your motivation and support along the way. At times you saw in me what I did not see in myself. I also want to thank my 2nd Committee member Dr. Andrea Tatkon-Coker, my University Research Reviewer, Dr. Mary Rodgers, and my Program Coordinator Dr. Nancy Moss.

Thank you to my village of support, without you, I would not have made it through this journey. To all my friends and family, thank you all for listening to me as I expressed positive and not so positive things during this journey. Your encouragement helped me maintain focus on my goals. Thank you to my mom for all your moral support and for having faith in me achieving the goals I set for myself. I want to especially thank my kids; you have sacrificed so much time with me over these last few years so that I could focus on school and project work. I appreciate your unconditional love!

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Section 1: Nature of the Project

Individuals are admitted to the hospital daily with ailments in addition to their admitting medical diagnosis. When a patient is experiencing suicidal ideation, treating this issue is just as important as treating the admitting diagnosis. When suicidal ideation is present along with other disease processes, care of all comorbidities is vital to the healing. Nurses play a major role in managing patients' care after a suicide attempt or those with suicidal ideation (Gholamrezaei et al., 2019). However, many nurses in the medical/surgical (M/S) areas lack basic knowledge about the management of this patient population.

Providing the nurses caring for this patient population with an evidence-based (EB) clinical practice guideline (CPG) can help them better manage the care of these patients. An EB CPG serves as a resource that the nurses can use to better recognize the characteristics of an impending suicide attempt and determine what interventions can be integrated into the patient's plan of care, benefiting the nurse, patient, and hospital.

Problem Statement

Suicide and suicidal ideation are high in the United States and is currently the 10th leading cause of death (Fazel & Runeson, 2020). The Joint Commission (TJC) identifies inpatient suicide as a sentinel event and states it should never happen (Williams et al., 2018). Suicide prevention is listed as a National Patient Safety Goal 15.01.01 (TJC, 2019). The total death rates by suicide for the practice site’s county, in the midwestern region of the United States, are higher compared to the national rates (PHDMC, 2019).

The latest available rates in the area are 15.6 per 100,000 compared to 14.5 per 100,000 in the state and 13.8 per 100,000 in the United States (PHDMC, 2019).

Nurses are at the forefront of patient's care when they come to the hospital for any reason and make up the largest segment of the healthcare workforce in the United States (Avery et al., 2020). When a patient is admitted after a suicide attempt or with suicidal ideation, some acute medical conditions or comorbidities are best managed on an M/S unit versus a behavioral health unit (Blair et al., 2018). However, when patients are admitted to the M/S unit after a suicide attempt, the focus of their treatment is to manage their general health and medical concerns. At the same time, their psychological wellbeing may receive minimal attention (Guptill, 2011). The risk for suicide is highest immediately after an attempt or shortly after admission to the hospital (Guptill, 2011; Mitchell & Lackamp, 2018). There is also a high incidence of M/S patients who receive a new diagnosis or a poor prognosis which can affect their feelings about wanting to live (Grimley-Baker, 2018).

Staff on M/S units are competent to care for the patients' acute medical condition. Still, they may not be equipped with the necessary resources to maintain a suicidal patient's safety (Avery et al., 2020). Informal conversation with the nurses on the M/S unit at the practice site identified that they did not believe that they were educated to manage patients experiencing suicidal ideation on the M/S unit (Staff nurses, personal communication, September 30, 2020). They feared that they may not recognize the signs of impending distress in a patient with suicidal ideation and there were no guidelines available on the unit to help them to recognize these signs. Historically, they received

email memos reminding them what to do when caring for a suicidal patient, which was typically based on an adverse event that already occurred.

The absence of an EB guideline, that enables nurses to provide a safe inpatient environment for this patient population that is free from dangerous objects, places the patient and nurse at risk for harm (Guptill, 2011). A different skill set is needed to care for a patient who believes that dying will ease or end all of their suffering (Guptill, 2011). Therefore, nurses caring for these patients need to be able to recognize warning signals of distress that the patient may present (Avery et al., 2020). Having established guidelines available to nurses caring for suicidal patients on the M/S unit may help them calm the patient and secure the environment to ensure safety (Bostwick & Rackley, 2007). Developing an EB CPG fills the gap in practice; it serves as a resource for nurses caring for suicidal patients on an M/S unit.

TJC requires that all patients with a primary diagnosis of a behavioral health condition be screened for suicidal ideation (TJC, 2019). The National Patient Safety Goal for suicide prevention no longer requires universal screening of all patients for suicidal ideation but warns that patients may have a comorbid behavioral health condition, recent medical diagnosis, change in clinical status with a poor prognosis, or psychosocial issues that may put them at increased risk of suicide (TJC, 2019).

The initial screening is an effective way to identify patients who are at risk for suicide and may require further screening to identify plan, intent, risk factors, and protective factors (TJC, 2019). Early identification of these patients is vital to preventing inpatient suicide (Grimley-Baker, 2018). Early identification gives the clinician time to

develop interventions to put in place based on the patients identified risk level (TJC, 2019). Having an EB CPG available to serve as a resource for nurses to use when providing care for patients who may be at risk for suicidal ideation on an M/S unit is essential to ensure positive care outcomes.

Purpose Statement

Nurses on the M/S unit are educated to manage and treat various medical conditions. Patients with suicidal ideation are admitted to an M/S unit to stabilize their medical condition; however, care for their psychological and emotional needs is also important. Nurses working on the M/S unit in a hospital located in the midwestern region of the United States, voiced their concern that they were not prepared to recognize the signs that may indicate an escalating emotional situation in the patient with suicidal ideation; in addition, there were no guidelines in the hospital to use as a resource. The purpose of this doctoral project was to develop an EB CPG for nurses to use as a guide when caring for patients with suicidal ideation admitted to the medical surgical unit for treatment of their acute medical condition. The practice-focused question was: "Can an evidence-based clinical practice guideline serve as a resource for nurses when providing care to patients who are admitted to a medical/surgical unit and may be at risk for suicidal ideation?" The EB CPG created serves as a resource for nurses to recognize signs that may indicate worsening of symptoms in patients with suicidal ideation and prevent further harm.

Nature of the Doctoral Project

Evidence from the literature, informal conversation with staff nurses and nurse educators, and the results from a risk assessment organization that focused on the regulatory requirements for care of patients with suicidal ideation identified the need to develop an EB CPG for the management and treatment of patients with suicidal ideation on the inpatient M/S unit. Evidence was obtained by electronic searches of databases such as CINAHL & MEDLINE Combined Search, PubMed, and Google Scholar. Search terms included a combination of the following terms: *inpatient suicide*, *medical-surgical unit*, *suicide prevention*, *nursing staff, psychosocial needs*, and *environment of care*. In addition, I searched professional websites, such as the National Institute of Mental Health, The Joint Commission, American Nurses Association, and the American Psychiatric Nurses Association. Information obtained from these sources provided a better understanding of the problem and justified the need to develop an EB CPG with the potential to directly impact the care provided by the nurses to this population.

The EB CPG was developed according to the Walden Clinical Practice Guideline Manual. I discussed my plan and obtained approval from the administrative staff at a local hospital to develop an EB CPG to provide a resource for the nurses to use for the management and treatment of patients with suicidal ideation on the inpatient M/S unit. I used the Appraisal of Guidelines for Research & Evaluation II (AGREE II) instrument as a guide to develop the EB CPG. I critically appraised the level of evidence from the literature using the Fineout-Overholt et al. guideline (2010). I then developed the EB CPG.

I obtained the Chief Nursing Officer (CNO) and Professional Practice Nursing Directors recommendation to identify a group of individuals who evaluated the guideline. Key stakeholders, end-users, and experts reviewed the guideline to validate the content, ensure usability as a resource, and provide a formative evaluation using the AGREE II instrument. Revisions were made based on their recommendations.

The development of an EB CPG for nurses to use as a guide when caring for patients with suicidal ideation on the M/S unit who are being treated for an acute medical condition helps in recognizing worsening of symptoms that may indicate the potential for a suicide attempt. Having this resource available helps fill the identified gap in practice by providing the nurses with knowledge to deliver holistic care. Having this EB CPG to use as a guide has the potential to increase the nurses' level of comfort and confidence in managing patients experiencing suicidal ideation on the M/S unit.

