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Staff Education to Improve Nurses' Knowledge and Confidence in Suicide Risk Assessment

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Sherica Nicole McBride

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Executive Summary: Staff Education Project
Staff Education to Improve Nurses' Knowledge and Confidence in Suicide Risk
Assessment

by

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Summary

The purpose of this Doctor of Nursing Practice staff education project was to strengthen nurses' knowledge and confidence in suicide risk assessments. Suicide remains a crucial patient safety issue, and nurses report uncertainty in early recognition and intervention; therefore, brief, practice-proximal training is essential. The practice-focused question that informed this project's purpose was whether a short education module with pre- and posttesting improves nurses' knowledge and confidence in suicide risk assessment. Three nurses participated in a structured session covering risk factors, warning signs, standardized screening, and safety planning. I then used descriptive analysis to compare their pre- and posttest scores and self-reported confidence ratings. Findings showed clear, short-term gains: Participants' mean knowledge scores increased from 60% on the pretest to 90% on the posttest, and their self-rated confidence rose similarly, suggesting that even a concise, practice-proximal education module can improve nurse readiness to screen and respond.

The project included the education module and a brief testing tool to track participants' knowledge and confidence. My recommendations to leadership are to institutionalize periodic refresher training; embed universal suicide-risk screening and safety-planning prompts into workflows; and monitor implementation, such as completion rates and documentation quality, to sustain gains over time. The project's implications for nursing practice include more consistent, earlier identification of risk and clearer escalation pathways. Regarding positive social change centered on diversity, equity, and inclusion, the project promotes equitable access to suicide prevention by

normalizing universal screening and encouraging culturally responsive safety planning for diverse patient populations.

Background

Nurses are often the first clinicians to detect suicide risk, yet variability in screening practices and low confidence persist, creating a clear practice gap (Chicoine et al., 2023). National drivers underscore the need for standardized, competency-based training. The Joint Commission's (n.d.) standards call for validated screening and staff-training or competence assessment, while the 2024 U.S. National Strategy for Suicide Prevention prioritizes workforce preparation across care settings (U.S. Department of Health and Human Services [HHS], 2024).

This project addressed this gap through the following practice-focused question: Does staff education with pre- and posttests improve nurses' knowledge and confidence in suicide risk assessment? The purpose was to deliver a brief, evidence-informed module to nurses and evaluate their immediate learning. This approach aligns with guidance to embed practical training on warning signs, use of validated tools, and safety planning within routine nursing workflows (see Cramer et al., 2019; HHS, 2024).

Current evidence supports education as an effective lever for change. A recent systematic review and meta-analysis of simulation-based suicide-prevention training among nurses, covering 96 randomized and nonrandomized controlled trials and pre-/posttest studies and involving over 43,000 participants, found consistent improvements in attitudes immediately after training and at 2–4 months as well as in self-perceived skills up to 6 months after training (Richard et al., 2023). However, the researchers also

noted that the effects on factual knowledge among the nurses were mixed, and patient-outcome data remained limited (Richard et al., 2023).

Similarly, a pre- and posttest pilot study involving 54 nurses in a tertiary hospital conducted by Saini et al. (2020) demonstrated that a brief, 2-hour education program significantly improved knowledge, clarified myths, and increased confidence and perceived competence in identifying suicidal patients and initiating appropriate referrals. The intervention also used paired comparisons and emphasized a feasible, workflow-conducive delivery (Saini et al., 2020).

In parallel, Ee et al. (2020) situated clinician education within an integrative collaborative care model that embeds clear, written protocols for triaging psychiatric emergencies (including suicide-risk assessment) and explicitly called for ongoing training and skills updates for all team members. They identified provider education, patient education, and systematic follow-up as core components that enhance early identification and consistent intervention. Outcomes synthesized by the researchers indicated that the collaborative care models within which these educational elements are embedded are more effective than usual care across multiple mental health conditions and may reduce disparities in healthcare access and outcomes. These findings suggest that structured education is a viable mechanism for standardizing risk recognition and assessment, promoting timely and coordinated intervention across diverse clinical settings.