Significance

Nurses' primary focus for patients admitted to the M/S unit is on their acute medical needs; limited attention is given to the psychological needs of the patient (Guptill, 2011). Patients should be treated holistically when admitted to the hospital. Therefore, their assessment should focus on their physical, social, and psychological needs (Hom et al., 2021). Zolnierek and Clingerman (2012) identified that nurses report experiencing challenges when providing care for a person with suicidal ideation in a general M/S setting. These challenges may occur when nurses working on the M/S unit do not have the skill set needed to care for the psychological needs of this patient

population. Standards that can be used by nurses caring for patients with a secondary diagnosis of suicidal ideation, admitted to a M/S unit, are lacking (Avery et al., 2020).

This CPG has the potential to impact positive social change for patients, nurses, the hospital, and the community that is served. Providing guidelines for nurse to use as a resource has the potential to empower them to develop holistic plans of care for patients admitted to their unit with a secondary diagnosis of suicidal ideation. This resource supports the nurse in providing EB treatment approaches to enhance the care received on the inpatient M/S unit (Elliot, 2016). Providing the missing pieces of the psychological care that is currently needed for this patient population not only equips nurses with the resources needed to provide better care, but it also ensures that the patient receives holistic care when admitted to an M/S unit with suicidal ideation. Providing the nurses with the resource needed to recognize early signs that may indicate an escalating emotional situation and initiate interventions to prevent further harm has the potential to decrease legal risk associated with inpatient suicide for the hospital and the care givers. Furthermore, ensuring that there is a standard of practice when providing care to this patient population can reduce the variances seen with nurses' assessments, communication, and comfort (Mitchell & Lackamp, 2018). This project supports the mission of Walden University, because it provided me with the skill set needed to transform into a scholarly practitioner.

Summary

Suicide is the 10th leading cause of death in the United States; therefore, suicide prevention is recognized as a National Patient Safety Goal (TJC, 2019). Nurses are

involved in many aspects of the patient's care and thus are required to be prepared in managing any signs of suicidal ideation. Medical/surgical nurses receive extensive education and training to manage various medical conditions. Still, they may not receive training to recognize the signs of escalating emotions in a patient with suicidal ideation. The purpose of this doctoral project was to develop an EB CPG for nurses to use as a guide when caring for patients with suicidal ideation admitted to the M/S unit for treatment of their acute medical condition. Having an EB CPG available to guide the nurse when caring for these patients will allow better recognition and management of any signs or symptoms exhibited.

The AGREE II instrument was used to guide the development of the EB CPG. Recommendation from the hospital's CNO and Professional Practice Nursing Director identified key stakeholders, end-users, and experts to review the EB CPG to validate the content, usability, and provide a formative evaluation using the AGREE II instrument. The recommendations from this group were used to make revisions as needed. Providing M/S nurses with this resource can affect the level of comfort and competence they experience when caring for patients, admitted for an acute M/S condition, who experience suicidal ideation.

Section 2: Background and Context

The lack of a resource for nurses on the M/S unit in a local hospital in the midwestern region of the United States to use when caring for patients experiencing suicidal ideation secondary to their primary acute diagnosis has created a gap in managing this patient population. The purpose of this doctoral project was to develop an EB CPG for nurses to use as a guide when caring for patients with suicidal ideation admitted to the M/S unit for treatment of their acute medical condition. The practice focus question was "Can an evidence-based clinical practice guideline serve as a resource for nurses when providing care to patients who are admitted to a medical/surgical unit and may be at risk for suicidal ideation?"

In this section, I will discuss concepts, models, or theories utilized and the rationale for their use. The relevance to nursing practice will also be presented, providing more history on this topic and addressing the current state and any strategies used in the past to address the management and treatment of the suicidal patient on the M/S unit. My role as a Doctor of Nursing practice (DNP) student is described, including my relationship to the doctoral project topic, participants, evidence, or institution. My motives, along with any potential biases, will also be discussed.

Concepts, Models, and Theories

The conceptual framework that guided this project is Orlando's (1961) nursing process discipline theory. Orlando's nursing background includes various nursing roles related to mental health psychiatric nursing. Her theory's development stemmed from her searching for facts about nursing's purpose (Faust, 2002). She developed the theory after

reviewing interactions between nurses and patients that were later categorized as “good” or “bad” nursing (May, 2013). Orlando’s theory is based on finding and solving problematic situations (May, 2013). In this theory, the behaviors of the nurse and patients are affected by each other. The assumption of this theory is that if the problem is not known, then it cannot be solved (May, 2013). The nurse must examine the patient’s actions to gather the full picture, which is vital to noticing potential self-harm attempts.

The theory is composed of five major concepts: professional nursing function, patient’s presenting behavior, immediate reaction, deliberative nursing process, and improvement (May, 2013). The nurse’s prominent role in providing patient care is to find out their immediate needs and help them (Petiprin, 2020). The nurse's role makes the concept of the professional nursing function the organizing principle for this theory (Petiprin, 2020). Orlando's approach focuses on the patient's needs now and considers the duty of the nurse unfulfilled until the needs of the patient are determined and satisfied (Petiprin, 2020). The concept of the patient's presenting behavior is related to the way the patient is pleading for help (Petiprin, 2020). Analyzing the behavior and realizing there is a problem helps the nurse respond to the patient's needs. The nurse’s response may provoke positive or negative responses from the patient (Petiprin, 2020). The concept of immediate action is closely tied to the concept of analyzing behavior. This concept is a compilation of all things the patient is sensing, which develops their internal response (Petiprin, 2020). The concept of deliberative nursing utilizes the nursing process when examining a patient's needs (Faust, 2002). The focus on the nurse and the patient's interactions helps ensure that the patient's needs are being met (Faust, 2002). There

cannot be an automation of reactions to a patient's behavior because the same patient can show the same action at different times, representing different needs (Faust, 2002). The final concept of improvement is resolving the patient's situation by fulfilling their needs (Petiprin, 2020). When the patient's need is satisfied, the nurse reflects on the results of his or her actions instead of the act itself (Petiprin, 2020).

Patients admitted to an M/S unit with suicidal ideation may manifest subtle signs and symptoms that may not be easily recognized by the nurse as an early sign of escalating emotional situation. The assumptions of this theory provided me with an understanding of the nurses' role in recognizing signs of distress that results from unmet needs of the patient with suicidal ideation, validating the observations with the patient, and responding appropriately. This theory applies to my understanding that effective therapeutic communication must be present to understand the patient's needs before responding to a situation. The development of an EB CPG provides the nurse with the resource needed to recognize the subtle signs that may indicate an escalating emotional situation for patients admitted to an M/S unit with suicidal ideation and respond appropriately.

Definition of Terms

The following words or phrases have been defined to clarify the meaning as used in this project:

Risk assessment: Identifying potential hazards or threats that may cause less than optimal results or ambiguities (Zio, 2018).

Suicide risk assessment: Identifying patient characteristics that are indicative of closer monitoring or increased clinical resources (Large et al., 2018).

Stigma: A negative label given by people to an individual or group that is different in regards of appearance, race, physical and mental health (Gholamrezaei et al., 2019).

Relevance to Nursing Practice

Suicide is a preventable problem and has reached epidemic levels in the United States (Stevens & Nies, 2018). In the past, suicide was viewed as an individual disorder, but it is now viewed as a social problem (Gholamrezaei et al., 2019). The nurse has a leading role in assisting patients to manage their suicidal thoughts by providing positive therapeutic care (Stevens & Nies, 2018). Gholamrezaei et al. (2019) stated that stigma held by the nursing staff towards patients experiencing suicidal ideations impacts the quality of care received. Depending on the nurse's attitude, care towards the suicidal patient may be neglected (Gholamrezaei et al., 2019). He reported that the basic education provided in nursing courses is not enough to manage this patient population (Gholamrezaei et al., 2019). He identified that increasing nurses' literacy in managing suicidal patients resulted in them experiencing less stress and more efficiency in the care they provided to these patients (Gholamrezaei et al., 2019).

More than half of the adults who attempt suicide seek medical attention, and about half of those who sought medical attention spent at least one night in the hospital (Stevens & Nies, 2018). The nurse regularly interacts with patients experiencing suicidal ideation and behaviors (Stevens & Nies, 2018). Stevens and Nies (2018) acknowledged

that because nurses spend more time with patients than other clinicians, they have more opportunity to recognize and prevent harm in patients with suicidal ideation. Therefore, it is vital that the nurse maintains a positive attitude towards patients with suicidal ideation. When a nurse displays a negative attitude towards a patient experiencing suicidal ideation, the patients' feelings of hopelessness and burdensome can be reinforced and may lead to future attempts (Stevens & Nies, 2018). Nurses that see themselves as being prepared to care for a patient with suicidal ideation have been shown to have an improved mindset towards managing the care of suicidal patients (Stevens & Nies, 2018).