The overall strength of evidence is high. Evidence from quasi-experiments, systematic reviews, and meta-analyses consistently shows short-term gains in knowledge and self-efficacy among nurses in the identification of and response to patients' suicide

risk following education, with convergent results across different settings and methodological designs.

Staff Education Project Development

In this project, three staff nurses participated in a brief, single-session education module. Each completed a pretest; engaged with scenario-based instruction, including role-prompted responses and clinical vignettes; and completed a posttest. The module targeted practical competencies reflected in the test blueprint and appendices, recognizing warning signs and myths, using a validated screener—the Columbia-Suicide Severity Rating Scale (C-SSRS; see Posner et al., 2008), documenting per policy, and sequencing next steps after disclosure.

Evidence comprised participants' paired knowledge scores (i.e., pre- and posttests) and a brief self-efficacy checklist. Knowledge scores were recorded immediately before and after instruction. I used a simple pre- and posttest (i.e., before-and-after) comparison, which was appropriate to the project's small, focused scope and quality improvement intent and in line with workforce training evaluations in the literature (see Labouliere et al., 2021). Proficiency was captured via several short pre- and posttests aligned with key tasks, such as recognizing warning signs, administering the C-SSRS instrument, documenting assessments, de-escalating, and making timely referrals. Self-efficacy was captured via a short Likert instrument. I did not plan or conduct any inferential testing.

I assessed the effectiveness of the education initiative on two predefined criteria: (a) an absolute or relative knowledge gain evident in the pre- and postscore improvement and (b) an increase in the median self-reported confidence or readiness to act. These

criteria mirror the clinician education-readiness workflow and evaluation practices, from screening to documentation and safety planning, outlined by Sparkman-Key et al. (2023).

Results

Immediately after the education session, the participants' ($N = 3$) aggregate knowledge increased by 30 percentage points, from a mean pretest of 60% to a mean posttest of 90%. This result indicates a clear short-term learning effect (see Figure 1 and Table 1). Participants' confidence in suicide risk assessment likewise increased on the posttest. Although baseline confidence ratings were captured, posttest self-efficacy scores were uniformly high across all tested domains, registering in the 4–5 range on a 5-point Likert scale for recognizing warning signs (see Table 1), administering the C-SSRS screener, documenting per policy, de-escalating, and connecting patients to crisis resources, consistent with improved readiness following training.

Table 1*Knowledge Outcomes and Posttest Self-Efficacy*

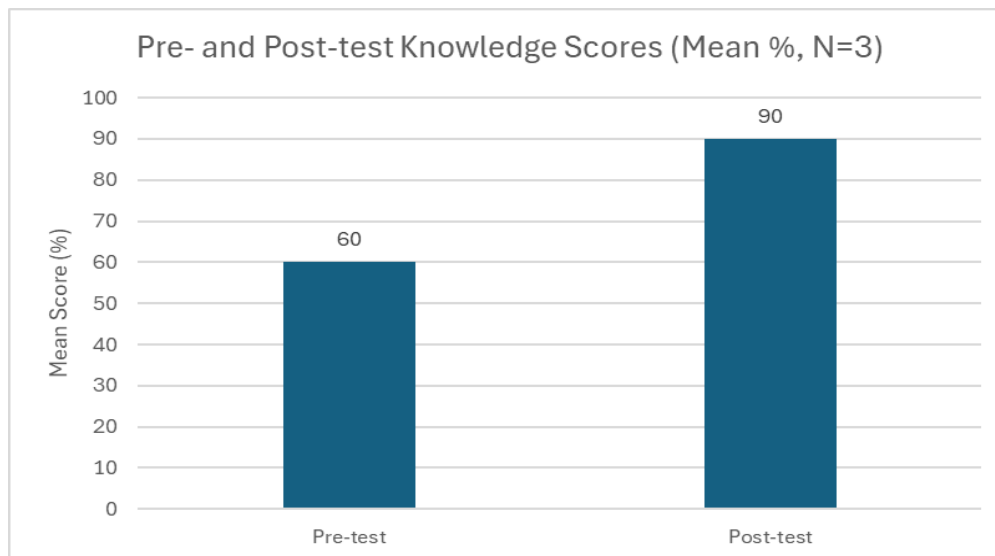
Measure	Pretest	Posttest	Change
Knowledge test (mean % correct)	60	90	+30 pts
Self-efficacy: Recognize warning signs (1–5)	-	4.67	-
Self-efficacy: Administer C-SSRS (1–5)	-	4.33	-
Self-efficacy: Document per policy (1–5)	-	4.00	-
Self-efficacy: Use de-escalation (1–5)	-	4.33	-
Self-efficacy: Connect to resources (1–5)	-	4.67	-