Improved educational focus on understanding, assessing, and preventing suicidal behavior is needed for nurses (Stevens & Nies, 2018). When nurses are prepared to intervene while managing the care of suicidal patients therapeutically, the patients' opportunities to engage with them are increased (Stevens & Nies, 2018). Having nurses in the M/S area of the hospital prepared to manage patients' treatment with suicidal ideation have the potential to improve the patient's mood and decrease their thoughts of suicide.

Local Background and Context

Suicide is the process of intentionally ending one's own life (Gholamrezaei et al., 2019). Suicide is the 10th leading cause of death in the United States (Fazel & Runeson, 2020). The total death rate in the local region of this county in the midwestern portion of the United States are higher compared to national rates (PHDMC, 2019). The rates in the area are 1.1 per 100,000 higher compared to the states level, and 1.8 per 100,000 higher when compared to the United States (PHDMC, 2019). This difference in rates, reflects

the need for intervention in the area to prevent further incidences of suicide. Nurses make up most of the healthcare workforce in the United States (Avery et al., 2020). They have a significant role in care management for patients when admitted to the hospital. It is crucial that nurses have the knowledge to care for a vast array of acute conditions. This includes having the knowledge to care for suicidal patients while managing other ailments.

The EB CPG was developed to serve as a resource for nurses working on an inpatient M/S unit in a hospital in the midwestern region of the United States. I discussed my proposal to develop the EB CPG with the CNO and Professional Practice Nursing Director at the hospital, and they agreed that having guidelines to serve as a resource for the nurses on the unit will have a positive impact on care provided to patients admitted to the M/S unit with suicidal ideation. Developing the guidelines for nurses working on the M/S unit, where the gap in practice related to treatment of patients with suicidal ideation on the M/S unit occurs, have the potential to empower the nurse with the information needed to deliver holistic care for patients admitted with acute medical illness and suicidal ideation.

Role of the DNP Student

I completed my master's degree in Clinical Informatics in 2016 and transitioned to a role within the organization as a Clinical Informaticist. The position allowed me to have a global view of the variations of nursing care delivery at the system level. With this expanded view, I noticed that the psychological care of patients experiencing suicidal ideation secondary to their acute medical condition was not a priority, as evidence by my

review of the record when providing care to these patients. The plan of care did not include information related to care of the patient experiencing suicidal ideation.

In this doctoral project, I functioned as a researcher, leader, and educator. My role as a researcher was to review the literature and other professional organization sites to identify the evidence related to management of the care needs of patients with suicidal ideation. As a project leader, I collaborated with staff in the facility to create an EB CPG that M/S nurses can use to manage the care of patients with suicidal ideation. As an educator, I provided information to administration and the nursing staff related to the need for an increased awareness of changes in practice needed when providing care to patients admitted to M/S units with suicidal ideation.

A potential bias to disclose for this project was that I had my idea of how nurses should manage and provide care to suicidal patients. I did not let this interfere with the development of the CPG. I used evidence from the literature and did not provide my own opinion on the care needs of the patients experiencing suicidal ideation. An evidence-based tool, AGREE II instrument, is the tool that was used to develop the guideline. This tool has preestablished questions that already have validity and reliability.

Role of the Project Team

The CNO and Professional Practice Nursing Director identified a group of stakeholders, end-users, and experts that evaluated the EB CPG. I used evidence from the literature to develop the EB CPG. The purpose of the project was discussed with this group. The EB CPG was provided to the group to validate the content, ensure usability as a resource, and provide a formative evaluation using the AGREE II instrument. The

timeline for review from this group was 2 weeks. This timeframe gave all members of the group time to review the EB CPG and left me time to make any necessary revisions based on the feedback received. This timeframe also allowed for time to prepare for the next month's shared governance councils, where I could share the quality score results with the panel.

Summary

The development of an EB CPG for nurses on the M/S unit to use when caring for patients with suicidal ideation secondary to their primary diagnosis was needed. Orlando's theory guided my understanding of the nurses' ability to ensure that the patients' needs are identified to respond effectively to a situation. Identification of these needs helps the nurse address the problems that may be causing the patient to have suicidal ideations. There are many interventions needed by nursing staff to ensure that a patient experiencing suicidal ideation does not have the means to complete suicide. The literature suggests that screening patients when being admitted to the hospital is a major key in identifying those with underlying suicidal ideation (TJC, 2019). Since suicide rates in this region of the state located in the Midwestern region of the United States are higher than the state and national rates, an intervention was needed. I developed the EB CPG using evidence from the literature and feedback from stakeholders, end-users, and experts.

Section 3: Collection and Analysis of Evidence

Suicide is a preventable public health problem that has reached epidemic levels in the Unites States and is the 10th leading cause of death (Stevens & Nies, 2018; Fazel & Runeson, 2020). A patient with an unsuccessful suicidal attempt may be admitted to an M/S unit for treatment of their acute medical condition. Nurses on the M/S unit are competent to care for the patient's acute medical condition but may not be equipped with the necessary resources to keep the suicidal patient safe (Avery et al., 2020). The psychological well-being of the patient may be jeopardized while nurses focus on acute medical concerns (Guptill, 2011). The purpose of this project was to provide nurses on the M/S unit with a resource to use as a guide when caring for patients with suicidal ideation in addition to their acute medical condition.

This doctoral project was completed at a large hospital in a state in the Midwestern region of the United States where the suicide death rates are higher when compared to the national rates. The focus was on the development of an EB CPG to serve as a resource for nurses working on the inpatient M/S unit. The CNO and Professional Practice Nursing Director of the hospital agreed that having set guidelines to serve as a resource for the M/S nurses will positively impact the care patients with suicidal ideation receive.

In this section, I discuss the practice-focused question and how it related to the problem and gap in practice while clarifying the purpose. Sources of evidence are also presented, providing a clearer understanding of how the sources helped address the practice-focused question. Finally, this section includes information about analysis and

synthesis of the evidence and how it was recorded, tracked, organized, and used to address the practice-focused question.

Practice-Focused Question

Currently, the hospital does not have a resource for nurses working on the M/S unit to use when treating and managing patients with suicidal ideation. The attention is given to the patients' acute medical condition which leaves the patients psychological wellbeing unmanaged. The lack of a resource for the nurses to use as a guide has created a gap in nursing practice when caring for this patient population. The practice-focused question for this project was: "Can an evidence-based clinical practice guideline serve as a resource for nurses when providing care to patients who are admitted to a medical/surgical unit and may be at risk for suicidal ideation?" Creating an EB CPG filled the gap in practice by serving as a resource to help the nurse with early identification of signs that indicate worsening symptoms and prevention of further harm to the patient experiencing suicidal ideation.

Sources of Evidence

I used evidence from the literature, informal conversations with staff nurses and nurse educators, and results from a risk assessment organization. Literature was obtained by electronic searches of databases such as CINAHL & MEDLINE Combined Search, PubMed, and Google Scholar. Search terms included a combination of the following terms: *inpatient suicide*, *medical-surgical unit*, *suicide prevention*, *nursing staff, psychosocial needs*, and *environment of care*. In addition to the literature search, I obtained information from professional websites such as the National Institute of Mental

Health, The Joint Commission, American Nurses Association, and the American Psychiatric Nurses Association.

Evidence Generated for the Doctoral Project

The participants who were key to the development of the EB CPG were the stakeholders, end-users, and experts. The EB CPG was reviewed for content validity to ensure it could be used as a resource, and a formative evaluation was provided using the AGREE II instrument. The group represented the inpatient M/S units across the hospital. There were six group members who were a part of the review process which included bedside nurses, clinical informaticists, the nursing educator on the inpatient behavioral health unit, the nurse manager on the inpatient M/S unit, and a nursing director over both areas. Selection of this group came as a recommendation from the hospital's CNO and Professional Practice Nursing Director. The group members were vital to the practice-focused question because they helped to determine the validity and usability of the EB CPG.

Procedural Steps

I was guided by the steps described in the Walden University *DNP Manual for Clinical Practice Guideline Development* to help develop the EB CPG. After obtaining Walden University Institutional Review Board approval (#05-25-21-0547534), I:

1. Critically appraised the evidence from the literature using Fineout-Overholt, Melnyk, Stillwell, and Williamson's guideline.
2. Synthesized the evidence from the literature and developed the EB CPG.

3. Presented the EB CPG to the identified group to review in order to validate the content, ensure usability as a resource, and provide a formative evaluation using the AGREE II instrument.
4. Revised the EB CPG based on their recommendations.
5. Finalized the EB CPG and present to the CNO and Professional Practice Nursing Director.

Ethical Protections

The aim of the project was to develop an EB CPG that could serve as a resource for nurses while caring for suicidal patients on the M/S unit. The guideline was developed to serve as a resource for the nurses on the M/S unit, and patients were not included in this project. I presented the hospital with a site approval form for the CPG development project. The panel received the Disclosure to Expert Panelist Form for Anonymous Questionnaires; this form was informational, and signed consent was not needed for this project.

Identification of the stakeholders, end-users, and experts who reviewed the EB CPG was not collected; therefore, their responses were anonymous. The questionnaires were presented using Survey Monkey and personal identifiers were not collected. The panels completion of the questionnaire acknowledged their permission to participate. Additionally, the hospital's name was not identified in any of the project’s documents or deliverables. When speaking of the hospital, only the regional location within the United States was disclosed. The data collected from the questionnaires completed by the group regarding their evaluation of the EB CPG is being kept on my personal computer; I alone

have the password to the computer. This information will be destroyed after 5 years as required by Walden University Institutional Review Board.

Analysis and Synthesis

The level of evidence of the literature gathered through an extensive review was critically appraised using Fineout-Overholt et al.'s guideline (2010). The literature review was organized using a literature matrix. The literature was categorized based on the level of evidence. The levels of evidence are Level I (systematic review or meta-analysis of all relevant trials); Level II (randomized controlled trials), Level III (non-randomized/quasi-experimental studies); Level IV (case-control and cohort studies); Level V (systematic review of descriptive and qualitative studies); Level VI (single descriptive or qualitative study); and Level VII (opinion of authorities and/or reports of expert committees) (Fineout-Overholt et al., 2010).

The EB CPG was provided to the stakeholders, end-users, and experts. The panel evaluated the EB CPG using the AGREE II instrument questionnaire. There were six domains on the instrument, and the panel individually scored the questions in each domain. Using a seven-point Likert scale, the maximum score was determined by taking the highest score of seven, multiplied by the number of items in the domain, then multiplied by the number of individuals who evaluate the EB CPG. Each domain's quality score was calculated by scaling the total as a percentage of the maximum possible score for that domain. The scaled domain score was calculated by taking the obtained score minus the minimum possible score and dividing that by the maximum possible score minus the minimum possible score. The threshold for the EB CPG to be acceptable

was a score greater than 70% of the maximum possible score. A comments section was included with each domain, and revisions were made based on the panel's recommendations. After review of their assessments of the EB CPG, I made revisions based on their recommendations. I will present the completed EB CPG to the CNO and Professional Practice Nursing Director.

Summary

The purpose of this project was to develop an EB CPG that can be used as a resource for nurses on the M/S unit for treating and managing patients with suicidal ideation. The sources of evidence used to address the practice-focused question were identified, along with how this evidence was categorized, recorded, and tracked. The participants' selection and the procedural steps for the review and validation of the EB CPG were discussed. Identification of how the hospital and the participants in the EB CPG review were protected was discussed. In Section 4, I discuss findings and implications, recommendations, contribution of the doctoral project team, and the strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The lack of a resource for nurses on the M/S unit in a local hospital in the midwestern region of the United States to use when caring for patients experiencing suicidal ideation secondary to their primary acute medical diagnosis created a gap in managing this patient population. The practice focus question was, “Can an evidence-based clinical practice guideline serve as a resource for nurses when providing care to patients who are admitted to a medical/surgical unit and may be at risk for suicidal ideation?” This doctoral project aimed to develop an EB CPG (see Appendix A) for nurses to use as a guide when caring for patients with suicidal ideations who are admitted to the medical-surgical unit for treatment of their acute medical condition.

The sources of evidence were obtained from the literature, informal conversations with staff nurses and nurse educators, and the results from a risk assessment of the organization. Literature was obtained by electronic searches of databases such as CINAHL & MEDLINE Combined Search, PubMed, and Google Scholar. Search terms included a combination of the following terms: *inpatient suicide*, *medical-surgical unit*, *suicide prevention*, *nursing staff, psychosocial needs*, and *environment of care*. In addition to the literature search, I obtained information from professional websites such as the National Institute of Mental Health, The Joint Commission, the American Nurses Association, and the American Psychiatric Nurses Association.

Findings and Implications

A panel of six stakeholders, end-users, and experts whose roles included that of a nurse educator, a nurse manager, a nursing director, clinical informaticists, and bedside nurses evaluated the EB CPG. Each panel member reviewed the EB CPG and rated the guideline using the AGREE II instrument. The structure and content of each domain of the AGREE II guideline development instrument can be found in Table 1.

Table 1

AGREE II Instrument

Domain	Structure and Content
1. Scope and Purpose	Overall aim of the guideline, the specific health questions, and the target population.
2. Stakeholder Involvement	Ensures that the guideline was developed by the appropriate stakeholders and represents the views of its intended users.
3. Rigour of Development	Process used to gather and synthesize the evidence, the methods to formulate the recommendations, and to update them.
4. Clarity of Presentation	Deals with the language, structure, and format of the guideline.
5. Applicability	Likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline.
6. Editorial Independence	Concerned with the formulation of recommendations not being unduly biased with competing interests.

Note. From *The AGREE II Instrument* by the AGREE Next Steps Consortium, 2017, http://www.agreetrust.org.

Results

Each expert panel member scored the CPG using the questions in each of the six domains of the AGREE II survey. Using a seven-point Likert scale survey, the maximum score was determined by taking the highest score of seven, multiplied by the number of items in the domain, then multiplied by the number of individuals who evaluated the EB CPG. Each domain's quality score was calculated by scaling the total as a percentage of the maximum possible score for that domain. The scaled domain score was calculated by taking the obtained score minus the minimum possible score and dividing that by the maximum possible score minus the minimum possible score. The acceptable threshold for the EB CPG was a score greater than 70% of the maximum possible score of 100%. A comments section was included with each question, and revisions were made based on the panel's comments and recommendations.

The AGREE II survey results (see Appendix F) shows that the domain quality score range obtained was 74% to 100%. The average score of each question ranged from 5.2 to 7. The overall quality score of the guideline was 6.7 out of 7, which reflects a 95% quality score. There were no unanticipated limitations or outcomes that could have impacted these findings. The implications resulting from the findings is that this EB CPG can help nurses on the inpatient M/S unit provide safe and effective care to patients experiencing suicidal ideation. The findings can also help patients receive more holistic plans of care when admitted to the M/S unit with a secondary diagnosis of suicidal ideation. Other implications resulting from the findings can also impact the community and institution by having a resource in place to support the treatment and management of

patients with suicidal ideation. The implications of the results of this EB CPG can positively impact social change for patients, nurses, the hospital, and the public community that is served. Providing this EB CPG to nurses to use as a resource can empower them to develop holistic plans of care for patients admitted to their unit with a secondary diagnosis of suicidal ideation. Results of the specific AGREE II domains are identified and described below.

Domain 1. Scope and Purpose

Domain 1 of the AGREE II instrument consists of three questions, and this domain's quality score is 98.9%. Question 1: Five out of the six-panel members rated this question a seven, and one rated it a six. The member comments for this question reflected that the content is easy to follow and locate, the information provided is clear and to the point, effectively outlines the screenings and interventions for inpatients at risk for suicide, and the intent, expected outcome, and patient population are clearly identified. These comments came from the panelist rating the question a seven and the panelist who rated the question a six. Question 2: All six-panel members rated it a seven. Question 3: All six panel members rated it a seven. There were no recommendations for revisions in domain one, therefore no changes were made to the EB CPG based on the ratings and comments.