Note. Knowledge means and change reflect local pre- and posttest results ($N = 3$). Self-efficacy values are posttest averages across five domains; baseline self-efficacy and confidence were not captured or retained. Data source: Project knowledge tests and self-efficacy ratings.

The direction of change is aligned with the project’s overarching intent: Focused staff education produced immediate gains in participant knowledge and perceived ability to act. Locally, this change translates to staff reporting greater preparedness to (a) recognize and verify warning signs using a validated screener, (b) document risk and protective factors and the plan of care, and (c) initiate escalation and referral steps. These shifts support safer frontline practice by standardizing “what to do next” after disclosure and building a common vocabulary around risk levels and documentation requirements. Thus, the unit has an education-supported baseline for universal screening and safety planning that can be reinforced in routine huddles and onboarding.

Figure 1

Pre- and PostTest Knowledge Scores (Mean %, N = 3)



Averaged across participants, the posttest self-efficacy scores were recognizing warning signs (4.67), administering the C-SSRS (4.33), documenting per policy (4.00), using de-escalation techniques (4.33), and connecting patients to crisis resources (4.67). These values triangulate with the participants' open-ended posttest responses, which consistently named immediate safety, C-SSRS-based risk assessment, and prompt provider involvement as first-line actions and identified clear documentation elements, such as risk level, risk and protective factors, and plans of care.

The high posttest self-efficacy scores are a crucial indicator that nurses will perform these steps under time and contextual pressures. Confidence in recognizing warning signs, using the C-SSRS, documenting per policy, de-escalating, and linking to resources translates into higher screening frequency; faster escalation; and more complete, defensible documentation, reducing missed cases and care variability. Organizationally, the project strengthens compliance with safety standards, improves

handoffs and continuity, and lowers risk exposure. For patients, reliable screening and prompt referrals shorten time to intervention and support safer transitions of care. Since confidence was strong across domains, the module is suitable for onboarding and annual competencies, promoting equitable, consistent practice across shifts and experience levels.

These patterns align with the current evidence base. Ee et al. (2020) positioned provider education as a core element of collaborative care that improves recognition and follow-through. Saini et al. (2020) reported pre- and posttest gains in clinician knowledge and readiness after brief, structured training. Likewise, Richard et al. (2023) documented short-term improvements. Consistent with these studies, this project's results show an immediate benefit while echoing the caveat that durability and patient-level outcomes require follow-up measurement.

However, the results should be interpreted cautiously. The small convenience sample ($N = 3$) limits generalizability and prevents inferential testing. Only immediate posttest outcomes were captured, and I did not assess the longer-term retention of knowledge and skills as well as impacts on clinical behavior, such as screening completion rates and the quality of safety plan documentation. Additionally, confidence ratings were self-reported and susceptible to social desirability bias and testing effects, particularly in a brief, one-group, pre- and posttest design (see Bernardi & Nash, 2023). Finally, item wording in the pretest suggests variability in prior knowledge, such as uncertainty about first steps and correct screening, which may inflate apparent gains due to the correction of misconceptions rather than deeper skill acquisition. Collectively,

these constraints emphasize the need for follow-up measurement, periodic refreshers, and implementation audits to sustain or verify effects over time.