Domain 2. Stakeholder Involvement

Domain 2 of the AGREE II instrument consists of three questions, and this domain's quality score is 86.7%. Question 4: Two out of six panelists rated it seven, two out of six panelists rated it six, one out of six panelists rated it a four, and one out of six

panelists rated it a two. The comments for this question reflected the need to identify the developer of the guideline and the roles of the project team members. Revisions based on this feedback included adding an introduction section to the EB CPG that incorporated information, already provided in the project draft, about the job roles of the project team and panel members that reviewed the EB CPG and about me, the developer of the guideline. Question 5: Four out of six panelists rated it a seven, one out of six panelists rated it six, and one out of six panelists rated it a four. The comments indicated that patient and public views were not identified. A revision based on this question included adding a statement under the target population section that communicated that patients and the public were not included in the expert panel reviewing this guideline. Question 6: Six out of the six panelists rated it a seven. There were no recommendations for revisions to the EB CPG based on the results of this question and no changes were made.

Domain 3. Rigour of Development

Domain 3 of the AGREE II instrument consists of eight questions, and the quality score of this domain is 88.3%. Question 7: Four out of six panelists rated it seven, one out of six panelists rated it a four, and one out of six panelists rated it one. The comments suggest adding the literature search methods to the EB CPG. Revisions made based on this feedback were to include the literature search databases and terms in the introduction section of the EB CPG. Question 8: Four out of six panelists rated it seven, one out of six panelists rated it six, and one out of six panelists rated it five. No comments or recommendations were provided from panel members on this question therefore, no revisions were made to the EB CPG. Question 9: Four out of six panelists rated it seven,

one out of six panelists rated it five, and one out of six panelists rated it two. Recommendations included addressing the topic of bias in the guideline. A revision made to the EB CPG to address this feedback was adding a statement in the introduction indicating that the use of the AGREE II instrument, that has established reliability and validity, controlled bias in the development of the EB CPG. Question 10: Four out of six panelists rated it seven, and two out of six panelists rated it four. Comments reflected that the guideline development process was not outlined. Revisions made to the EB CPG based on this comment included the addition of information about the use of the AGREE II instrument, information that was included in the project draft. Question 11: Five out of six panelists rated it seven, and one panelist rated it six. The comments for this question were that the benefits were identified, and this EB CPG appears to be low risk. Question 12: all six-panel members rated it seven. One panelist indicated that the link between the recommendations and the supporting evidence was perfectly displayed in the table. No revisions were made to the EB CPG based on the results of questions 11 and 12. Question 13: Three out of six panelists rated it seven, two out of six panelists rated it six, and one out of six panelists rated it two. One comment indicated that the reviewers were not identified, and another comment said that the reviewer is a part of the expert panel and is currently providing feedback. Revisions made to the EB CPG included adding a statement indicating that the EB CPG went through formative evaluation by stakeholders, end-users, and experts all of whom were included as members of the expert panel. Question 14: All six of the six-panel members rated it seven, and there were no

comments. No revisions were recommended, and none were made based on the review of this question.

Domain 4. Clarity of Presentation

Domain 4 of the AGREE II instrument consists of three questions, and the quality score of this domain is 100%. For all three questions the six-panel members rated all the items seven. A domain quality score of 100% indicates that the EB CPG was presented clearly, and the needed information was easily identifiable. One panel member commented that the table format made things “very easy to see". There were no revisions recommended or made based on the feedback obtained in this domain.

Domain 5. Applicability

Domain 5 of the AGREE II instrument consists of four questions, and the quality score of this domain is 78.7%. Question 18: Four out of six panelists rated it seven, one out of six panelists rate it five, and one out of six panelists rate it two. Despite the score of two from one of the panelists, no comment was included to indicate what revisions were recommended therefore there were no changes made to the EB CPG. Question 19: Five of the six panelists rated it seven, and one out of six panelists rated it three. The panel member who rated the score of three did not provide any comments to indicate what revisions were recommended; therefore, no edits were made based on this score. Question 20: Four out of six panelists rated it seven, one out of six panelists rated it three, and one out of six panelists rated it one. The comment received regarding this question was that the EB CPG did not include a cost-benefit analysis. There were no revisions made to the EB CPG based on this feedback, due to this student not being able to speak

of the hospitals' financial status at the time of EB CPG implementation. Feedback regarding cost-analysis is provided in the strength and limitations area of this section. Question 21: Three of the six panelists rated it seven, one out of six panelists rated it six, one out of six panelists rated it four, and one out of six panelists rated it two. The comment for this question was that no future auditing criteria was noted for the EB CPG. To address this comment for this question, a statement was added to the EB CPG that indicates the recommended review schedule of every three years aligns with the evidence regarding updating clinical practice guidelines every 3 to 5 years (Kredo et al., 2016; Vernooij et al., 2014).

Domain 6. Editorial Independence

Domain 6 of the AGREE II instrument consists of two questions, and the quality score of this domain is 74.2%. Question 22: Four out of six panelists rated it seven, one out of six panelists rated it four, and one out of six panelists rated it two. The two comments received in this section were that the question was not applicable, and to indicate if no funding was involved that could influence the development of the EB CPG, then list that in the guideline. Based on this comment, I added a statement in the guideline's introduction section that there was no funding source for the EB CPG and that it was prepared as a doctoral project. Question 23: Two out of six panelists rated it seven, two out of six panelists rated it six, one out of six panelists rated it four, and one out of six panelists rated it one. The comment made regarding this question is that the information regarding competing interest was not available. Revisions were made to the

CPG by adding a statement indicating that there were no competing interests to disclose from me or any of the panelists.

Overall Guideline Assessment

Question 24 of the AGREE II instrument asked the panel to rate the overall quality of the guideline. Four out of six panelist rated it seven and two out of six panelists rated it six. No revisions were recommended, and none were made based on the ratings or comments of this question. Question 25 asked the panelist if they would recommend this guideline for use. All six-panelist said yes and included comments stating that this is important work to address a patient population need and that the guideline offers the M/S nurse tools to care for their patients at risk for suicide. Another panelist commented that they would absolutely recommend this guideline and that it is wonderful and would be a huge benefit for the inpatient staff and patients. Based on the comments and ratings in this section, there were no additional changes made to the guideline other than those mentioned in previous sections.

Recommendations

Having an EB CPG available as a resource for nurses who work on the M/S unit will help address the identified gap. When implementing the EB CPG, staff awareness about the available resources is essential. Also essential to successful implementation of the EB CPG is staff education on the content of the EB CPG to ensure everyone fully understands how the organization will utilize the information in coordination with current policies. The organization can use the implementation of this EB CPG as a quality improvement project. The measurement of success for the implementation of this

guideline will be determined by how prepared the M/S nurses are when initiating the use of the EB CPG. It is recommended that the hospital's education team develop additional outcomes to measure the success of implementing and assessing the successful use of this EB CPG.

Contribution of the Doctoral Project Team

The CNO and Professional Practice Nursing Director identified a panel of six guideline reviewers that was comprised of stakeholders, end-users, and experts. The organizational roles of these panel members were nurse educator, a nurse manager, a nursing director, clinical informaticists, and bedside nurses. After the project's purpose and the guideline evaluation criteria were discussed with the panel members, they performed a formative evaluation of the EB CPG using the AGREE II scoring instrument. This evaluation was to validate and ensure that the content could serve as a resource for the end-users to benefit the patient population.

Strengths and Limitations of the Project

One strength of this project is that it was developed using the AGREE II instrument, an EB tool that has established reliability and validity. The rating for the quality of the guideline was 88.3%, which is greater than the 74% threshold for the EB CPG to be acceptable. This CPG has the potential to bridge the identified practice gap and provide nurses with a resource to use when caring for patients on the M/S unit. Another strength of this project is the different roles of the project team that reviewed the EB CPG. Having reviewers in different roles evaluating the guideline ensured that the CPG met the organization's needs at all levels, including those who will provide

education about the material and those who will use the material. Overall, the reviewer comments received from using the AGREE II instrument to assess the CPG were valid and were already included in the project draft but were not included in the guideline package that was provided to the panelist. A limitation of this project is that a cost-benefit analysis was not identified because this author cannot speak to the hospital's financial status. However, evidence exists that supports the use of some guidelines and the cost saving that can be realized by eliminating some unneeded services; additionally, some cost can increase by utilizing more of a suggested service from the guideline such as one-to-one observation; and in other areas cost can shift related to the use of the guideline (Field & Lohr, 1990). Having the CPG can help the nurse focus on what is needed to be done while managing patients with suicidal ideation instead of spending efforts on low-value care, which could save time and money (Verkerk et al., 2018). At the time of implementation, the leadership team can look at the financial implications for the hospital in all the associated areas as well as on nursing workload.

Recommendations for future projects addressing similar topics could focus on establishing CPGs for other patient care areas within the hospital such as labor and delivery, the emergency department, procedural, and critical care areas. Another recommendation for a future project could be to develop an EB CPG with community health nurses as the target setting and audience since this EB CPG targets inpatient nurses.

Section 5: Dissemination Plan

The CPG which resulted from this project will be made available to the practice site hospital. The hospital's CNO and Director of Professional Practice will have the EB CPG and will be able to provide it to the inpatient hospital units where it will be applicable and assist in determining the guideline roll-out. I will remain a resource for the organization. My contact information will be available if any questions arise regarding the EB CPG.

Analysis of Self

This doctoral project has been an arduous voyage. The impact of COVID-19 on my educational experience made it, at times, seem impossible to complete. At the beginning of my project, I lacked access to some of the needed opportunities to better hone in on the issue identified in the gap analysis. The major issue I encountered was face-to-face interviews with nurses about their current workflows to identify what could be done differently. This issue taught me how to adjust to the "new" way of doing things and afforded me different experiences to connect with the nurses.

As a practitioner, I saw that there was an issue with suicide, an issue that was reiterated by the site administrators, at the project institution. When thinking about addressing the issue of suicide, I became overwhelmed when trying to determine a project approach to address the problem. My mind was stuck on reducing suicide rates. After speaking with bedside clinicians at this hospital and researching the literature, I determined that staff needed a resource to help them care for the patients experiencing suicidal ideation, especially patients who were admitted with a medical diagnosis.

Providing the nurses with a resource to help in treating patients with suicidal ideation would enhance patient care and assist these professionals with care consistency, which can improve patient outcomes. This project sparked a flame within me to become a Psychiatric Nurse Practitioner in the future.

As a scholar, the research for this project has heightened my awareness of the skills and knowledge needed to manage patients with suicidal ideation(s). Researching was not one of my favorite things, but during this project, I learned to love and appreciate all the information that my searches revealed on this topic. The search skills acquired and the ability to translate the research into evidence-based practice will help me throughout my nursing career. As a scholar, the knowledge I obtained will allow me to educate others and improve nursing practice.

As a project manager, I learned time management regarding meeting deadlines. Time management became most crucial during this project when I needed the assistance of others to complete a task before moving on to the next. I had to ensure that I provided enough information about my project to the individuals I met with to gain insight or to those who provided me feedback. Strict deadlines are crucial in project management to achieve the final goal.

The completion of this project has taught me more than I anticipated. As mentioned above, I grew as a practitioner, scholar, and project manager, but I also grew as a human being. I found, through this project, that communication is golden, especially when encountering someone with suicidal ideation. The nurse must communicate with the patient when trying to identify if a patient is having thoughts of suicide, which can be

done using a validated screening tool (TJC, 2019). Once it is determined that the patient has suicidal ideation, the nurse must use an EB process to perform a suicide risk assessment to identify the severity of the suicidal ideations (TJC, 2019). The risk level for suicide and the plans for mitigating that risk should be documented where all clinicians can access the information (TJC, 2019).

A big challenge faced during this journey was the COVID-19 pandemic. The pandemic put the world on a halt for a while. At that moment, the need for the EB CPG I was creating increased. The emotional toll that COVID-19 put on people who had to isolate, quarantine, and seclude themselves from things they enjoy caused some to have feelings of hopelessness and thoughts of suicide (Islam et al., 2021; Varma et al., 2021). In addition to the emotional toll from COVID-19, loved ones were dying from this virus. The family could not spend the final hours with loved ones the way they may have wanted to due to the COVID-19 infection and the associated high level of communicability.

I assisted the local hospitals to ensure that nursing resources were not depleted by working extra hours in areas outside of my regular job assignment. The help needed from my peers and me was overwhelming as we took time away from our loved ones to help each other while caring for patients with COVID-19. As I provided professional help during the pandemic, I managed to maintain my home, as a single mother of three, and find the time to work on this project. I am grateful it has come to an end, not for myself, but for those who will benefit from the EB CPG, and for my family.

Summary

Inpatient suicide is a never event, meaning; it should never occur in a healthcare facility (Williams et al., 2018). Suicide can be prevented. The goal to address suicide is early identification of patients experiencing suicidal ideation and having the tools and resources available to treat those experiencing suicidal ideations adequately. As part of this project, a gap analysis identified a lack of a resource to guide nurses caring for a patient with suicidal ideation. This topic also hit home. My grandfather lost his life to suicide when I was a child, and at the time, I did not fully understand suicide. More recently, my oldest daughter expressed thoughts of suicide as a means of stress relief. Having this directly impact me as a mother and a nurse motivated me to develop this guideline so that my fellow nurses could help patients experiencing suicidal ideation. My search provided me with information to help me develop this EB CPG to assist nurses and provided me with information about assisting others outside of the nursing profession.

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Appendix A: Evidence-Based Clinical Practice Guideline

Title of Project: Treatment and Management of Patients with Suicidal Ideation for Nursing: A Clinical Practice Guideline

Introduction

This clinical practice guideline (CPG) has been developed by a student pursuing their Doctor of Nursing Practice (DNP). There is no funding source for this guideline because it is prepared as doctoral work. The information was gathered using Literature was obtained by electronic searches of databases such as CINAHL & MEDLINE Combined Search, PubMed, and Google Scholar. Search terms included a combination of the following terms: *inpatient suicide*, *medical-surgical unit*, *suicide prevention*, *nursing staff, psychosocial needs*, and *environment of care*. In addition to the literature search, I obtained information from professional websites such as the National Institute of Mental Health, The Joint Commission, the American Nurses Association, and the American Psychiatric Nurses Association. Using an evidence-based (EB), Appraisal of Guidelines, Research and Evaluation II (AGREE II) instrument that has established reliability and validity, controlled bias in the development of this CPG (Brouwers et al., 2010; Dans & Dans, 2010).

The guideline went through a formative evaluation by stakeholders, end-users, and experts, and changes were made based on the feedback received. The panel of six comprised a nurse educator, a nurse manager, a nursing director, clinical informaticists, and bedside nurses. There are no competing interests to disclose from this author or any of the panelist.

Objective

To establish a consistent process for screening, evaluation, and individualized patient care by staff who have been educated and trained on suicide prevention of patients, on the inpatient medical-surgical (M/S) unit, with risk for suicidal behaviors. Measurement of success from the impact of implementation will be determined by how prepared the M/S nurse will be while using the CPG.

Target Population

Nurses on the inpatient M/S unit caring for patients with suicidal ideation admitted to the M/S unit for treatment of their acute psychiatric/medical condition. Patients and the public are not included in the target population for this guideline.

Problem Statement

Will an EB CPG serve as a resource for nurses when providing care to patients, who are admitted to a M/S unit, who may be at risk for suicidal ideation?

Background and Significance

Suicide and suicidal ideation are high in the United States (U.S.) and is currently the tenth leading cause of death (Fazel & Runeson, 2020). The Joint Commission (TJC) identifies inpatient suicide as a sentinel event and states it should never happen (Williams et al., 2018). Suicide prevention is listed as a National Patient Safety Goal created to improve the quality and safety of individuals being treated for a behavioral health condition and those identified as being at risk for suicide (The Joint Commission, 2019). The total death rates by suicide for the Midwestern Region of the U.S. are higher compared to the national rates (Public Health Dayton and Montgomery County, 2019). The latest available rates in the Midwestern Region of the U.S. are 15.6 per 100,000 compared to 14.5 per 100,000 in the state and 13.8 per 100,000 in the U.S. (PHDMC, 2019).

Individuals admitted to the hospital with a medical diagnosis may have additional diagnoses that may need to be addressed while they are hospitalized. During hospitalization, the patient may experience suicidal ideation based on their admitting diagnosis or a new prognosis. When a patient is experiencing suicidal ideation, treating this issue is just as important as treating the admitting diagnosis. When suicidal ideation is present along with other disease processes, care of all comorbidities is vital to the patient's healing. Nurses play a major role in managing patients with suicidal ideation and/or patient's care after a suicide attempt (Gholamrezaei et al., 2019). When speaking with a nurse leader on the M/S unit, she indicated that many nurses in the M/S areas lack basic knowledge about the management of this patient population (B. Henderson, personal communication, April 23, 2019).