In broader contexts, suicide prevention is a global patient safety priority, and brief, competency-based education that standardizes screening and first response steps is transportable to other ambulatory and inpatient settings where nurses are frequently the first point of contact. This project offers a replicable micromodel, entailing a short education module, pre- and postassessments, and workflow-aligned content, which can be embedded into onboarding and annual competency training. Broader dissemination would support workforce readiness, reduce missed opportunities for risk detection, and contribute to more equitable access to evidence-based prevention, especially in understaffed or high-throughput environments (see Saunders et al., 2021).

As the project site unit scales training, leaders could add run-chart monitoring for screening completion and safety plan documentation, integrate brief scenario drills into huddles, and schedule refresher modules at 6–12 months to reinforce skills and assess retention. These pragmatic steps would convert a one-time educational boost into a maintained practice standard.

Conclusions

This brief staff education project delivered measurable improvements relevant to organizational practice. Immediately after implementation, nurses demonstrated higher knowledge, evident in a mean increase from 60% to 90%, and stronger self-efficacy in core tasks, such as recognizing warning signs, administering a validated screener, documenting according to policy, de-escalating, and linking patients to resources. Beyond test scores, the unit now shares a clearer, standardized first response sequence

after risk disclosure, improving internal consistency, handoffs, and readiness to escalate care. These outcomes advance local compliance with safety expectations, including validated screening protocols and documented competencies, and align with national prevention priorities that emphasize workforce preparation across care settings (see HHS, 2024; Joint Commission, n.d.).

To consolidate and extend these gains, I have developed several recommendations. First, the organization should scale the module to all unit nurses and incorporate it into onboarding and annual competencies. Second, it should integrate decision support into documentation (as seen in the C-SSRS prompts; see Appendix A) to embed the appropriate next steps in the workflow. Third, the organization should monitor simple process indicators on a run chart, such as screening completion, timelines of risk verification, and the presence and quality of safety plan documentation, to sustain improvement and identify drift. Additionally, it can schedule annual or biannual short refreshers to protect against skill delay and adopt a “train-the-trainer” approach to create local capacity, pairing coaching with brief observational audits to reinforce the fidelity of the materials. Finally, the organization should plan a pragmatic follow-up evaluation schedule that adds behavior and outcome measures, including but not limited to screening rates, appropriate referrals, and read-through of documentation, to complement the immediate learning results.

The project’s implications for nursing practice are direct. Standardized education reduces variability, provides nurses with a common language for risk assessment, and clarifies when and how to escalate, strengthening clinical judgment under time pressure (Ee et al., 2020). The resulting confidence and shared procedure support safer bedside

decisions and more complete, defensible charting. Interprofessionally, a consistent assessment pathway facilitates collaboration with physicians, behavioral health specialists, and case management, shortening time to intervention and smoothing care transitions. The project's low resource demands, entailing a single module, aligned tools, and simple measures, make it feasible for busy units and portable to diverse care settings.

Finally, positive social change, diversity, equity, and inclusion are central to this approach. Universal screening counters implicit bias by making risk assessment routine for all patients, not only those who appear high-risk. Education that emphasizes culturally responsive communication, language access, and inclusive safety planning can better meet the needs of populations with disproportionate suicide burden, including racial and ethnic minorities; lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual/aromantic/agender plus individuals; and people in rural and resource-limited contexts. Embedding clear, equity-minded prompts in documentation and decision support helps ensure that protective factors, culturally relevant supports, and patient preferences are captured consistently. In doing so, this Doctor of Nursing Practice project advances equitable access to evidence-based suicide-prevention strategies and contributes to a broader culture of safety in healthcare settings (see HHS, 2024).

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