Nurses are at the forefront of patient's care when they come to the hospital for any reason and makes up the largest segment of the healthcare workforce in the U.S. (Avery et al., 2020). When patients are admitted for treatment of an acute medical condition after a suicide attempt, with suicidal ideation, or develops suicidal ideation during admission while being treated for a medical condition, they are best managed on a M/S unit versus a behavioral health unit (Blair et al., 2018). However, when patients are admitted to the M/S unit after a suicide attempt, the focus of their treatment is to manage their medical concerns and their general health. At the same time, their psychological well-being may receive minimal attention (Guptill, 2011). The risk for suicide is highest immediately after a failed attempt or shortly after admission to the hospital with a new diagnosis or poor prognosis (Guptill, 2011; Mitchell & Lackamp, 2018). There is also a high incidence of patients admitted to the M/S unit that receive a new diagnosis or a poor prognosis which can affect their feelings about wanting to live (Grimley-Baker, 2018).

Providing the nurses caring for this patient population with an EB CPG will help to better manage the care of these patients. The CPG will serve as a resource that the nurses can use to better recognize the symptoms of an impending suicide attempt and determine what interventions can be integrated into the patient's plan of care, benefiting the nurse, patient, and hospital.

Definition of Terms

One-to-One (1:1): Consists of one-to-one continual patient observation by staff that would allow for immediate intervention when required which assures safety for all (Kiley et al., 2020). Video monitoring should only be used in place of one-to one monitoring when it is unsafe for a staff member to be physically located in the patient's room. The staff member must be either a Registered Nurse (RN), Patient Care Technician (PCT), Mental Health Technician (MHT), or Safety Companion. This level of observation can be implemented by an RN or Licensed Independent Practitioner (LIP) but requires a LIP order to discontinue. The LIP is the attending physician or nurse practitioner.

Environmental Precautions: Identification of any item available to the patient, that may be harmful to the patient or may be used by the patient to harm themselves (Frost et al., 2020).

Protective Factors: Those factors, which safeguard people from the risks associated with suicide such as family/social support, cultural or religious beliefs, children, resilience, or future orientation (Huang, & Wang, 2019). These factors are important resources that the clinician can draw upon when working with a suicidal individual (Huang, & Wang, 2019).

Risk Factors: Anything that increases the likelihood that a person will attempt suicide including genetic or biological influences, personality traits, environmental factors, and psychiatric diagnosis (Huang & Wang, 2019).

Safety Companion: A member of the staff who has been trained and educated on the roles and responsibilities of providing one-to-one observation of patients (Wood et al., 2018). Family members cannot be assigned as observers/Safe Companions while the patient is hospitalized at this organization.

Suicide: The act or an instance of taking one's own life voluntarily and intentionally (Gholamrezaei et al., 2019).

Suicide Precautions: Suicide precautions are continuous interventions aimed at providing a safe environment for patients identified as exhibiting suicidal behavior and/or ideations (TJC, 2019).

Suicide Risk Assessment: A comprehensive assessment of risk factors and protective factors of each patient completed by staff during face-to-face preadmission assessment, that can be indicative of the patient's risk for suicide and the need for closer monitoring or increased clinical resources (TJC, 2019).

Part I – Screening and Assessment	Recommendation	Level of Evidence/ Quality ratings	Comments	Source of Evidence
1. Screening completed by the admitting nurse using the Columbia-Suicide Severity Rating Scale (C-SSRS) tool Screening occurs during the nursing admission assessment for patients admitted to a non-behavioral health location.	Strongly Recommended Recommended Strongly Recommended Conditionally etc.	Level IV	The C-SSRS screening tool is located in the electronic health record (EHR) in the admission navigator under the section titled “Safety Screen.” Also, in Appendix B	Grant & Lusk, 2015 Roaten et al., 2018
Positive Screens: 1. For patients who screen positive during the initial screen, the C-SSRS Frequent Screener Tool is completed every shift and/or with a change in condition. 2. This tool is used to determine if the patients suicide risk level is staying the same, improving, or getting worse.	Strongly Recommended	Level IV	The C-SSRS Frequent Screener Tool is located in the EHR on the assessment flowsheet under the group titled “Frequent Safety Screener”. Also, Appendix C This tool will only appear on the assessment flowsheet if the patient screens positive on the C-SSRS.	Grant & Lusk, 2015
Unresponsive Patient: 1. If a patient cannot respond, i.e., unconscious, and the reason for the patient being brought to the hospital suggests a suicide risk, the screen is conducted using the C-SSRS tool when the patient is conscious and can participatein the screening process.	Strongly Recommended	Level III	The C-SSRS screening is deferred until the patient is medically stable and cognitively able to answer questions.	Pumariega et al., 2020

During Admission: At any time during admission for a non-behavioral health chief complaint, patients that express suicidal/self-injurious ideation, homicidal ideation, or the caregiver believes there are reason that screening needs to take place, the patient should immediately be screened using the C-SSRS tool, and appropriate interventions implemented.	Strongly Recommended	Level IV	The nurse shall perform the initial screening of the patient using the same C-SSRS screening tool that is used on admission regardless of how many days the patient has been in the hospital when suicidal ideation is expressed or perceived.	Roaten et al., 2018
Part II Implementation				
Referral for Comprehensive Assessment: Referrals are made for any patient who screens positive, or if, in the nurse's clinical judgment based on statements and/or behaviors determines a patient is at risk for suicide.	Strongly Recommended	Level IV	The nurse shall contact the physician for additional orders. Appropriate interventions are implemented as indicated based on the level of risk indicated and physician orders.	Grant & Lusk, 2015
Positive Screening: 1. Upon a positive screen for high risk of suicidality, the nurse shall initiate one-to-one (1:1) observation by assigning a safety companion to the patient and notify the physician. The patient shall remain in an appropriate level of supervision until collaborative decision making can be made with the LIP.	Strongly Recommended	Level V Level V Level V	The safety companion (any staff member who has been trained to monitor suicidal patients and has maintained annual competency through the online learning module) will immediately notify the nurse of any negative changes in patient's affect, behavior, cognition, and compliance with the safety interventions, listed in Part III of this guideline, throughout 1:1 observation.	Liberatore, 2019 Navin et al., 2019 Smith, 2018

2. Implement environmental precautions by removing all items (if possible) with the potential to harm. Complete the environment of care checklist (See Appendix D).	Strongly Recommended	Level V Level III Level V Level V Level V	The environment of care checklist is completed at each change of shift, any change in staff, or visitor leaving.	Liberatore, 2019 Liberatore & Rose, 2019 Navin et al., 2019 Smith, 2018 Watts et al., 2017
3. Implement suicide precautions interventions based on the patient's risk level (See Appendix E). This includes but is not limited to; the provision of behavioral health safe attire, hospital-issued socks, and underwear (if they choose to wear), and the removal of all personal belongings.	Strongly Recommended	Level IV Level III	Reassure the patient that their belongings are secure and will be returned. Undergarments and religious clothing and accessories will be inspected for safety/hazards and may be returned at the discretion of the care team (consider risk for safety). Communicate initiation of suicide precautions to all team members.	Knesper, 2011 Liberatore & Rose, 2019
4. Once confirmed as suicidal, a care plan is created in the EHR, and the patient is monitored according to hospital policies for suicidal patients.	Strongly Recommended	Level V Level I	The hospital policy indicates that: Interventions for safety are of primary importance for all patients. The goal is to provide protection for the patient in the least restrictive environment that allows for necessary levels of observation by staff. All patients who screen positive for suicidal ideation are placed on close observation and/or suicide precautions on admission. The registered nurse or physician may order an increased level of observation if necessary. The patient is then placed on 1:1 observation. Physician orders are required to discontinue or decrease any level of observation.	Navin et al., 2019 Stanley et al., 2018

Part III Discharge				
Once Medically Cleared: 1. Those patients who are assessed by a physician and meet criteria for inpatient mental health care, may be admitted to the Behavioral Health Unit using the criteria for emergency involuntary hospitalization hold pursuant to Ohio law, or they may be admitted voluntary.	Strongly Recommended	Level V Level I	The nurse shall oversee the gathering of all patients' belongings and removal of any medical apparatuses prior to transfer to the Behavioral Health Unit. Finalize all documentation related to this patient's inpatient encounter including medication administration, safety monitoring, care plans, and restraint documentation if utilized.	Holleran et al., 2019 Stanley et al., 2018
2. Those patients who are assessed by the physician and do not meet criteria for inpatient mental health care, will be provided with resources for outpatient referral at discharge and an individualized safety plan. This will be arranged by the patient's case manager.			The National Suicide Prevention Lifeline number: 1-800-273-TALK (8255) and/or the regional crisis hotline numbers are provided to all patients on discharge. Crisis Text Line provides free, 24/7 support via text messaging. Individuals can text 741741 from anywhere in the U.S. and get connected to a trained volunteer crisis counselor.	

Guideline Monitoring – In alignment with the organizations policy review schedule, this guideline will be reviewed every three years by the System Nursing Director of Professional Practice, System Chief Nursing Officer, Clinical Informaticist, and the Exemplary Professional Practice Committee. This review schedule aligns with what evidence states regarding updating clinical practice guidelines (Kredo et al., 2016; Vernooij et al., 2014).
The next review of this guideline will be due on March 1, 2025.

Appendix B: Safety Screen + C-SSRS

1) Do you feel like harming yourself or other? (*multi-select: if self is selected proceed with assessment despite other direction)*
   No-*Stop Assessment*
   Self-*Answer Questions 2 and 3*
   Others-*Stop Assessment*

2) In the past month, have you wished you were dead or wished you could go to sleep and not wake up?
   Yes-*Low Risk*
   No

3) In the past month, have you had any actual thoughts of killing yourself?
   Yes-*Go to Question 4*
   No-*Skip to Question 7*

4) In the past month, have you been thinking about how you might kill yourself?
   Yes-*Moderate Risk*
   No

5) In the past month, have you had these thoughts and some intention of acting on them?
   Yes-*High Risk*
   No

6) In the past month, have you taken any steps toward making a suicide attempt or preparing to kill yourself?
   Yes-*High Risk*
   No

7) In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?
   Yes-*Answer question 8*
   No

8) Was this withing the last 3 months?
   Yes-*High Risk*
   No-*Moderate Risk*

9) C-SSRS Risk Level (*Select the most severe risk level of all questions asked on Safety Screen + C-SSRS Screening Tool*)
   Low
   Moderate
   High

Appendix C: Frequent Safety Screener

1) Have you actually had thoughts about killing yourself?
   Yes-*Go to Question 2*
   No-*Low Risk; Skip to Question 5*

2) Have you been thinking about how you might do this?
   Yes
   No-*Moderate Risk*

3) Have you had these thoughts and had some intention of acting on them?
   Yes-*High Risk*
   No

4) Have you started to work out or worked out the detail of how to kill yourself? Do you intend to carry out this plan?
   Yes-*High Risk*
   No

5) Have you done anything, started to do anything, or prepared to do anything to end your life?
   Yes-*High Risk*
   No

6) Frequent Safety Screener Risk Level (*Select the most severe risk level of all questions asked on Frequent Safety Screening Tool*)
   Low
   Moderate
   High

Appendix D: Environment of Care Checklist

1) Potentially Harmful objects out of patient reach?
   Yes
   No

2) Personal belongings secured?
   Yes
   No

3) Patient dressed in hospital-provided attire only?
   Yes
   No

4) Plastic bags out of patient reach?
   Yes
   No

5) Patient care equipment (cords, cables, call bells, lines, and drains) shortened, removed, or accounted for?
   Yes
   No

6) Potentially toxic materials removed or secured?
   Yes
   No

7) Sharps container removed or secured?
   Yes
   No

8) Cabinets secured?
   Yes
   No

Appendix E: Interventions Based on Risk Level

Low Risk:

- Environmental/room checks
  - Complete the environmental risk assessment and remove all items that could be used for self-harm. The checklist is to be completed by the PCT or RN at change of shift, change of staff, or visitor leaving.
- Place the patient in hospital approved paper scrubs
- Check the patient to ensure they do not have any contraband on them.
- Encourage use of coping skills such as social-emotional support, humor, venting, religion, distractions, formulation of crisis management plan, instilling hope, or drawing on things that have worked for the patient in the past (Solano et al., 2019; Smith, 2018).
- Provide support/establish therapeutic rapport with patient.
- Place on elopement precautions to alert others to the risk of patient leaving the hospital against medical advice.
- The nurse will inspect any items being brought to the patient's room to ensure that items that can be used by the patient to harm themselves is not taken into the room (ex. Pop cans, medications, or any weapons). Items that could be used to potentially cause harm will not be permitted.
- Nursing staff to accompany patient to any off-unit testing and ensure patient remains in direct line of sight.
- Instruct patient to let staff know if they feel like harming themselves.
- 1:1 supervision is required when patients are using dangerous hygiene products (razors, etc.).
- Use of disposable utensils
- Individualized safety plan that the nurse and the patient develop together to verbalize how each person will ensure safety.

Moderate Risk:

- Place the patient in a hospital room close to the nurses' station with continuous video monitoring.
- Document observed patient behaviors at least every 15 minutes or with change in behavior on the "Safety Companion" flowsheet. This can be done by the RN or PCT.
- Perform mouth checks with medication administration to ensure patient is not pocketing medications in the mouth.
- Evaluate appropriateness of phone privileges by discussing with physician.
- Communicate risk status to ancillary staff who enter unit to ensure that they keep the patient and themselves safe.
- All visitors must report to the nurse's station prior to entering the patient room.

- Provide finger foods so that the patient does not need heavy duty utensils which could be used for self-harm.
- Follow all the low-risk interventions listed above

High Risk:

- 1:1 direct observation always (Video monitoring when unsafe for staff member to be physically located in the room).
  - Must accompany patient to the bathroom.
- Limit visitors until cleared by provider and/or crisis worker.
- Follow all the low and moderate risk interventions listed above

Appendix F: AGREE II Survey Results

AGREE II Domains	AGREE II Criteria	Survey Respondent						Total	Domains Quality Score
		#1	#2	#3	#4	#5	#6		
Domain 1. Scope and Purpose	1. The overall objective of the guideline is specifically described.	7	6	7	7	7	7	6.8	98.9%
	2. The health question covered by the guideline is specifically described	7	7	7	7	7	7	7	
	3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	7	7	7	7	7	7	7	
Domain 2. Stakeholder Involvement	4. The guideline development group includes individuals from all relevant professional groups.	6	4	6	7	2	7	5.3	86.7%
	5. The views and preferences of the target population (patients, public, etc.) have been sought.	7	6	7	7	4	7	6.3	
	6. The target users of the guideline are clearly defined.	7	7	7	7	7	7	7	
Domain 3. Rigour of Development	7. Systematic methods were used to search for evidence.	7	4	7	7	1	7	5.5	88.3%
	8. The criteria for selecting the evidence are clearly described.	7	6	7	7	5	7	6.5	
	9. The strengths and limitations of the body of evidence are clearly described.	7	5	7	7	2	7	5.8	
	10. The methods for formulating the recommendations are clearly described.	7	4	7	7	4	7	6	
	11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	7	7	7	7	6	7	6.8	
	12. There is an explicit link between the recommendations and the supporting evidence.	7	7	7	7	7	7	7	

	13. The guideline has been externally reviewed by experts prior to its publication.	6	6	7	7	2	7	5.8	
	14. A procedure for updating the guideline is provided.	7	7	7	7	7	7	7	
Domain 4. Clarity of Presentation	15. The recommendations are specific and unambiguous.	7	7	7	7	7	7	7	100%
	16. The different options for management of the condition or health issue are clearly presented.	7	7	7	7	7	7	7	
	17. Key recommendations are easily identifiable.	7	7	7	7	7	7	7	
Domain 5. Applicability	18. The guideline describes facilitators and barriers to its application.	7	5	7	7	2	7	5.8	78.7%
	19. The guideline provides advice and/or tools on how the recommendations can be put into practice.	7	3	7	7	7	7	6.3	
	20. The potential resource implications of applying the recommendations have been considered.	7	3	7	7	1	7	5.3	
	21. The guideline presents monitoring and/or auditing criteria.	7	4	7	6	2	7	5.5	
Domain 6. Editorial Independence	22. The views of the funding body have not influenced the content of the guideline.	7	4	2	7	7	7	5.7	74.2%
	23. Competing interests of guideline development group members have been recorded and addressed.	6	4	7	6	1	7	5.2	
Overall Guideline Assessment	24. Rate the overall quality of this guideline	7	6	7	7	6	7	6.7	95%
	25. I would recommend this guideline for use	Yes	Yes	Yes	Yes	Yes	Yes		
Total		6.9	5.5	6.8	6.9	4.5	7	6.3	88.3%